# Lessons for the Living: The Use of Religious Resources in the Care of the Dying and Bereaved

Jennie English

Senior Religion Thesis

Gustavus Adolphus College

Of all the wonders that I yet have seen,
It seems to me most strange that men should fear
Seeing that death, a necessary end,
Will come when it will come.

Shakespeare, Julius Caesar

While death cannot be doubted to be "a necessary end," people do fear its arrival in their lives, whether it be their own death or the death of a loved one. Perhaps no other aspect of life is more written about, thought about, and feared than its end. Human beings constantly ask questions about what will happen after death. Will there be an afterlife? Is there reincarnation? Will we simply cease to exist? These difficult questions and the fact that they do not have a knowable answer plague human life continually. When faced with the death of a loved one or with one's own death, these questions become stronger and more urgent, even for those with clear beliefs about death.

Along with these rather philosophical questions exist more basic questions, such as, will I/my loved one feel pain? Have I/my loved one lived a full life? Am I/is my loved one dying with respect and dignity? These questions are equally valuable to the dying person and their loved ones. Yet, unlike the philosophical questions above, these questions are often not addressed in our current society. Secular society's avoidance of questions dealing with the reality of death is often attributed to an attitude of death-denial in American society. While a consensus does not exist on whether Americans are death-accepting or death-denying, a convincing argument can be made for the latter.[1] The hesitation to talk seriously about death, the inability to understand why

[1] Discussion found in Richard G. Dumond and Dennis C. Foss. *The American View of Death: Acceptance or Denial?*, (Cambridge: Schenkman Publishing Company, Inc., 1972).

people would want to work in professions which constantly expose them to death, and even the common avoidance of the word "death" all demonstrate the extreme American discomfort with death and death related subjects.

This attitude of discomfort greatly affects the way people go through the processes of dying and grieving. It has also prevented the development of resources for aiding people in these processes. For this reason many people have turned to religious resources. Religion, specifically Christian religion in America for the purposes of this paper, offers many resources for dealing with dying and bereavement. These include spiritual support, religious ritual, and pastoral care.

Current American attitudes and views concerning death are quite different than they were one hundred years ago. Advances in medical technology have led to extended life spans; as people live longer, the average person is exposed to death less often. This lack of exposure has been one explanation for the attitude of death-denial in America. Exposure to death tends to increase one's thinking about one's own mortality. When individuals are not frequently faced with the reality of death, its existence becomes easier to deny. Then when confronted with the death of a loved one or the self, Americans are thrust into an experience with which they have very limited experience. Our society must become more comfortable talking about death issues so that people may begin to understand death and the feelings surrounding death before it affects them directly and personally.

Although an effort has been made in recent years to better address the issues of death, society's avoidance and discomfort with the issue of death still manifests itself in many ways. For example, when a family member dies, the bereaved are usually given

time off of work to attend the funeral and see to family matters. When they return a consolation card from co-workers may be waiting and they may receive many sympathetic inquiries about their well-being. Within a week, however, they are usually expected to be "over it" and functioning as well as before back on the job. A similar attitude is seen at the funeral. People tend to have great respect for those who are able to "hold up well" at the funeral of a loved one. Those who cry continually, "break down," or scream are generally frowned upon. Great respect is given to the griever who remains completely in control of his/her emotions.

Another example of the avoidance of the reality of death is seen in Deanna Edwards' statement, "In America people never die and they never cry."[2] The bereaved are not given free reign to show their emotions and other mourners are careful not to say the word "died" or "death." The person in question has "passed on" or "gone to rest." Mourners do not want to face the bereaved with the fact that the loved one is, in fact, dead. However, these actions merely serve the desire of society to avoid dealing with the uncomfortable issue of death. They do not serve the purposes of the grieving individuals. This forced stoicism and denial of the reality of death are often not the best way for people to progress through the healing process, as we shall later see.

Traditionally the medical field has also contributed to the attitude of death avoidance, despite an attempt in recent years to be more sensitive to the dying. The purpose of medicine is to keep people alive; for this reason it traditionally rarely helps them to die. Death denial in the medical community is exemplified in the large number of people who are treated in vain in institutions where they eventually die, debates over

---

[2] Deanna Edwards, *Grieving: The Pain and the Promise*, (American Fork, Utah: Covenant Communications, Inc., 1989), 81.

continued life support and the "right to die," and the tendency of some medical practitioners to do whatever is in their power to save a patient, despite protestations from family members. With this medical denial of death, patients who are dying are often unable to have certain needs met. People are often unable to die in their own homes, get facts from their doctors about their impending death, or receive the personal care they need and want during this difficult time.

Another example of medical professionals' discomfort with death is found in a study done by Richard Kalish. Kalish timed nurses' response times to patient calls. Nurses were repeatedly found to respond more slowly to patients who were dying than to those who were improving. Kalish hypothesizes that this may be due to nurses' unconscious desire to avoid death.[3] The ability of medical professionals to overcome this common discomfort with the topic of death is necessary in order for patients to have their dying needs met.

Thus, the needs of the dying and grieving often go unmet due to society's death-denial. For this reason people are turning to religious resources to help them through these processes. Religious resources have been proven to be effective coping devices for dealing with life stresses. For example, Kenneth Maton has done a study which found perceived support from God to be positively correlated with self-esteem and negatively correlated with depression in recently bereaved parents. Spiritual support was also shown to be positively related to the personal-emotional adjustment of college freshman under high life stress.[4] David Balk found that religion was an important factor for bereaved adolescents coping with the death of a sibling. He noted that the

---

[3] In Dumont and Foss, p. 38.

[4] Kenneth I. Maton. "The Stress-Buffering Role of Spiritual Support: Cross-Sectional and Prospective Investigations," *Journal for the Scientific Study of Religion* 28 (1989): 310-323.

use of religion as a coping device increased as bereavement continued.[5] He did not find, however, that having a strong faith erases the pain of grief. The dying and grieving experience pain and have needs. The role of religious resources is to help them cope with their pain while still being allowed to experience it, and to help meet other needs.

In the development and use of these resources several questions must be asked. What are the needs of the dying and grieving persons? How are Christian religious resources meeting these needs? In what ways can religious resources better meet these needs? These questions can be asked about the person who is dying, watching a loved one die, or who is grieving. These questions and their answers will show how religion provides effective coping devices for dying and bereavement and will also present new possibilities for pastoral care.

## The Needs of the Dying

We have seen how the needs of the dying are often ignored in this death-denying society. While physical needs are obvious, non-physical needs are easier to ignore. Yet, some of their greatest needs are not physical; needs can also be psychological, emotional, financial, social, and/or spiritual.[6] Since the medical profession's goal is to keep the patient alive, they are often at odds with helping the patient to die. For this reason the medical profession alone cannot meet all the needs of the dying patient. Resources for handling these non-physical needs must be found elsewhere. Religion provides many resources, such as, spiritual support, religious ritual, and pastoral care,

---

[5] David E. Balk. "Sibling Death, Adolescent Bereavement, and Religion," *Death Studies* 15 (Jan.-Feb. 1991): 1-20.

[6] John Morgan, ed., *Personal Care in an Impersonal World: A Multidimensional Look at Bereavement,* (Amityville, New York: Baywood Publishing Co., 1993), 23.

which all help meet the needs of the individual so s/he may die with dignity.

In order to meet the needs of the dying, one must first understand what those needs are. Elisabeth Kubler-Ross' book On Death and Dying is the authoritative source on the psychological process of dying. Kubler-Ross conducted seminars on death and dying for medical students, nurses, chaplains, and other interested persons, in which she interviewed dying patients. The seminar participants hoped to learn what the experience of dying was like from the patients themselves. In the process of these interviews Kubler-Ross detected five stages experienced by most dying people. Each of these stages has its own aspects, needs, and ways of being worked through. Knowledge of these stages and their characteristics will help to see how religious resources can address the needs of the dying.

Kubler-Ross does not describe the stages of dying as a firm pattern through which all patients move in a predictable manner. Each patient will spend a different amount of time in each stage, one stage may be replaced by another, and stages may exist side by side.[7] She offers this model as a general, systematic way of explaining the patients' needs and wants at different times in the dying process. There are also several overriding needs she describes. One of these is the patient's need to know the truth about his/her condition. Many doctors will try to protect the patient by not revealing the seriousness of the disease. However, Kubler-Ross explains that the patient often knows s/he is dying, even without direct word from the physician. The patient must be informed of the truth in a sensitive manner, one which is considerate of the patient's feelings and situation, and which also offers some sense of hope. This hope is the

[7] Elisabeth Kubler-Ross, *On Death and Dying*, (New York: Macmillian Publishing Co., 1969),138.

second overriding need. The third is that of a caring, listening presence.

