Chapter 8

RELIGION AND DEATH

O death, where is thy sting? O grave, where is thy victory?

I am a frightened child in the presence of death.

Death is an endless night.

Let me die the death of the righteous.

It is impossible to experience one's death objectively, and still carry a tune.

Achieving immortality is surprisingly simple. . . . To reach human immortality we must follow Rule No. 1 of anti-aging medicine: *Don't die.*[1]

DEATH AND RELIGION: A FRAMEWORK

We humans do not take kindly to death. Shakespeare (1604/1964, p. 81) called it "a fearful thing," and Matthew Arnold (1853/1897, p. 288) viewed death as "a hideous show." One may speak of "noble deaths," "death with dignity," "eternal paradise," or "ultimate rewards," or may state that "nothing can happen more beautiful than death" (Whitman, 1855/1942, p. 18), but its immediate reality is terrifying to virtually all of us. We lament those who die, and dread the awareness that we too, in time, will confront the end of our own existence. Many of us refuse to come to terms with death. We repress, deny, shun, and withdraw where possible from reminders of death, and above all, we fight to delay death. If there is a basic purpose to medicine, it is to reduce mortality and increase longevity. And when we die, the customary North American way of death includes embalming, which Aries (1974) interprets as a "refusal to accept death" (p. 99). In other words, we wish to keep our bodies unchanged. Furthermore, our faiths inform us that we do not simply die; we move to another realm—heaven, hell, limbo, purgatory, or life with God. Finally, there is resurrection: We return to everlasting life. In sum, we never die; our destiny is immortality. Religion guarantees it.

Theologian Paul Tillich (1952) championed such an inference by claiming that "the anxiety of fate and death is the most basic, most universal, and inescapable" (p. 40). Reasoning further, the noted anthropologist Bronislaw Malinowski (1965) maintained that "Death, which

1. These quotations come, respectively, from the following sources: I Corinthians 15:55; Maeterlinck (1912, p. 4); Paul Theroux, quoted in Andrews, Briggs, and Seidel (1996, No. 57808); Numbers 23:10; Woody Allen, quoted in Peter (1977, p. 134); and McFatters (2002, p. 1W).

of all human events is the most upsetting and disorganizing to man's calculations, is perhaps the main source of religious belief" (p. 71). In one study of clergy, only 2% felt that concern about death was not a factor in religious activity (Spilka, Spangler, Rea, & Nelson, 1981).

Even though Western religion assures us of our continuation, it often treats death as a correlate of evil. Scripture is replete with references to death as the appropriate punishment for sin. We are told that it all started with Adam and has been our heritage ever since: "Wherefore, as by one man sin entered into the world, and death by sin; and so death passed upon all men, for that all have sinned" (Romans 5:12). Through death, therefore, religion engenders hope, guilt, and fear.

Wheeler (1971) cites what he terms the "complaint" of the philosopher and poet Unamuno (1921/1954), who somewhat pessimistically opined:

> We require God to exist because we must die. Death is not only unacceptable, it is insulting. It makes life absurd. Because death exists God must also exist in order to eliminate the absurdity of life. Of course, if things were different among men—if men ceased to die—then the ontological existence of God would no longer be necessary. (quoted in Wheeler, 1971, p. 11)

Relative to the theory of religion presented in Chapters 1 through 3, we recognize death as the ultimate threat to our sense of control, and religion has historically been our culture's dominant means of coping with the inevitability of our own demise. Religion makes death meaningful. Death is a mystery that we must unravel. As an unknown, it belies meaning and demands explanation. We do not tolerate ambiguity easily. We have questions, and religion offers us the desired answers. Taken at face value, death implies a simple, final termination. Understandably, we do not easily accept the prospect of ultimate extinction; it is not just that we want to live on indefinitely, but that we desire certainty that this will occur. Religion provides assurance that this will eventually take place. Unamuno (1921/1954) further asserted that the theme of "immortality originates and preserves religions" (p. 41).

Institutionalized faith, as we have seen, plays many roles in life, but the issue of death lies at its core. Kearl (1989) gets to the heart of the matter when he points out that "religion has historically monopolized death meaning systems and ritual," and helps "create and maintain death anxieties and transcendence hopes as mechanisms of social control" (p. 172). Social control easily translates into personal control, another major function of religion (see Chapters 1–3). Expectations of judgment in an afterlife can prompt socially conforming behavior and give people the feeling that they are in charge of their final destiny. Underlying this perspective is the obvious fact that death is the ultimate challenge to our sense of personal control, or, as Langer (1983) puts it, the "illusion of control" (p. 59). Especially in individualistic, achievement-oriented U.S. society, this means, as the historian Arnold Toynbee observed, that death is "un-American, an affront to every citizen's inalienable right to life, liberty, and the pursuit of happiness" (quoted in Woodward, 1970, p. 81). Religion, therefore, stands as the only major bulwark against the threat of death.

RELIGION, DEATH, AND IMMORTALITY

Belief in an Afterlife

Table 8.1 indicates that beliefs in an afterlife, heaven, and hell have a strong grip on the minds of U.S. adults. Whereas the General Social Survey (GSS) in the United States indicates that 81.9% of its respondents believe in an afterlife (GSS, 1999), the International Social Survey

TABLE 8.1. Beliefs in Afterlife, Heaven, and Hell by Religion, Gender, Age, and Education

	Afterlife (%)	Heaven (%)	Hell (%)
Religion (25,190)			
Protestant	84.0	73.2	61.2
Catholic	78.6	63.0	47.7
Jewish	39.7	18.6	10.4
None	54.1	24.2	17.9
Gender (25,190)			
Male	76.3	57.4	48.2
Female	81.5	70.1	55.5
Age (24,737)			
20–29	77.7	60.5	49.0
30–39	80.5	62.4	50.4
40–49	81.1	62.9	53.4
50–59	78.9	68.4	53.5
60–69	78.4	66.5	55.8
70+	79.1	72.1	55.1
Education (9,123)			
0–8 years	77.0	86.1	63.0
High school graduate	80.0	70.1	58.9
College graduate	79.5	50.0	40.2

Note. Data from the General Social Survey (GSS) (1999). Numbers in parentheses at left indicate the total number of valid cases for each domain. Belief in afterlife is indicated by a simple "yes"; beliefs in heaven and hell are given as "definitely yes."

Program data for 1998 reveal no European country with such a high proportion of its population holding these views (Greeley, 2002). Cyprus with 80% and Ireland with 79% are close, but most of the other nations are in the 30–60% range. Since the mid-1950s, however, the general tendency has been toward an increase in such beliefs among Europeans (Greeley, 2002). Morin (2000), utilizing data from the National Opinion Research Center (NORC), has recently reported a similar pattern in the United States. This finding holds for Jews in the GSS, but not for Protestants and Catholics (Harley & Firebaugh, 1993). According to the NORC, between the 1970s and 1990s, belief in life after death increased from 19% to 56% among Jews and from 74% to 83% among Catholics (Morin, 2000). A satisfactory explanation for these findings has yet to be offered. There is need to understand such considerations further, in the light of the rapid rate of technological development, national and international stresses, and a certain tenuousness to life (as shown by terrorist activities such as the World Trade Center tragedy). In a sense, we might hypothesize that for many people, the world has "gotten away from them." The personal sense of control may be increasingly threatened, and the search for immortality may be one effort to regain the security that the "illusion of control" confers.

There are a number of other patterns in Table 8.1 that should be noted. First, belief in an afterlife does not mean that one accepts notions of heaven or hell. Considerable room exists for other beliefs. It would be of interest to define these possibilities and discover their origins and correlates.

Second, people are less inclined to believe in hell than in heaven. Given the religious criteria for being consigned to either realm, self-examination might prompt a considerable aversion on the part of most people to recognizing the potential for a postlife hell. A Harris

Poll (Taylor, 1998) supports this hypothesis: 79% of this poll's respondents believed they would go to heaven, and less than 2% felt that their final destination would be hell.

Third, the distribution of afterlife beliefs by faiths is more or less what one might expect. These ideas have a long history within Christianity, but not within Judaism. In the latter, an undefined eschatology essentially prevails. Note that the 39.7% of Jews accepting an afterlife observed by the GSS (1999; see Table 8.1) is considerably less than the 56% reported by the NORC (Morin, 2000; see text above). Such discrepancies call to our attention the methodological problems one faces in survey research.

Considering the evidence that women are more religious than men, it comes as no surprise to note that they believe more strongly in an afterlife, heaven, and hell. As regards age correlates, there is a slight tendency for beliefs in heaven and hell to increase with age. The youngest age grouping (those in their 20s) are furthest from expected death, and show less belief in an afterlife, heaven, and hell. Sampling variation might account for the highest beliefs in an afterlife for those in the 30–50 age range. Though not truly striking, these higher percentages could also reflect the typical concerns at these ages with supporting a family and raising children. Further verification of these observations is necessary, as well as hypothesis testing to explain such findings.