Once the patient has met the first need and heard the truth concerning his/her condition, s/he enters the first stage of dying, denial. Perhaps due in part to our death-denying society, the first reaction of most patients is that there must be some mistake. This denial period lasts for different lengths of time for different individuals, ranging from hours to months. A certain amount of denial is actually healthy. Denial serves as a defense mechanism which allows the patient to protect him/herself from having to deal with the shocking news all at once. Denial becomes unhealthy when the patient never abandons it to proceed through the other stages. One who never deals with the reality of one's own death will never reach a state of acceptance which allows dignity in death.

The greatest need of the patient in this first stage is to be allowed to experience denial. The patient must feel free to deal with the shocking news on his/her own terms and in his/her own time. Denial should not be encouraged, yet, the patient should not be constantly reminded of the bitter reality of the situation. When the patient becomes ready to accept his/her impending death, then s/he will need someone who is willing to listen to all of the concerns which inevitably come with this situation. In order to be an effective listener in this stage, and in all stages of the dying process, one must be willing to accept the fact of one's own mortality. The listener will then be less likely to engage in death-denying behaviors which also deny the patient's needs.

After the patient has passed through the stage of denial, the reality of the situation occurs to him/her and the next reaction is that of anger. This anger is understandable, the individual is about to lose everything: home, family, job, friends, and life itself. An angry response to such tragedy is not uncommon. Anger may come

out at medical personnel, family members, the church, and, quite often, God. The patient in this stage often asks "Why me?" The situation appears cruel and unfair. And so anger is displaced onto others. Another explanation of this anger is that it is a form of gaining attention for the individual who fears s/he will be forgotten after death.

The patient in this stage needs to be treated with patience. Responding to the patient's anger with hostility will only cause the situation to escalate. Again the patient needs to know that there is a caring presence who is willing to listen to his/her anger and sense of having been done an injustice. The patient needs to know that this presence will continue to be there, even if the anger is displaced onto it. If these needs are met, the patient may move into the third stage, bargaining.

Once the patient has stopped denying the reality of death, and realized the futility of her/his anger, s/he enters a stage of bargaining. This bargaining typically occurs between the patient and God. The patient constantly asks for an extension of time to live. Requests often take the form of wanting to live to see a certain event or have a particular experience. The promises made in the course of these bargains may sometimes be associated with a "quiet guilt"[8] felt by the patient. There may be guilt about not having attended church regularly, of having been a 'bad person' and now suffering as a result. These patients believe that if they can promise to be a 'good person' they may be allowed to live longer. The patient in this stage needs to be able to discuss these feelings of guilt and be assured that they themselves are not the cause of their illness and death, and that bargaining will not buy more time.

When the patient realizes his/her inability to bargain for more time on Earth, depression sets in. Kubler-Ross distinguishes between two types of depression for the

[8] Ibid., p. 84.

dying individual. One is the depression that results from the many losses the dying patient is currently experiencing including the loss of physical functions, loss of control over one's own life, and the financial burdens of health care. This type of depression may be alleviated by being cheerful and optimistic. For example, patients will want to know that the family is functioning well (and will be able to continue to do so after the patient's death), and that there are ways to alleviate physical discomfort. At the same time, the patient may also go through another important form of depression, known as "preparatory grief."[9] Kubler-Ross describes this as a silent grief in which the patient contemplates the impending loss of everything, including the self. Optimism and abundant cheerfulness are not what the patient needs in this stage, for that would simply be a denial of the reality of death. Instead, the patient needs a caring presence to listen to his/her concerns and emotions. S/he needs people who are comfortable enough with their own mortality to listen to all s/he has to say about the experience of dying. Only after successfully passing through this preparatory grief may the patient move on to acceptance.

Acceptance is the final stage in Kubler-Ross' model. As she describes it, this is not a "happy stage" in which the patient comes to full terms with death and meets it open-armed. Instead it is a very quiet stage in which the patient begins to slowly separate him/herself from the world. S/he may ask to have fewer visits, may sleep more as a gradual separation from the world, and needs to begin to detach the self from the world in order to make dying easier. During this stage Kubler-Ross says the family may actually need more support than the patient.[10] However, the patient does still have

[9] Ibid. p. 87.

[10] Ibid., p. 113.

needs. S/he needs to know that someone will be there in the end, usually someone who is willing to wait in accepting silence with him/her. S/he need to know that s/he has not been considered cowardly for "giving in," for we all must die eventually. In short, s/he needs to be able to end life with dignity.

A more extensive discussion of Kubler-Ross' model is found in her book. One can see a common trend of three basic needs for the dying patient throughout these stages. The patient needs to know the truth, to have a caring presence, and to be able to experience hope through every stage. These needs can be met in a variety of ways by the secular and religious communities. One program which has developed in response to the realization of the extra-physical needs of the dying patient is the hospice program. St. Christopher's Hospice was founded in England in 1967 by Dr. Cecil Saunders. The first American program began in the early 1970's in New Haven, Connecticut, under the direction of Sylvia Lack. These were the official beginnings of the modern hospice movement. However, the philosophy is based upon other palliative care models which existed earlier, some as early as 1908.[11]

The hospice philosophy is built on a model of palliative care. Palliative care is the opposite of allopathic care, which is the standard model of hospitals. In allopathic care everything possible is done to preserve life. In palliative care, the patient is allowed to die, but is given care in terms of symptom control and psychological support. The hospice model seeks to care for the entire patient, not only the patient's body, using an interdisciplinary team of workers. The characteristics of hospice care are coordinated home care, control of symptoms, provisional care by an interdisciplinary

[11] Vincent Mor, *Hospice Care Systems: Structure, Process, Costs, and Outcome*, The Springer Series on Death and Suicide (New York: Springer Publishing Co., 1987), 1.

team, services available on a 24 hour/7 days a week basis, treating both patient and family as the unit of care, bereavement follow-up, utilization of volunteers, structured staff support and communications systems, and acceptance of a patient based on need and not on the ability to pay.[12]

The hospice model is an example of the way a sector of the medical profession has attempted to meet all of the needs of the dying patient. The religious community, too, has developed and utilized certain resources which help the dying person to pass through the stages of dying with dignity and support. Although Kubler-Ross states that she has noticed no differences between religious and non-religious patients in terms of how well they progress through the stages of dying,[13] patients in many of the interviews talk about their faith and the importance of faith for them in the process of dying. These are typically patients who had a strong faith before their illness. People will tend to die as they lived; if they lived a religious life with a strong faith they will utilize religion and faith to help them. Religion can be a useful resource for these people as they attempt to work through the stages of dying. Spiritual support, religious ritual, and pastoral care are all elements of religion which assist the dying through this process.

## Spiritual Support

Spiritual support can be an important source of comfort and strength for the dying patient. The role of perceived spiritual support during times of crisis is discussed in the introduction. This is as true for coping with the stress of dying as it is coping with the

---

[12] Sylvia A. Lack, "The Hospice Concept -- The Adult with Advanced Cancer," *Hospice Care: Principles and Practice*, ed. Charles A. Corr and Donna M. Corr (New York: Springer Publishing Co., 1983), 43.

[13] Kubler-Ross, p. 265.

stress of bereavement. As previously mentioned, hope is one of the three fundamental needs of the dying patient. Kubler-Ross devotes an entire chapter to the importance of hope. Hope exists in and through all of the stages, from the moment the patient learns of his/her illness to the moment of death itself. Even the individual in the acceptance stage must maintain a certain aspect of hope that a cure may be discovered. Hope can be maintained while still acknowledging the reality of death. Kubler-Ross notes that when a patient gives up hope before the acceptance stage, s/he will fall into despair and will not be able to die with the dignity s/he deserves. Hope is what sees him/her through the suffering and difficult times. However, during the acceptance stage, giving up hope is usually a sign of immanent death. The patient gives up hope when s/he knows the fight is over. This is a healthy abandonment of hope. As Kubler-Ross states, "While we maintained hope with them, we did not reinforce hope when they finally gave it up, not with despair but in a stage of final acceptance."[14]

This discussion of hope occurs here because one of the important aspects of spirituality and spiritual support is its ability to provide hope. The Christian may have hope in his/her doctor, nurse, pastor, and family. Yet when hope in these earthly things can no longer be maintained, there still exists a hope that comes through faith. Christians are a hopeful people; they hope continually for the kingdom of God. Christians also live in a hope of the resurrection and "life in the world to come." This may be seen by many as a death-denying activity. However, it also serves the very important function of providing hope, and with all hope exists the possibility of denial. Thus, faith in God and trust in the promise of resurrection and eternal life may provide the Christian with needed hope.

---

[14] Ibid., p. 140.

Another fundamental need of the dying patient is for a caring presence. S/he may find this caring presence in God even when doctor, family, and clergy are not providing it. The faithful Christian has hope that God will not only provide comfort in the world to come, but will journey with him/her to the point of death. God is viewed as a constant presence, one who offers grace and love. This may be an invaluable asset to the dying patient, especially if health professionals and loved ones are so busy denying their own mortality and encouraging the patient to do the same that they are unable to listen to and care for the patient. Of course, during certain stages of the dying process, particularly the anger stage, God is not viewed as a caring figure. Instead the patient will often blame God for his/her illness and death. Yet, there is a belief that God will forgive these outbursts of anger and will still be there when the patient is ready. The patient needs this presence which understands the process s/he is going through and will promise to be there to listen when needed. It is to be hoped there are human beings fulfilling this role for the patient, yet often there are not. The added comfort of the constant caring presence of God can be an invaluable source of strength for the dying.

**Religious Ritual**

In these ways, and possibly many more depending upon the individual's faith and concept of God, religion provides a spiritual support for the dying. The earthly institution of religion is also able to offer support and to meet the needs of the dying. One way is through religious ritual. Religious ritual serves many purposes for the dying: it connects the patient to the entire community of believers, it provides a sense of

comfort, it helps to reduce anxiety about death, and it provides the patient with a sense of closure.

Gisbert Greshake describes the role of religious ritual during the process of dying in the following fashion, "In the liturgy of the dying, the church accompanies the dying person to the boundary and as it were hands him over to God and the heavenly 'community of the saints.' Thus it is a sign of the hope that dying does not destroy the community of love."[15] An important aspect of the role of religious ritual in meeting the needs of the dying is found in this connection between the patient and the "community of love." Rituals, such as the sacrament of communion, allow the dying individual a tangible way of participating with the entire church. The dying person is participating in the same ritual in which the rest of the community of believers has participated. This rite reminds the dying person of the existence of a community which cares for and supports him/her. The patient may be reminded of the many times s/he has participated in the sacrament in the church service where there were prayers offered, including prayers for the dying. S/he may realize that s/he now exists on that list and that his/her name is constantly being brought before the community of believers. In this way the patient may feel less isolated; thus, the need for a caring presence and support is provided by the entire group of believers. Rituals such as the commendation for the dying serve to connect the individual in a similar way to the community of saints, those who have died before. This may serve as a reminder that dying is a very natural process, one through which all human beings will pass, and such knowledge may also offer a sense of comfort and support.

---

[15] Gisbert Greshake, "Toward a Theology of Dying," *The Experience of Dying*, ed. Norbert Greinacher and Alois Muller, (New York: Herder and Herder, 1974), 95.

This connection to a group of fellow believers is one way religious ritual provides a sense of comfort. However, comfort is also found in the act of the ritual itself. The familiar and the repetitive tend to be comforting for people. At a time when the individual may feel out of control and confused, religious ritual provides him/her with something familiar. The patient who cannot maintain a conversation may be able to recite the Lord's Prayer, giving them a sense of accomplishment and comfort that they are still able to participate in life. The repetition of familiar words and phrases and familiar actions, such as the taking of communion and the laying on of hands provide a sense of comfort. The individuals, both patient and clergy, may feel safe within the ritual. Here they are not forced to come up with things to say, they do not feel they have to hide their feelings and they are not allowed to deny their own deaths. In the ritual they may be themselves and be comforted by this.

The use of religious ritual may also be used to help reduce anxieties about death before death is imminent. Ash Wednesday and Good Friday remind the Christian that "you are dust, and to dust you shall return." Even in the ritual of baptism the individual is baptized into the *death* of Christ.[16] The Christian is faced with his/her own mortality on a regular basis through these rituals and thus is forced to think about death. Thinking about and accepting the reality of death before the process of dying begins helps the individual better cope with anxieties related to the dying process.

Finally, religious ritual may bring closure to the dying person's life. The final taking of communion and the ritual of the commendation of the dying let the patient know that they have not been abandoned. These rituals give patients the opportunity to

---

[16] "The Commendation of the Dying" found in *Of Resurrection and Life: Preparing for Death and Grief*, eds. Philip H. Pfatteicher and S. Anita Stauffer (Philadelphia: Parish Life Press, 1987), 8-9.

say good bye, both to their loved ones and to themselves, in much the same way that their loved ones will have the opportunity to say good bye during the rite of the funeral. They may feel that they can now die in peace, that nothing is left undone once the ritual has been performed.

The role of religious ritual in aiding the dying can be seen clearly in a discussion of one specific ritual. Some Lutherans use a service of commendation of the dying which fulfills many of the roles of ritual for the dying person. The rite begins with a reminder of Baptism. This serves to connect the individual with the community of believers. It also reminds the Christian that in baptism they were "sealed by the Holy Spirit and marked by the cross of Christ forever," symbolizing the constant presence of God discussed earlier. The ritual then proceeds with a litany. In this responsive reading, the dying individual and their family members give the repetitive responses of "have mercy on your servant," "good Lord, deliver him/her," and "we implore you to hear us, good Lord." This part of the rite provides the repetition which allows the dying individual to participate and gives a sense of comfort. The litany includes such well know aspects of liturgy as the Agnus Dei ("Jesus, Lamb of God"), the Kyrie ("Lord, have mercy"), and the Lord's Prayer. These familiar phrases remind the individual of the worship service and serve as a connection to the supporting community of believers. Next in the ritual one of the following prayers is offered:

> Lord Jesus Christ, deliver your servant, (name), from all evil and set him/her free from every bond, that he/she may join all your saints in the eternal courts of heaven, where with the Father and the Holy Spirit you live and reign, one God, now and forever. Amen.
> OR
> (Name), our brother/sister in the faith, we entrust you to God who created you. May you return to the one who formed us out of the

> dust of the earth. Surrounded by the angels and triumphant saints, may Christ come to meet you as you go forth from this life.
> Christ, the Lord of glory, who was crucified for you, bring you freedom and peace.
> Christ, the Hight Priest, who has forgiven all your sins, keep you among his people.
> Christ the Son of God, who died for you, show you the glories of his eternal kingdom.
> Christ, the Good Shepherd, enfold you with his tender care. May you see your redeemer face to face and enjoy the sight of God forever. Amen.[17]

These prayers, particularly the second one, give an example of the ways religious ritual meets the needs of the dying. The second prayer alludes to the fact that the individual was taken "out of the dust of the earth," recalling the Ash Wednesday ritual and other periodic reminders of death experienced prior to this moment. Christ will come to meet the individual "surrounded by the angels and triumphant saints." This is a reminder of all of the saints that have gone before and of the normality of death. The first petition then describes Jesus as the Lord of glory who brings freedom and peace, two needs of the dying individual. This helps maintain the needed hope, hope for freedom and peace, in the patient. The next petition reminds the individual of the forgiveness of God. Even if the individual has expressed extreme anger at God, God will forgive and still offer the support the individual needs. In this way the individual is reminded of the constant, loving presence of God. The knowledge of forgiveness is also important in reducing the amount of anxiety the individual will experience when encountering death. If the individual sees death as a moment of judgement in which s/he may be damned to punishment for sins, death becomes unbearable. However, the promise of forgiveness helps to reduce this anxiety about death.

---

[17] Pfatteicher and Stauffer, p. 16.

The third petition mentions the "glories of his eternal kingdom." The inclusion of this petition keeps alive the hope of the patient that there may be something better to come, as discussed earlier. The final petition discusses the "tender care" of the "Good Shepherd" in order to remind the individual once again of the loving presence of God, and to still any remaining anxieties.