An interesting earlier study of church members revealed that only 46% of Protestants and 71% of Catholics claimed that "what we do in this life will determine our fate in the hereafter" (Stark & Bainbridge, 1985, p. 53). In addition, there seems to be considerable reluctance to change one's ways to avoid hell (Litke, 1983; Stark & Bainbridge, 1985). Since over half of the Protestants and almost a third of the Catholics surveyed by Stark and Bainbridge agreed that heaven and hell are our destiny for reasons other than the way we live, one wonders whether we are seeing a return to Calvinistic predestination. Again, further detailed investigation into afterlife beliefs is warranted.

A certain vagueness attends these beliefs, since personal continuation is usually viewed as applying to the spirit rather than the body. Still, for many believers, the afterlife is succeeded by resurrection of the body. Contemporary Christianity prefers to conceptualize this as a "spiritual" body rather than a physical one (Badham, 1976). Those desiring further details are often referred to faith and "trust in the Lord." Under such circumstances, this imagery becomes individualized. Nevertheless, the promise that one will not simply and totally cease to exist is present and is widely believed.

Transcending Death

"Transcending death" means overcoming its existence as a simple and final termination of further life in any form. Afterlife beliefs interpret transcendence as simple transformation from one realm to another—a transition from predeath life to a postdeath form.

Lifton (1973) speaks of a universal need to keep in contact with life, to transcend death. Utilizing the rubric of "symbolic immortality," he suggests five ways of accomplishing such a goal. "Biological immortality" lets one live on through offspring and descendants. This potential is further realized in a broader framework in which the person continues through contributions to larger biosocial units, such as attachments to groups ranging from one's family to the human species. "Theological immortality"or "religious immortality" stresses spiritual attachment, implying the triumph of spirit over bodily death. "Creative immortality" is attained through one's works and achievements, the lasting contributions one hopes to make to the future. "Nature immortality" deals with our continuation as part of an undying, enduring, permanent nature. Lastly, there is a state of "experiential transcendence"

or a mystical kind of immortality, "a state so intense that in it time and death disappear. . . . the restrictions of the senses—including the sense of mortality—no longer exist" (p. 7).

Modern science, especially medicine, has extended the notion of biological immortality. Males have preserved their sperm in "banks" for use after they have died. In a number of instances, widows have been artificially impregnated with their deceased husbands' sperm.

A few research efforts have related these modes of immortality to personal faith. Gochman and Fantasia (1979) found, as might be expected, that the religious form is strongest among devout persons, while the remaining types appear to be independent of religion. Religious immortality is also associated with short- and long-term life planning, implying a flexible time perspective—a tendency also noted in the positive relationship between time perspective and religion found by Hooper and Spilka (1970).

Utilizing a cognitive theoretical framework, Hood and Morris (1983) constructed a more rigorous quantitative assessment of Lifton's modes, relating these to forms of personal faith and death perspectives. This work is described in Research Box 8.1.

Research Box 8.1. Toward a Theory of Death Transcendence (Hood & Morris, 1983)

With sensitivity to the necessity of theoretically guided research, Ralph Hood and his associate Ronald Morris denoted what they termed "transcendent" and "reflexive" facets of the self. The former is conceptually associated with immortality, in which the person "survives" this world. The reflexive self or selves, which exist in this world in a real sense, can also survive after bodily death. Cognitive issues come to the fore in thinking about transcendent–reflexive relations and the various forms of the latter. Robert Lifton's (1973) modes of biological, creative, and nature immortality/transcendence, which have been cited in the text above, fall into the reflexive category.

Applying these ideas, Hood and Morris developed reliable measures of the Lifton modes from interviews with 39 persons averaging 65 years of age. Independent judges agreed 94% of the time on classifying the responses to the modes. In terms of their presence or absence, 27 people were identified with nature transcendence, 30 with biological (now viewed as biosocial) transcendence, 31 with religious transcendence, and 33 with the creative mode. These people were then administered scales assessing death anxiety and death perspectives, as well as the Allport–Ross scales for Intrinsic and Extrinsic religious orientations. Patterns of meaningful relationships were obtained, suggesting the usefulness of both the Lifton modes and Hood and Morris's transcendent–reflexive distinction with elderly persons.