Next in the ritual is the laying on of hands. In this gesture there is human contact between the individual and a member of the faith community. This serves as a reminder of other rituals of laying on of hands in the individual's life such as baptism and confirmation.[18] During this familiar ritualistic gesture, the pastor gives the blessing of "Child of God, go forth..."[19] This prayer and gesture are a symbolic sending of the individual and provide closure for the individual, allowing him/her to die in peace. As the pastor says in the final prayer, the Nunc Dimittis, "Lord, now let your servant go in peace."[20]

This ritual, like any other, will be most useful for those who have had past experience with rituals. Those who do not come from liturgical churches or for other reasons have not had much exposure to ritual will find the experience more strange and confusing than familiar and comforting. There are ways, however, to introduce ritual and make it meaningful for these people as well. If the ritual is performed a number of times before the actual moment of death, it may become comfortable and meaningful. Still, religious ritual is not the best resource for all people, although it serves an invaluable role for many.

---

[18] Pfatteicher and Stauffer, p. 19.

[19] Ibid., p. 18.

[20] Ibid., p. 20.

## Pastoral Care

Performance of these rituals is usually the responsibility of the clergy. In addition to performing rituals, there are other ways the clergy may provide pastoral care to the dying. Pastoral counseling and care has been given a great deal of emphasis in the last two to three decades. One program which has resulted from this is Clinical Pastoral Education (CPE). Many seminaries require a unit of CPE for all of their potential ministers. In CPE the student works in a health care setting, often in a capacity such as hospital chaplain, and learns to minister to those in sickness and dying related situations. This is an invaluable program, aimed at helping pastors to better understand the stages and needs of the dying, so as to be able to help patients where they are.

Pastoral care may meet the needs for hope and a caring presence. A hospice chaplain describes three types of hope the pastor should give to the patient: the hope of physical healing and remission of disease (a prophetic hope), the hope of healthy and loving personal relationships (a pastoral hope), and the hope of finding meaning in the face of death (a priestly hope).[21] The pastor may express a sense of hope when the patient needs it, and at the same time allow the patient to feel his/her own emotions, whether they be of extreme hope or depression. The pastor may remind the dying individual of the resources of spiritual support which aid in finding and keeping hope.

The minister may also serve as a caring presence. In order to serve in this role the minister must accept the reality of his/her own mortality, and be comfortable allowing the patient to express all of his/her feelings freely. One of the most important things for the pastor to keep in mind in this situation is to meet the patient where s/he is.

---

[21] Trevor Hoy, "Hospice Chaplaincy in the Caregiving System," *Hospice Care: Principles and Practice*, ed. Charles A. Corr and Donna M. Corr (New York: Springer Publishing Co., 1983), 188.

Kubler-Ross discusses the importance of this throughout her book. The pastor must be willing to listen to the patient talk when the patient is ready. There may be days the patient would rather be in a state of denial, but when the patient is ready to talk, s/he must have a listener at the ready, otherwise it may be too late. The minister can serve the role of this listening, caring presence. The minister can also discuss feelings about death and dying with the family so that they may serve as a resource which the dying individual may use to discuss thoughts, feelings, and fears. Talking to the individual, listening, and sometimes sitting in silence can be exactly the support the individual needs and is not getting elsewhere.

There are also many ways the pastor can minister to the dying by ministering to all the members of a congregation before their own deaths are obviously near. The pastor may use the pulpit to discuss the reality of human mortality and the normality of death. S/he may also discuss the needs of the dying as they have been outlined here, particularly the need for a caring community and hope. Thus when people begin the dying process, they may better understand what they are going through. Another thing the pastor can do is emphasize redemption in preaching. In this way the congregation will not view death as a day to be feared because of impending judgement. In these ways the congregation may be better prepared both to support its dying members and to go through the dying process as individuals.

In addition to using the pulpit, the pastor may encourage discussion about issues of death and dying within the congregation. These may be begun by a sermon, but also through workshops, seminars, and other special events. By making death a common topic of conversation, people will think about their own mortality more often and

hopefully be better able to accept the fact of their own deaths. This will lead to a community which is much healthier in the ways they live, support the dying, and die.

While there are many ways religion is currently successfully meeting the needs of the dying, there are also ways it can improve. When dealing with the dying, people often use religion in ways contrary to the Christian message. While their intentions may be good, their uses of religion can be harmful to the well-being of the dying person. For example, the Christian hope of a life to come and a resurrection may be translated by some to mean that the dying individual should meet death with great anticipation and joy. However, this belief could only come from someone who clearly has not seriously considered his/her own mortality. While some individuals may carry this extreme hope of resurrection in the final stage of acceptance, they will still progress through the stages of anger, depression, and bargaining. During these stages they must be allowed to express their true emotions, and not feel they have to remain "strong" at all times in order to be considered good Christians.

Religion could also better use its resources by fully utilizing the congregation as a community of care. Unfortunately, however, this community often ceases to be supportive the longer a person is sick. The Christian community must never forget its dying members. Society often hides the dying in institutions as a means of denying death. The Christian community, however, cannot in good faith do the same. Christians are constantly reminded of their own deaths, including dying with Christ, and must in the same way constantly remember their dying fellow members.

## The Needs of the Loved Ones of the Dying

The church and religion must support their dying members. However, when a person is dying s/he is not the only one in need of love and care. The family and other loved ones of the dying person also have needs, but are often forgotten until the actual death occurs. Doctors, nurses, and ministers are busy caring for the one who has limited time and the loved ones feel lost in the shuffle; yet they have real needs. Mourning begins even before the death of the loved one occurs. There are many emotions and other situations which the loved ones of the dying person are going through and religious resources may help meet these needs.

Little has been written about the needs of loved ones of the dying, in comparison to the large amount of literature dealing with the dying and the bereaved. However, Kubler-Ross does devote one chapter of her book to the families of the dying and literature about hospice often discusses this group. Still, they are largely forgotten, despite the fact they have needs as strong as those of the dying patient. According to the literature that does exist, the needs of the loved ones are similar to those of the dying and tend to progress through similar stages. What follows is taken from Kubler-Ross' discussion of the needs of the loved ones and how they are similar to the stages the patient is experiencing.[22]

The loved ones, like the dying patient, have a need to know the truth. Family members should be informed of the seriousness of the loved one's condition and be aware of the prognosis. The manner of informing the family should be considered just as seriously as how to inform the patient. The family must be told the truth, but with

[22] Kubler-Ross, p. 157-180.

compassion and understanding. The family will usually first experience a feeling of denial, much as their dying loved one does. Just as the dying patient needed to be given time to digest the reality of the situation, so too must the loved ones.

The loved ones will also go from a state of denial to a stage of anger when they finally fully realize what is happening. This anger can be projected in all directions, at medical staff for not catching the illness sooner, at the dying loved one for not taking better care of themself, at themself for not doing something differently to help, or at God for allowing this to happen. The last three forms of anger lead to another prevalent emotion in the loved ones, guilt. Guilt will be discussed in more detail shortly. The family must be allowed to express their anger, just as the dying loved one does. Sometimes they must express anger at the patient, which can be difficult. However, hostility between the patient and the loved ones can be solved only when discussed.

After proceeding through anger and associated feelings of guilt, the loved ones will enter a stage of "preparatory grief."[23] The more the loved ones can work through grief at this time, the less difficult their grief will generally be after the death. At the same time, grieving after the death occurs cannot be avoided. The advantage of preparatory grief lies in the ability to begin grieving before the event of the death. Any unfinished business or other stumbling blocks to healthy grieving may thus be dealt with while the loved one is still alive. The griever may communicate their love for the patient before it is "too late." As Kubler-Ross states, "If members of a family can share these emotions together, they will gradually face the reality of impending separation and come to an acceptance of it together."[24] There is a decided advantage to going through a

[23] Ibid., p. 169.

[24] Ibid., p. 170.

stage of preparatory grief.

While the family members go through stages similar to those of their dying loved one, they also have emotions and stresses which are unique to their situation. One of these involves dealing directly with the dying loved one. The family members feel they must try to be supportive of the patient, and they should. However, people often take that to mean they must deny their own feelings and assume a cheerful demeanor for the good of the patient. Kubler-Ross and other authors note that this is not the best way to deal with the situation for any of the parties involved. Both the dying and the loved ones need to be able to talk freely about their emotions, both good and bad. Often times they will be feeling the same things and could support one another, yet are afraid to say anything.

After working together through the process of dying, the family finally sees their loved one reach the stage of acceptance. Yet, in this stage the patient often asks to have fewer visitors and begins to separate him/herself from the world. This may make the family members who are not asked to be the one who sits quietly with the patient feel abandoned. They have stood by the patient through the entire process, and now when they feel it matters the most, the patient no longer seems to care about them. At this point the loved ones should be reminded of the stages of dying and that the patient's separation is not a function of hostility toward the loved one, but a natural part of dying.