Hood and Morris found that the religious mode was associated with perceptions of death as (a test of) courage, and with belief in an afterlife of reward. It further prevented not only fear of death, but perceptions of death as pain and loneliness, failure, the unknown, or a loss of experience and control—tendencies not found with the other modes. The experiential/mystical mode negated the idea of death as a natural end. The biological (now biosocial) mode shared the positive religious correlation with courage and an afterlife of reward, but added death as failure. The creative mode was tied to perceptions of death as pain and loneliness, the unknown, forsaking dependents, and failure, as well as with indifference toward death. These findings suggest that personal achievement is antithetic to ideas of death—which, of course, terminates individual accomplishment.

Using a broader range of samples, Vandecreek and Nye (1993) redeveloped the Hood and Morris measures, but did not relate them to religious variables.

The Search for Evidence of Immortality

The idea of total termination is rightfully terrifying to most people; hence the need to convince oneself that life never really ends is intensely pursued on all fronts, from the humanistic to the scientific. Most people take the religious promise of immortality very seriously.

A massive psychological literature testifies to how perceptions and cognitions are influenced by our beliefs, values, expectations, and desires. When motivation is extremely high we seek information to buttress our convictions, usually making inferences that go beyond the pertinent data. This is probably nowhere more true than in the way we deal with death. We desperately want to believe that life must continue after death, and grasp at every possible sign that this supposition bears the mark of absolute truth. An excellent illustration of this tendency may be seen in making a leap of faith from near-death experiences (NDEs) and possible contact with the dead to the existence of an afterlife. Even though these phenomena pose interesting theological problems, they are compatible with religious thinking in this sense: They imply that people do not simply die and cease to exist, but are transformed and have the potential of remaining connected to the living.

Near-Death Experiences

What we call an NDE has been formally studied since 1882, when the Society for Psychical Research was founded. Undoubtedly, this phenomenon has fascinated people since antiquity (Blackmore, 1991).

The concept of the NDE was greatly popularized during the 1970s. Rather easily, many people transformed the idea of "near death" to "after death." It was commonly believed that those undergoing NDEs had really died, entered an aspect of the afterlife, and then returned to tell about what occurred to them. Little does more to legitimate extraordinary occurrences than to have such events backed by experts. The volume *Life after Life* by psychiatrist Raymond Moody (1976) performed such a function, and, in the process, Moody became quite celebrated. Criticality, logic, and alternative explanations were acceptable only in limited quarters.

The noted pollster George Gallup, Jr., and his associate William Proctor (1982) point out that NDEs (which they term "verge-of-death experiences") have much in common with mystical and religious experiences, in that all may be triggered by extreme threats to life. They even suggest seven different situations that can elicit these episodes. (Keep in mind, as we indicate elsewhere in this volume, that at least a third of the U.S. population reports having had mystical experiences, and that among religious persons the percentage is far higher.) According to Gallup and Proctor, 15% of their respondents claimed to have had NDEs. The possible identification of religious encounters with NDEs suggests that those who report the former may be inclined to have had the latter, and this appears to be true. Gallup and Proctor (1982) found that 23% of those claiming religious experiences also stated that they had had NDEs—a percentage 8 points above that for the general populace. Another variation on this theme is apparent in consistently found correlations between NDEs and belief in other extraordinary phenomena, such as UFOs, reincarnation, and the likelihood that the living can contact the dead.

Turning to a specific group that is likely to question NDEs—namely, scientists—Gallup and Proctor (1982) reported that 10% admitted personal involvement in an NDE. Though 32% believed in an afterlife, only 3% felt that they had actually had a supernatural encounter. The overall tendency of scientists was to separate NDEs from the idea of an afterlife, and many attempted theoretical explanations of these phenomena in terms of physiological changes related to brain chemistry and function under oxygen deprivation, anesthetic effects, or the operation of endorphins. It is also significant that many religionists are also reluctant to claim that NDEs represent proof of an afterlife.

Even though one reads of NDEs in relation to terminality and the appearance to the experiencer of having "died," there is evidence that what occurs in an NDE is also found when drugs have been taken, or even in the normal course of everyday life (Blackmore, 1991).

Further doubt is cast on the supernatural origins of NDEs by the fact that these seem to have changed over time, and are also affected by place (Osis & Haraldson, 1977; Zaleski, 1987). In addition to much individuality entering the picture, cultural influences are obviously present (Osis & Haraldson, 1977; Kastenbaum, 1981). To some religionists, the rather general absence of religious content in NDEs raises questions about their authenticity. The claim has also been made that NDEs often profoundly affect the lives of those who have these perceptions (Ring, 1984). Suggestions of increased social concern and compassion, less materialism, improved self-esteem, and greater internal control have been reported (Ring, 1984).