Still, the loved one may feel hostility. The loved one may also have felt hostility at the patient during other parts of the process, as mentioned earlier. During the loved one's stage of anger they will find what they believe are ways the situation/illness could have been avoided. They will tend to blame the patient for not taking better care of

him/herself, or blame themself for not taking better care of the patient. All of these emotions will eventually lead to feelings of guilt. These feelings of guilt are some of the most prominent emotions for the loved ones, and perhaps the ones they are least able to deal with. Again, the loved one needs to be reminded that these are normal thoughts and feelings. They need to be told that they may be angry and feel the way they feel. Ideally communication can be opened up between the loved one and the patient so that the angry feelings may be dealt with before they turn into a source of overwhelming guilt.

In addition to these added emotional burdens, there are the stresses of everyday life with which the loved ones must deal. While the patient is dying, life in the world continues as usual. The loved one of the patient may have to deal with balancing work, taking care of the family, housework, responsibilities that were usually the job of the patient, and providing support for the patient. This puts the loved one under a great deal of stress. Added to these stresses may also be the financial burden of long term health care.

These added stresses take a toll on the health and emotions of the loved one, affect his/her interactions with the patient, and may affect the entire family system. Having a family member dying puts a great deal of stress on the family system and this stress may accentuate problems that existed in the family before but were not very pronounced.[25] For example, the "rebellious stage" of a teen-ager may cause much more conflict in the family than it would have had the family system not been under the

---

[25] Howard Leventhal, Elaine A. Leventhal, and Tri Van Nguyen, "Reactions of Families to Illness: Theoretical Models and Perspectives," *Health, Illness, and Families: A Life-Span Perspective*, eds. Dennis C. Turk and Robert D. Kerns (New York: John Wiley and Sons, 1985), 110, 117.

stress of the situation of the dying member. Families need to take time out to deal with these stresses and avoid feeling guilty for not constantly keeping a vigil at the bedside of the patient. It is normal and healthy to think about other things and attend to the other aspects of life, this is not a form of abandoning the loved one.

As with the needs of the dying, religion contains many resources which can help support the loved ones of the dying. They, too, can find help in spiritual support, religious ritual, and pastoral care.

## Spiritual Support

The resources of one's spirituality may be used to maintain much needed strength and hope throughout the dying process of the patient. The manner in which the loved ones use spiritual support will be very similar to the way the patient does. Hope can be found in the promise of forgiveness and the resurrection. This belief helps the person to hold on to hope that their loved one will not cease to exist after death. Also, a caring presence can be found in God, with whom they can be honest and share their true feelings.

The promise of forgiveness is very important for the loved ones, but in a way different from its importance to the dying. The loved ones may be comforted by the belief the patient will not be judged. This image may also reduce their of fear their own death, making them a greater comfort to the dying patient and to themselves. Yet, this promise of forgiveness is also important in light of the guilt so often felt by this group. With the promise of grace, the family member may be more likely to allow him/herself to feel angry, but to know those feelings are normal and are forgiven by God. In this way

many of the feelings of guilt may be avoided, and those that are not are still forgiven. This promise provides a much needed peace of mind for the loved ones when dealing with their often confusing emotions.

Another important aspect of spiritual support is that of strength given by God. Many believe that God is present with people in times of trial and will help them by supporting them with the strength they need. If the families of the dying need one thing, it is strength. They need the strength to deal with all the added stresses, with a drastically changed family system, and with trying to help comfort and support the dying and other family members while not denying one's own emotions.

## Religious Ritual

One important way people look to obtain strength and support is through the ritual of prayer. Harold Kushner, in his book *When Bad Things Happen to Good People,* gives an explanation of how he believes strength is gained through prayer.[26] He explains that the strength comes from a connection to two sources of support, the community of believers and God. Prayer, he says, puts us in touch with other people. In this way prayer is a religious ritual which connects the participant to other believers who perform the same ritual. This helps the person to realize that s/he is not alone. Prayer helps the individual avoid feelings of isolation, an emotion often experienced by the loved ones of the dying. This connection also serves as a reminder of the caring community discussed in the first section. The caring community can be used to minister to and support the family in the same way it does the dying.

---

[26] Harold S. Kushner, *When Bad Things Happen to Good People* (New York: Schocken Books, 1981), 113-131.

Kushner also states that prayer puts the participant in contact with God. Communicating with God, like communicating with someone on Earth, helps to strengthen the relationship. The stronger the relationship between the individual and God, the more the individual may feel they can count on God to help them through difficult times. Kushner explains that the prayers God answers are the prayers for God's presence, strength, and comfort in a time of need. Even with this strength and comfort the way will still be hard, but perhaps it will become bearable.

Another useful ritual for the family of the dying individual is the commendation of the dying, discussed previously. The familiar phrases, repetition, and reminders of the support of God and the caring community are used in similar ways by the family as they may be by the patient.

## Pastoral Care

The discussion of "pastoral care" in the previous section focused primarily on the pastor as caregiver. This is appropriate in the care of the dying. The pastor is the one who does the most direct ministering to the dying. When discussing the role of "pastoral care" in ministering to the loved ones of the dying and to the bereaved, however, one may safely talk to two types of pastoral care. One is the traditional pastoral care given by the pastor of the congregation. The other is the care given by the lay members of the church, all of whom may serve as ministers to those in need.

Ample opportunity exists for these lay people to provide ministerial care to the families of the dying. Members of the community may provide much needed services by cooking meals, cleaning house, taking care of young children, running errands, and

doing any other number of jobs that need to be done. These services will help reduce the stress on the family and allow them more time to spend with their dying loved one. They will also have more time to spend quietly alone thinking and feeling and more time to take advantage of those who will listen to them as they express their wants, fears, and other emotions. Members of the congregation can serve as those willing to listen to these wants, fears, and needs without judging, and, perhaps, without talking. This is an important service which can be provided by any member of the caring community.

Another service members of the community may provide is to help the family members to get their minds off the dying patient for a time.[27] As discussed earlier this is important and healthy, even though the initial reaction would be that staying away from the patient for a time is horrible. In the long run, however, taking a break will help to avoid added feelings of hostility and then guilt on behalf of the loved ones. Allow me to offer an example. Two summers ago a friend of the family informed us her husband had suddenly developed acute leukemia. He was given extreme chemotherapy and was not expected to live. All of their nine children hurried home and he had members of the family with him around the clock. He survived the chemotherapy, but was very weak and doctors were not sure how much more he could handle. This continued for over a month. His wife and children spent hours each day commuting between their home and the hospital. Dinner conversations were either non-existent or consisted of talk of tests, red blood cells, and whether or not Dad would survive. The air in the house was constantly tense. Then one of the children decided they needed to have a party. The father and husband had survived another week, and they were going to celebrate. So, they bought party hats and streamers, refreshments, and planned

[27] Kubler Ross, p. 159.

games. There was one rule, there was to be no talk of hospitals or sickness. The father could certainly be discussed, but no talk of illness. The whole family, except the sick father, gathered in the home and laughed and enjoyed the night and each other's company. After this night of celebration they all went back to visit their father and husband renewed and happy. The house was the busy place it should have been, without the constant hush of a home where only death, not laughter, was allowed to dwell.

The father in this story did survive against all odds. His family contributes this to the support of all those who love him and the power of prayer. While the party this family had may seem cruel and like an act of simple denial, it was actually a very important respite which allowed family members to later minister to their father even more effectively. This type of celebration, "time off" from the constant bedside vigil, can be encouraged in good pastoral care by lay persons and clergy alike.

The clergy may minister to the loved ones of the dying in many of these same ways. Pastoral care to this group will strongly resemble the care to the dying. The loved ones need the same caring presence who is willing to listen and not judge. They need the same reminders of forgiveness and hope in the resurrection.

The clergy may also serve as a mediator in conversation. S/he may be willing to help with difficult discussions between the patient and the loved ones. S/he also should be willing to be sure the family is getting all the information they need from the medical staff. In this way the clergy serves a very important function in helping the loved ones of the dying.

## Needs of the Bereaved

In time the patient will die, and the family will shift its role from being loved ones of the dying to being the bereaved. Family members may be in the room when the patient dies. Hospice encourages the family to stay with the body for as long as they are comfortable after the death occurs.[28] The family's needs are beginning to be met by allowing them to stay with the body. The bereaved share the same need for truth which has been seen with the dying and their loved ones. The truth in this situation is the reality of death. The family may also acknowledge the death and commit one last act of care and love by being involved with washing and dressing the body. In their new role as the bereaved, the loved ones now have a new set of needs which religious resources help in new ways.

The bereaved begin the process of "grief work" immediately following the death.[29] Dr. Erich Lindemann introduced this term in his 1944 article outlining the important aspects of grief, one of the first studies of its kind. Those who research and write about grief today still base much of their work on the ideas of Lindemann. Lindemann explains that grief work must be done in order for the bereaved individual to experience healthy grief as opposed to neurotic grief. "Healthy grief" seeks to accomplish the following goals, according to Lindemann: a release of ties to the deceased, readjustment to the new environment without the deceased, and formation new relationships. Contemporary writers agree with these as the goals of grief.[30]

---

[28] Marjory Cockburn, "Nursing Care of Dying Persons and Their Families," *Hospice Care:Principles and Practice*, eds. Charles A. Corr and Donna M. Corr (New York: Springer Publishing Co., 1983), 131.

[29] Erich Lindemann, "Symptomatology and Management of Acute Grief," *The American Journal of Psychiatry*, (Sept. 1944, reprinted June 1994): 155-160.

[30] for example, Kenneth R. Mitchell and Herbert Anderson, *All Our Losses, All Our Griefs:Resources for Pastoral Care*, (Philadelphia: The Westminster Press, 1983), 86, give the same goals for grief, as do other authors.

Grief is thought to approach these goals through a series of stages much like the stages of dying. In fact, many people generalize Kubler-Ross' stages of dying to the process of grief. Kubler-Ross' model is similar to the model for stages of grief; however they are two distinct ideas. Many authors have presented versions of the stages of grief, ranging in size anywhere from four stages to ten. Yet there are common elements that can be found in most of these paradigms. They are typically organized around Lindemann's observation of five characteristics of grief: somatic distress, preoccupation with the deceased, guilt , hostile reactions, and a loss of patterns of conduct.[31] The majority of the models use a system of stages, yet they also emphasize the point that no two people grieve in exactly the same way. The situation surrounding the death, the relationship between the deceased and the bereaved, and a host of other factors influence the grief process. Some of the common elements in the models for grieving are shock, extreme emotion, anger, and depression. One can easily see the parallels between these common themes and Kubler-Ross' model.

The classic source for a discussion of the stages of grief is Granger Westberg's booklet *Good Grief.* Here he describes ten stages in the grieving process. The first stage is shock. Shock and denial have already been shown to be the first responses to traumatic news for the dying and their loved ones. The same holds true for the bereaved. The needs of the bereaved individual in this stage are like those of a dying patient one or their loved ones. The individual must to come to terms with the reality of the situation in his/her own time. This is where being with the body at the time of death and being able to acknowledge the reality of the death might prove to be helpful. When

[31] Lindemann, p. 156. Also found in Mitchell and Anderson and Granger Westberg, *Good Grief,* (Rock Island, Il: Augustana Press, 1962).

the body is never seen and the death not recognized as real, the mourner may be unable to get beyond the first stage of grief and go on to complete his/her grief work.

The second stage Westberg outlines is that of extreme emotion. He emphasizes the importance of having the freedom to show emotions. People in our society, particularly men, are taught that crying is not appropriate. Yet in a time of grief it may be the best and only response. In our death-denying culture we tend to have more respect for the person who was a "rock" and held up others while keeping their own sorrow inside than for the individual who cries and screams. Generally, the latter individual is the one who will be able to move more successfully through grief work.

After this emotional stage comes a time of depression and loneliness, according to Westberg. This is when the bereaved person feels completely abandoned and forgotten. Getting through this stage successfully is essential to meeting the goal of being able to live in the environment without the deceased. The person going through this stage needs companionship to alleviate their loneliness. They also need to know that what they are feeling is normal and there will come a time when they will feel better, even if that seems impossible at the moment.

Stage four consists of physical symptoms. These symptoms are addressed by both Westberg and Lindemann. Some of the common symptoms during bereavement are loss of appetite, insomnia, and general weakness. Lindemann discusses a specific type of physical symptom shown by those who are grieving. He describes people who will take on the former symptoms of the deceased loved one.[32] He also mentions several medical disorders which tend to be associated with the bereaved, including,

[32] Lindemann, p. 158.

ulcers, rheumatoid arthritis, and asthma. Such symptoms are typically labelled psychosomatic. Psychosomatic symptoms are not "in the patient's head" as many believe. The psychosomatic illness or pain is very real, it just does not have a physiological cause. For this reason the person with these symptoms is not adequately treated by medical science alone. They need to work through the problems which are causing their symptoms. Often the psychosomatic physical symptoms can be overcome by continuing through the grief work.

The fifth stage in Westberg's model is panic. The individual is experiencing many new thoughts and emotions during bereavement, some of which may not seem quite "normal" to him/her. The bereaved are often obsessed with thoughts about the loved one, are uncertain of their depressive and other symptoms, and may even see visions of the deceased. In short, the individual may become panicked with the overwhelming new thoughts and feelings, as well as the fear s/he may be approaching insanity. Mitchell and Anderson discuss what they call the "craziness of grief."[33] They describe the fear involved in experiencing such extreme and confusing emotions, particularly the process of searching for the lost object (the deceased loved one) and having visions of the loved one. These experiences may cause one to question one's own sanity. The person in this stage needs to be informed that their radical mood swings, visions, and other strange emotions are normal. People should, in fact, be made aware of this before the panic stage even begins so that it may possibly be prevented all together.

Stage six describes another very intense emotion of the bereaved, guilt. Guilt was discussed in the section concerning the loved ones of the dying. Some of that guilt

[33] Mitchell and Anderson, p. 72.

may linger with the person as they go through the grieving process. The griever may also develop a new, stronger sense of personal guilt for the death. They may begin to think the death could have been avoided somehow if they had simply noticed the loved one was sick sooner, gotten a second opinion, made them rest more, or done any number of things differently. They may also feel guilty for things they did not do for the loved one when s/he was alive. A certain amount of this type of guilt is normal. However, Westberg is careful to make a distinction between normal guilt and neurotic guilt. The person who blames themselves for things that were not their fault and/or is unable to resolve their guilt experiences a neurotic guilt which interferes with the process of grieving.

The seventh stage in Westberg's model is feeling hostility and resentment. This hostility stage is very similar to the anger stage in Kubler-Ross' model for the dying. The anger of the bereaved person is directed in any number of ways: at the loved one for dying, at medical personnel, and particularly at God. In this stage the bereaved individual questions how a supposedly good and loving God could take away the person that s/he loved. This question is the central theme in Kushner's book, mentioned earlier. Kushner is a rabbi who experienced the long illness and death of his son. His own experience and witnessing the experiences of others prompted him to write a book attempting to explain why even "righteous" people suffer. His argument states that God does not will bad things to happen. Kushner acknowledges that there is a sense of randomness in the universe and not all things are necessarily caused by God. Our belief that all things are the will of God and that bad things only happen to bad people are the result of our need to make sense of the world. God does not

intervene to stop the tragic from happening because doing so would interfere with the human ability to make choices. The ability to make choices is what makes us human, according to Kushner, and these choices carry consequences that may lead to the suffering of innocent people. Yet God does not interfere because doing so would limit our humanity. The Christian would describe this as God allowing us to experience our free will and requiring us to live with the consequences.

In this way Kushner tries to explain that God does not cause the bad things to happen. This explanation may help the person who is experiencing anger. However, according to Kushner, the angry question of "Why did God do this to me?" is often not the theological question it appears, but is instead a cry of anguish. For this reason one who seeks to help the bereaved should allow them to ask these angry questions and to feel their pain and anger so they may eventually work through it.

The process of grieving continues with the inability to return to usual activities, the eighth stage. Even though the individual may feel s/he is well along in grief work, there is still an inability to go back to many of the daily activities of life. Westberg contributes this to an inability to grieve openly in today's society. This "conspiracy of silence"[34] keeps the bereaved prisoners to their grief. No one is willing to discuss the death, the deceased or the grieving process. This halts the individual's grief work. It also keeps them from forming working memories of the deceased which will eventually allow them to release their ties to the deceased and begin to develop new relationships.