One may ask whether certain characteristics of the experiencers may dispose them to have NDEs. Kastenbaum (1981) notes that many persons who have "died" and been resuscitated report no NDEs. In addition, various kinds of NDEs have been identified; some people indicate that they perceived one type, whereas others describe different forms. Though most of these are considered positive, frightening or otherwise negative NDEs are also endured. Lastly, people who report NDEs are also apt to have had other paranormal experiences (Kastenbaum, 1981). This last work suggests an avenue for further exploration with regard to personality, suggestibility, and reality contact, among other possibilities. The cross-cultural work of Osis and Haraldson (1977) is widely cited. Even though its findings are in line with other observations on NDEs, there is a "softness" to this effort that is representative of much of the research in this area. Research Box 8.2 presents a number of the issues raised, along with the findings.

The initial enthusiasm that greeted NDEs in the 1970s and 1980s has subsided. Interpretation of these experiences varies widely—from their acceptance as proof of an afterlife, to the concept of NDEs as "spiritual experiences," to analyses in terms of consciousness and brain function. Our psychological perspective assumes that the last possibility may prove of greater importance to a scientific approach than the first two.

Contact with the Dead

The idea of contact with the dead is very popular in Western society. One Internet browser listed 2,040,000 Web sites pertaining to this topic in January 2002, but this appeal to electronics may have originated in 1928, when Thomas Edison unsuccessfully attempted to build an electrical device that would permit one to contact the dead.

To be able to communicate with the deceased means that they are still somehow "alive," existing in a state that is "connected" to our life realm. Death thus means transformation, not termination. For some years, approximately 40% of U.S. adults have believed that they had some degree of contact with a deceased person (GSS, 1999). In 1973, a NORC survey

Research Box 8.2. At the Hour of Death (Osis & Haraldson, 1977)

These researchers have presented their work as the culmination of three major surveys: a pilot study, a U.S. survey, and a survey conducted in India. The last two efforts constituted the final comparative study. The pilot study, which was undertaken in 1959, sampled 5,000 physicians and 5,000 nurses. We read that "640 medical observers returned their questionnaires. These reported a total of 35,540 observations" (p. 27). In other words, there was a 6.4% return rate, which was not further defined by the nature of the "medical observers." Still, an effort is made to imply validity with reference to over 35,000 pieces of data, but these themselves remain largely undefined. In any event, a respondent return rate as small as the one obtained here casts considerable doubt on the generalizability of the information. Apparently 190 cases "of interest" were followed up with questionnaires and phone interviews, but again vagueness prevails. Given the use of questionnaires and the low return rate, one also wonders about the completeness of the returned forms. This is not discussed.

The real "meat" of the work by these researchers consisted of the further studies in India and the United States. In the United States, mail questionnaires were sent to 2,500 physicians and 2,500 nurses. The return rate was 20%, or 1,004 responses. A more personal procedure was used in India; 704 medical professionals responded, which the authors indicate comprised almost all who were approached. Unhappily, again, an unscientific lack of precision is present in the descriptions of both the sampling and responses. Still, an attempt is made to provide data, some of which are interesting and possibly useful.

If we concentrate on the India–U.S. comparisons relative to religion, the categories employed often lack the necessary exactitude. It makes good sense to see that only Indian respondents viewed the apparitional figures of Shiva, Rama, and Krishna, and a grouping of Mary, Kali, and Durga. If we interpret this latter grouping correctly, it mixes Christian and Hindu beings. The same is true of "saints and gurus" and of "demons and devils." Of special interest to us is the finding that there were 418 apparitional figures seen and only 140 religious beings. Of the figures seen by the U.S. respondents, only 12% were religiously identified. The comparable proportion witnessed by the Indian sample was 37.5%.

This work is more useful for hypothesis construction and testing than it is for making reliable and valid inferences. Its subjectivity demands rigorous cross-checking. Considerable room is left for the expectations and values of researchers and interpreters of NDEs to introduce bias, while giving the impression that such work is scientifically rigorous. A door has been opened to understanding a fascinating phenomenon. To date, however, there has been much more talk than solid research (Bailey & Yates, 1996).

indicated that 27% of the U.S. population felt they had participated in such an interaction; this number increased to 42% by 1987 and has been fairly steady since (Greeley, 1987; Morin, 2000). If this represents a real trend between the 1970s and the 1990s, we need to understand what has been happening.

Kalish and Reynolds (1973) found that 44% of those they interviewed claimed contact with someone who had died. A study of widows (Glick, Weiss, & Parkes, 1974) revealed that 64% still thought a great deal about their deceased husbands a year after their deaths. In this work, almost all reported that they frequently experienced a sense of the presence of the de-

parted one. The descriptions often fell into an intermediate category between thinking about the dead spouse and a sense of actual contact. In all likelihood, the dividing line between perceived contact and obsessive thinking is often quite tenuous, and it is difficult to know how to distinguish the two. The combination of desire, need, hope, and other factors may create the conditions necessary for one to experience some alteration of consciousness that leaves the impression of contact with the dead. If someone has died recently, thoughts about that individual can be expected to occupy one's mind for some time to come. Many environmental cues may stimulate such ideas, along with anniversaries of birth, death, marriage, and other important events.

With its emphasis on an afterlife, religion may be influential in reports of contact with the dead. Sixty-six percent and 68% of Catholics and Mormons, respectively, feel that "religious observances by the living" (Kearl, 1989, p. 185) may actually benefit those who are deceased. All other Christian groups are considerably less likely to feel this way; nevertheless, such ideas keep alive the idea of a connection between the living and dead. In general, however, religion's effects do not appear to be major. This is seen in Table 8.2, which presents national survey data.

If religion is not a major influence, are those who report having contacts with the dead different in any other way from those denying such experiences? Data suggest a number of possible influences. On the sociological level, race and gender are significant. Specifically, blacks report more contact than whites, and females are more responsive in this regard than males (Kearl, 1997; MacDonald, 1992). The cultural circumstances of women and blacks are suggested as the reasons for these findings. Psychologically, the tendency of individuals to perceive contacts with the dead increases when they have had more recent experience with friends and relations dying; MacDonald (1992) inteprets these associations as functions of stress and change.

As with those who report NDEs, propensities to claim paranormal encounters are more common among those who state that they have had contact with the dead (Kearl, 1997). The possible role of religion in these observations has not been explored, though the influences of both extremely conservative faiths and New Age orientations are worthy of investigation.

People appear to seize on virtually anything in order to maintain a belief in immortality. The final possibility, which may have mental health ramifications, is simply to believe that someone has not died. Most people probably toy with such an idea immediately after a death. The problem comes when someone refuses to give up these convictions. In a less serious mood, we may ask what can be done to help those who claim that Elvis Presley or other

TABLE 8.2. Responses to the Question "How Often Have You Felt as Though You Were Really in Touch with Someone Who Died?"

	Percentages reporting contact with a deceased person			
Religion	Never	Once or twice	Several times	Often
Protestant	61	23	11	4
Catholic	56	26	12	5
Jewish	65	26	7	2
None	68	23	6	4

Note. Data from GSS (1999), based on 40,933 cases.

deceased notables still walk the earth in disguise. Happily, one's faith is not likely to be implicated directly in such notions.

RELIGION, DEATH ANXIETY, AND DEATH PERSPECTIVES

North American culture has a religious heritage that affirms ideas such as resurrection and life after death in the strongest terms. In one form or another, these views also seem to be worldwide. Such beliefs offer much gratification and help to alleviate a basic source of fear and anxiety. This last concern has been central to much work on the association of religion and death, for it deals with the immediate issue of how people conceptualize and confront death.

Death continually surrounds us. The mass media reveal its presence in daily news accounts of accidents, crimes, natural disasters, and war, and more specifically in ever-present obituaries, death notices, and funeral announcements. However, we tend to be inured to the impersonality of death and dying, because death is usually distant from our everyday lives. The front page is easily put aside; young people ignore everyday reports of death. Their elders increasingly attend to this information, not so infrequently seeing the names of those they have known. Nevertheless, we all must personally encounter death—beginning in childhood with the loss of pets and the demise of elderly relatives. And we often seek explanations and solace in afterlife notions that family, friends, and religious authorities reinforce.

We are suggesting here that we all know from childhood that death is inevitable, and that we don't like it; it is to be feared, and therefore elicits from us a pervasive underlying anxious awareness of death. Many psychologists have attempted to comprehend this phenomenon, and have found that it consistently correlates with religious beliefs and behavior.

Religion and Anxiety about Death and Dying

The principal death-related variable that has been studied in relation to faith has been variously termed "fear of death," "death anxiety," or "death concern."