Gradually, in the midst of all this work, hope begins to appear. This is the ninth stage Westberg describes. This period of hope may come at different times for different people. Some people may take only a few months to complete the grieving process

[34] Westberg, p. 48.

while others take several years. There is no one right amount of time to grieve. Grieving longer does not mean one will never complete the process or that one is "dwelling" on the topic, and grieving for less time does not mean the individual loved the deceased any less. Yet all people who go successfully through grief work will reach this stage of hope that life will eventually return to normal. Of course this state of normalcy does not equal the life lived with the deceased. The environment and the situation is different, yet the bereaved will slowly find they are able to function in this new environment.

This leads to the final stage in the process, the struggle to readjust to reality. Westberg makes a point to say this is not the same as "returning to our old selves again."[35] People grow and change through the process of grieving. Deanna Edwards spends much of her book discussing the opportunity to grow and create through the grieving process. Those who successfully work through their grief will tend to find themselves better able to help others work through the same sorts of problems.

Throughout his discussion of the stages of grieving, Westberg includes ways people are able to use their faith to help them through the process. These ideas may be expanded to include the religious resources of spiritual support, religious ritual, and pastoral care which have been the focus of this paper.

## Spiritual Support

> Talk to me about the truth of religion and I'll listen gladly. Talk to me about the duty of religion and I'll listen submissively. But don't come talking to me about the consolations of religion or I shall suspect that you don't understand. C.S. Lewis, *A Grief Observed*, p. 28

[35] Ibid., p. 55.

People often try to console those who are grieving by offering profound, usually religious, statements and advice. This quotation of C. S. Lewis demonstrates how such words do not meet the needs of the bereaved. Kubler-Ross notes in a similar fashion, "Once the patient dies I find it cruel and inappropriate to speak of the love of God."[36] People who have just lost a loved one do not want to hear that it was "God's will" that their loved one died. The idea of their loved one happy in paradise does not reduce the amount of pain of loss they are, and should be, feeling. Such transcendental and theological statements which, in effect, deny the experience of the bereaved individual are certainly "cruel and inappropriate."

Another way religious resources are used inappropriately is the misquotation of 1 Thessalonians 4:13. This line of scripture declares, "We wish you not to remain in ignorance, brothers, about those who sleep in death; you should not grieve like the rest of men, who have no hope" (1 Thess. 4:13, NEB). This passage is often erroneously quoted and interpreted to mean that Christians should not grieve. However, the key to this passage is that they should not grieve "*without hope.*" Even in feeling the pain of grief, the bereaved should try to maintain a glimmer of hope that comes through faith in God. These examples show that the bereaved individual must be able to express his/her pain and sense loss without feeling judged by those try seek to comfort by using such statements. The bereaved need a listening, caring presence for this purpose just as the dying and their loved ones do.

Just as God can be the caring presence for the patient and loved ones during the dying process, so too can God be the caring presence for the bereaved individual. Again, God serves as someone with whom the griever can be completely honest about

[36] Kubler-Ross, p. 177.

their feelings. Even if the griever had expressed extreme anger at God during the dying process and certain stages of grieving, the promise of forgiveness gives the griever the freedom to always go back to God.

In the beginning stages of grief people are usually not comforted by promises of the resurrection or the life to come, of God's ability to give them the strength to deal with their grief, or the promise that their loved one is no longer suffering. The individual is bereaved, and should be allowed to be so. Trying to explain away and comfort a person's grief with words at this time is inappropriate and ineffective. Such actions serve the helper's need to hide grief in order to deny death more than serving the needs of the griever. At the beginning stages of grief the individual will usually be more comforted by the lament psalms than New Testament promises of resurrection. These psalms let the griever know that others have felt the same way, that their grief is normal. They are also a source of comfort because they "validate a person's grief."[37]

The lament psalms offer one way for the griever to express their anger and feelings of isolation at God. The Hebrew tradition is full of God's people expressing their anger at God. This is often a denied tradition in Christianity. However, the griever must be allowed to express these feelings freely so they may move on with the grieving process. Mitchell and Anderson give the example of a man who felt it would be a sign of poor faith to cry or be angry at God. His pastor responded, "Stifling your crying . . . means that you're hiding what you really think and feel from God. What kind of theology is it if you can't yell at God? Whatever it is, it isn't a living relationship with God."[38] This explanation emphasizes the importance of being in a relationship with God and

[37] Mitchell and Anderson, p. 124.

[38] Ibid., p. 124.

being able to express your true feelings to God, the caring presence and constant forgiver.

Once the bereaved individual is able to express his/her true feelings to God and work through them, s/he is then able to accept the comfort of the resources of spirituality and religion. One important comfort to be found in spirituality is the strength gained from God. This strength is gained through prayer, as discussed earlier. Strength can also be found in the knowledge that God is always present and the griever need not suffer alone. Traditional Christian theology also tends to believe that God suffers with us. This belief in the constant presence and empathy of God helps to support the individual even when Earthly religious and secular resources may not.

The Christian may also find many sources of consolation and support in the New Testament of the Bible. The Christian knows that grieving is not unfaithful, as some would have them believe. In fact, Jesus himself grieves and cries at the grave of his friend, Lazarus. He also cries out the words of the psalmist, "My God, my God, why have you forsaken me?" as he dies upon the cross. These both give validity to the process and pain of grieving. Yet Jesus also offers a message of hope for the bereaved during the sermon on the mount when he preaches, "Blessed are those who mourn, for they shall be comforted." Those who mourn certainly may be comforted, but Jesus himself has given the example that they are not to be comforted prematurely, they must be able to cry out in their pain and work through their grief. Through these lessons, Christianity supports the need of the bereaved to feel pain, hurt and anger, and also provides the knowledge that God suffers with them and will provide strength when needed, that they will indeed be comforted.

## Religious Ritual

The bereaved can also find support through the use of religious ritual. One of the most well known rituals in our society is the funeral. Often times people who never had strong ties to the church are given funerals. The purpose of the funeral is many, it serves as a worship service, celebration of the life of the deceased, opportunity for the community to come together to offer support in the time of grief, and as a ritual of comfort for the bereaved. The funeral is for the sake of the living, yet the reality of the life and the death of the deceased must not be denied.

Often in today's society the funeral becomes a means of actually denying the reality of death. The family is not as involved in the preparation of the body and of the ceremony as they were in decades past. The funeral industry has become a huge business in which people make a profit through other people's need to deny death. This death-denial displays itself in the desire to embalm the body, buy cement vaults for grave sites, and purchase coffins which are guaranteed to preserve the body well. Many authors who write on the topic of bereavement are critical of the funeral industry. They mourn the loss the times when people were able to be more actively involved in the process of commending their loved one to God. They also realize the death-denying aspects of the current funeral industry and that without accepting the reality of death successful grief work is impossible.

Yet, the church may keep some of the traditions of the religious ritual which do not deny the death and will aid the mourners in their suffering. For example, the funeral helps the grievers to give words to their suffering. They may do this safely within the structure of the ritual. At the same time, the funeral should proclaim the

message of hope that is to be found in the resurrection. These feelings of pain and hope must be kept in balance. For this reason, the mourners should be encouraged to express their emotions freely during the funeral service. Crying should be allowed and encouraged. In the funeral comes the realization of the reality of death. The viewing of the body at the wake or before the funeral often helps the mourners to accept the reality of the death, especially if they were unable to be present at the time of death. The funeral service should not avoid mentioning the fact that the loved one has, in fact, died. Coming to terms with the reality of death, especially in a supportive context and community, is important to the grieving process.

The funeral is also a time when the mourners may begin making memories of the deceased person. The eulogy may serve this function. By committing the deceased to active memory, the bereaved to begin to detach themselves from the deceased, leaving them free to begin making new relationships and thus fulfill two of the goals of successful grieving.[39]

Thus, the funeral serves many important functions. It walks the line between offering messages of hope and resurrection while giving a voice to the pain and loss being felt by the mourners. The ritual gives a sense of comfort, a sense of the familiar when all the world may seem confusing. The ritual also serves as a means of closure. Mitchell and Anderson describe it as a "ritual of ending."[40] The loved ones are able to say good-bye and go on with their grieving. Active participation in these rites is an important element in the mourner's ability to accept the reality of death and bring closure to the relationship with the loved one. Deanna Edwards writes about the choice

[39] Ibid., p. 143.