Research Problems

Certain problems attend this research. First, the domains of religion and of death fear/anxiety have been confounded by measures from both areas containing similar items (e.g., belief in an afterlife). Second, a number of scholars have commented on such deficiencies as poor experimental designs, weak measurement indices, inadequate controls, inappropriate statistical analyses, and the use of questionable samples (Lester, 1967, 1972; Martin & Wrightsman, 1964). With respect to the last issue, most researchers have examined college students—a young population with limited experience of death. Other workers have studied children, elderly persons, psychiatric patients, student nurses, medical students, terminally ill individuals, seminarians, and regular churchgoing community members. Finally, we have described in Chapter 2 how measurement in the field of religion has gone from simple unidimensional scales to more refined and complex multidimensional instruments. A parallel development has occurred in efforts to assess death anxiety. Unitary approaches once dominated the field; now measures are usually multiform in nature.

Despite all these problems, it has been claimed that "one of the major functions of religious beliefs [is] to reduce a person's fear of death" (Groth-Marnat, 1992, p. 277). There has been a great deal of research on this issue; hence we may reasonably ask, "Does faith lessen concern about death?" Initially, we find inconsistency. Our own survey of this literature in the first edition of this book (Spilka, Hood, & Gorsuch, 1985) found that of 36 studies, the majority, 24, evidenced negative relationships between death fear on the one hand, and faith and afterlife beliefs on the other. Seven studies suggested that these domains were independent of each other, while three showed an unexpected positive association. Two others, which were more complex (e.g., assessing different levels of death fear, such as conscious and unconscious expressions), demonstrated two of the three possible relationships. Another examination of 16 studies conducted in the 1980s indicated that six evidenced a negative relationship, three a positive association, and five no affiliation between religion and death concern (Gartner, Larson, & Allen, 1991); there were also two studies with curvilinear patterns. These inconsistencies may be a function of the shortcomings noted above, plus other factors such as cultural influences (Pressman, Lyons, Larson, & Gartner, 1992). Again, we feel the necessity of appreciating the complexities of the religion and death fear realms, which unfortunately are sometimes ignored. Despite a minority of discrepant findings, our overview of this literature suggests that the more exacting research, particularly in terms of samples and instruments, argues for the reduction of death anxiety when religious commitment increases. We are not foreclosing other options, but feel that the best case can be made for this alternative, theoretically and operationally.

The general label of "religiosity" may mask certain factors that reduce death anxiety. Even though religion and afterlife beliefs correlate positively, especially among Christians, we need to consider the degree to which institutional faith in general includes belief in an afterlife as significant. Thorson (1991) further points out that belief in an afterlife correlates more strongly in a negative direction with death anxiety than does religiousness. Others confirm the centrality of afterlife ideas in resisting death distress and related depression (Aday, 1984–1985; Alvarado, Templer, Bresler, & Thomas-Dobson, 1995). Confounding may well occur between religion and belief in an afterlife.

Rasmussen and Johnson (1994) bring another issue to the fore—namely, the question of spirituality versus religiosity. Their research showed no relationship of death anxiety with religiosity, but a noteworthy association with scores on a Spiritual Well-Being scale. Because of the often great overlap between spirituality and religiosity (see Chapters 1 and 2), this relationship needs to be explored further, particularly with regard to afterlife beliefs.

Experimenting with Death Fear

We know that belief in an afterlife correlates negatively with death anxiety, but can we say that increasing concern with death might actually influence one's belief in an afterlife? In an ingenious study, Osarchuk and Tatz (1973) posed this question, and found that inducing death fear could affect one's afterlife beliefs. This work is described in Research Box 8.3.

When significant research findings such as those of Osarchuk and Tatz are obtained, their findings should be confirmed before congratulations are offered. Too often in psychology—or, for that matter, in all of the sciences—initial findings are later contradicted. This is suggested by another, more recent study (Ochsmann, 1984). Differences in method call for more research with new controls, in order to resolve the discrepancies between these studies.

Research Box 8.3. Effect of Induced Fear of Death on Belief in an Afterlife (Osarchuk & Tatz, 1973)

To test their hypothesis that making fear of death more salient would increase belief in an afterlife, these researchers constructed two equivalent and reliable 10-item scales of belief in an afterlife (Forms A and B). Two groups were created. Half of the people in each group received Form A initially; the other half received Form B first. From each group, 10 members were assigned to a death threat subgroup; 10 were assigned to a shock threat group; and 10 were designated as controls. Six subgroups were thus formed—three with high belief in an afterlife, and three with low belief. To the death threat subgroups, a taped communication was played giving an exaggerated estimate of the probability of an early death for individuals aged 18–22, due to accident or to disease caused by food contamination. The tape contained a background of dirge-like music. A series of 42 death-related slides was coordinated with the communication, including scenes of auto wrecks, realistically feigned murder and suicide victims, and corpses in a funeral home setting.