[40] Ibid., p. 141.

of some people to watch the interment of the body and for the family to fill in the grave.[41] This sort of participation helps the griever to become involved in the process of grieving so that s/he may in time proceed successfully through grief work.

## Pastoral Care

While the ritual of the funeral is important and can provide a great deal of comfort and support, the bereaved will also need the loving care of fellow human beings to help them through this difficult time. Again, the field of pastoral care can be divided up into the lay community and the pastoral community.

Lay communities have developed many resources for aiding the bereaved. One such resource is the Stephen Ministry program in which lay members are trained to help others through grief and other difficult situations. This program provides the griever with a listening, caring presence. The program also offers someone other than the pastor who will be responsible for visiting the bereaved on a regular basis and note their progress in the grief process.

Lay members also form a caring community. As with the dying, the very presence and knowledge of the community can be comforting. The bereaved individual knows they do not have to suffer alone, that the community of believers is there to offer strength and support. The caring community can also help in active, tangible ways. When a person begins the process of grieving they are often so overwhelmed that daily tasks seem monstrous. This is when members of the community may step in and help. One author suggests that people offer to perform specific tasks.[42] The well intended

[41] Edwards, p. 18.

[42] Ibid., p. 165.

offer "call me if you need anything" is rarely utilized by the grieving. However, offering to bring a specific meal, take care of children while the funeral is being planned, or perform some other needed function can be of great practical assistance, while also showing that the helper care and is willing to give needed support.

While the entire community may minister to their grieving members, a large number of responsibilities still lie with the clergy. The pastor may be present at the time of death and must immediately begin working with the process of bereavement. If not, s/he will soon be called and must begin ministering then. Ministering usually begins with the first pastoral call. During this call the pastor is likely to fill the role of the listening, caring presence, allowing the bereaved to express his/her grief, anger, and confusion. The pastor may also help the individual to begin dealing with all the things which must now be attended to. The experienced pastor will have been through this process before and know what details need to be attended to. This knowledge and careful direction by the pastor can be helpful to the bereaved individuals who have no idea what must be done first.

A condolence call can be given by the clergy and the laity alike. A pamphlet on being a "grief helper" gives ideas for performing a helpful condolence call. The pamphlet suggests the caller do the following things: be sincere, affirm the loss, be accepting, make room for genuine cheerfulness, don't be judgmental, look beyond the brave front the bereaved may have put up, be a good listener, offer specific help, communicate clearly, and let your faith help you. These suggestions show the importance of listening and communicating honestly with the bereaved. The reality of the death must be affirmed, the minister should not be afraid to talk about the deceased

and mention them by name. Yet, there should also be "room for cheerfulness," the atmosphere need not be entirely somber. Happy memories may be shared, but only if the griever is comfortable with this; they should not be forced into a position of cheerfulness.

These are some ways the clergy and the laity may minister to their grieving members. These resources of religion can be valuable in comforting and offering strength and support to the bereaved. However, religion can also be used in harmful ways in these situations. The use of certain statements such as "it was God's will" can be very harmful, as discussed at the beginning of this section. Deanna Edwards gives a list of things one should never say to a grieving individual. These include: "I understand exactly how you feel," "Don't cry. You'll see him again," "He lived a long life, he was ready to go," and "God gave you this trial to make you stronger."[43] These statements are almost always said with the intent of comforting the bereaved. However, they negate the importance of the person's grief and try to use religion to hide the fact of suffering in grief.

In a similar manner, people may try to hurry the bereaved through the grief process if long grief is seen as a sign of weak faith. They may believe that if the grieving individual had more faith in the resurrection and the hope of a life in the world to come they would not grieve for their loved one. Yet the loved one must be grieved for no matter how strongly the bereaved believes in the resurrection. If the bereaved is aware of this attitude in people, s/he may try to hide his/her grief and in this way will halt the process of working through grief successfully.

Kushner addresses another problem of certain religious attitudes in successfully

[43] Ibid., p. 147-150.

ministering to the bereaved. He notes that people will often feel they have to defend God and what they see as God's decision to take the person's life. This is usually done at the expense of the griever. The defender may try to make excuses, such as, the family had a lesson to learn and this was God's way of teaching it, or the deceased deserved punishment for some act. This is one of the most harmful possibilities current religion lends itself to. In addition to not supporting the needs of the bereaved, it also adds to their feelings of guilt and helplessness. Kushner answers this problem well with his belief that God does not actively cause individuals to die. God does, however, suffer with and support people through the entire experience of grief.

Thus we have seen the many needs of the dying, loved ones of the dying, and the bereaved. These needs are often silent because of society's denial of death. However, one must understand these needs and how they are met. All people will someday encounter death. When they do they should have the knowledge of what "normal" thoughts and feelings are, as well as how religious resources may be used to help them through the process of dying or grieving.

One may hope that as time goes on the resources religion provides for dealing with these topics will continue to increase. While many advances have been made, the critical sections of this paper have shown how religion is still used in harmful ways and can be better utilized. Programs such as hospice, Stephen Ministry and pastoral, as well as lay, care can be expanded and emphasized. The use of religious ritual can be expanded so that people become more familiar and comfortable with the rituals before they ever need to use them. People should also be informed that they have these resources available to them.

The church can take an active role in refusing to deny the reality of death and thereby contributing to the "conspiracy of silence." The needs of the dying and bereaved can only be completely met when society is willing to accept the reality of death and to understand the needs of those experiencing death and grief. Through the promise of strength and forgiveness and the hope of the resurrection, the Christian church has the potential to lead its members through successful death and grief, if it is brave enough to accept the challenge.

## Sources Consulted


Backer, Barbara A., Natalie Hannon, and Noreen A. Russell. *Death and Dying: Individuals and Institutions.* New York: John Wiley and Sons, inc., 1982.

Balk, David. "Sibling Death, Adolescent Bereavement, and Religion." *Death Studies* 15 (Jan-Feb. 1991): 1-20.

Corr, Charles A. and Donna M. Corr, eds. *Hospice Care: Principles and Practice.* New York: Springer Publishing Co., 1983.

Dumond, Richard G. and Dennis C. Foss. *The American View of Death: Acceptance or Denial?*, Cambridge: Schenkman Publishing Company, Inc., 1972.

Edwards, Deanna. *Grieving: The Pain and the Promise.* American Fork, Utah: Covenant Communications, Inc., 1989.

Greinacher, Norbert and Alois Muller, eds. *The Experience of Dying.* New York: Herder and Herder, 1974.

Kubler-Ross, Elisabeth. *On Death and Dying.* New York: Macmillian Publishing Co., 1969.

Kushner, Harold S., *When Bad Things Happen to Good People.* New York: Schocken Books, 1981.

Lindemann, Erich. "Symptomatology and Management of Acute Grief." *The American Journal of Psychiatry* (Sept. 1944; repr. 151 June 1994).

Manning, Doug. *Don't Take My Grief Away.* San Francisco: Harper and Row, 1984.

Maton, Kenneth, I. "The Stress-Buffering Role of Spiritual Support: Cross-Sectional and Prospective Investigations." *Journal for the Scientific Study of Religion* 28 (1989): 310-323.

Mauritzen, John. "Pastoral Care for the Dying and Bereaved." *Death Studies* 12 (1988): 111-122.

Mitchell, Kenneth R. and Herbert Anderson. *All Our Losses, All Our Griefs:Resources for Pastoral Care.* Philadelphia: The Westminster Press, 1983.

Mor, Vincent. *Hospice Care Systems: Structure, Process, Costs, and Outcome.* The Springer Series on Death and Suicide. New York: Springer Publishing Co., 1987.

Morgan, John, ed. *Personal Care in an Impersonal World: A Multidimensional Look at Bereavement.* Amityville, New York: Baywood Publishing Co., 1993.

Munley, Anne. *The Hospice Alternative: A New Context fro Death and Dying.* New York: Basic Books, Inc., 1983.

Pfatteicher, Philip H. and S. Anita Stauffer, eds. *Of Resurrection and Life: Preparing for Death and Grief.* Philadelphia: Parish Life Press, 1987.

Thompson, Mervin E. *When Death Touches Your LIfe.* Burnsville, MN: Prince of Peace Publishing, 1986.

Turk, Dennis C. and Robert D. Kerns. *Health, Illness, and Families: A Life-Span Perspective.* New York: John Wiley and Sons, 1985.

Westberg, Granger. *Good Grief.* Rock Island, IL: Augustana Press, 1962.