The members of the shock threat group were informed that they would receive a series of painful electric shocks (to which, of course, they never were subjected). The control groups engaged in ordinary play for the same amount of time that the other groups underwent the death or shock threats. All were then given the alternate form of the belief-in-afterlife scales that they had not taken earlier. The results were partially as predicted. Those with low belief in an afterlife, regardless of what group they were in, revealed no changes in their beliefs. In contrast, only those initially holding strong afterlife beliefs who were exposed to the death threat manifested a meaningful increase in these views. It appears that heightening one's concern with death can influence belief in an afterlife. It would have been interesting to see whether other religious views (such as belief in God) were also similarly affected, but this was not done here. The question is one of focus—for, as the 18th-century man of letters Samuel Johnson put it, "when a man knows he is to be hanged in a fortnight, it concentrates his mind wonderfully" (quoted in Boswell, 1791/n.d., p. 725).

The Influence of Circumstances

The Threat of War. It is a far cry from assessing death anxiety among college students and healthy adults to examining such concerns among those who have dealt with, or are likely to confront, life-threatening situations. Even though we are, in a sense, all born "terminally ill," death is rarely "real" to most of us. Among such groups as the military, terminally ill persons, or gays and bisexuals in proximity to HIV/AIDS, awareness of death is far more than an intellectual exercise.

With regard to military experience, Florian and Mikulincer (1992–1993) focused on Israeli involvement in Lebanon during the 1980s. They were able to study religious and nonreligious participants who (1) were not in Lebanon; (2) were in Lebanon, but had no death-related experiences; and (3) were in Lebanon and had death-associated experiences. Fear of death was highest among those in the last group, but the researchers could not distinguish between the religious and nonreligious subgroups within this group. Still, of six fear-of-death factors, the nonreligious respondents scored higher in five. Florian and Mikulincer discuss

the surprising complexity of trying to control for all of the relevant variables in work like this. Despite their creative effort, it is unfortunate that they could not deal with all confounding possibilities.

The Iran–Iraq war of the 1980s offered another opportunity to deal with the influence of confronting death. In a study of almost 1,200 Iranian Muslims, it was found that death anxiety and depression was highest among those exposed to war trauma who were least religious. Religion apparently performed a buffering role, it was felt through its support of belief in an afterlife (Roshdieh, Templer, Cannon, & Canfield, 1998–1999).

The Threat of AIDS. Another type of life-threatening situation is found primarily among gays and bisexuals. In this population in particular, the threat of AIDS is ever-present if one is sexually active. Research Box 8.4 details one significant study in this troubled area.

The Bivens et al. study charts a path to even more complex and insightful work regarding how religion may be employed as a resource to reduce fear of death by individuals suffering from a chronic, life-threatening disease. Concurrently, religion may play a negative role. One can also read the punishment motif of orthodox Christianity in Bivens et al.'s findings. This last theme may also be seen in other work, which found that the more men with AIDS attended church, and the more similar this church was to the one in which they were reared, the more death anxiety they showed (Franks, Templer, Capelletty, & Kauffman, 1990–1991).

In Franks et al.'s work, the greater death fear associated with religious activity in patients with AIDS does not necessarily point to the external stigmatizing role that religion may

Research Box 8.4. Death Concern and Religious Beliefs among Gays and Bisexuals in Variable Proximity to AIDS (Bivens, Neimeyer, Kirchberg, & Moore, 1994–1995)

A sample of 167 gay or bisexual men was obtained; 24 were HIV-positive and 19 had full-blown AIDS. These 43 were termed the "HIV+" group. The remaining men were HIV-negative ("HIV–"). Sixty-nine of the latter were defined as the "AIDS-involved" group, as they helped patients with AIDS in a variety of settings. The remaining participants were denoted "AIDS-uninvolved." All participants were administered a multidimensional scale that yielded eight measures of death fear/concern. An index of personally perceived threat from the potential of one's death was also used. This instrument yielded three factors plus a total score. Intrinsic and Extrinsic religious orientations were assessed by the Allport–Ross scales. Also included were a scale assessing Christian orthodoxy, and a more general inventory of religious beliefs and practices.

The HIV+ group displayed greater fear than the other two groups with respect to the likelihood of a premature death. No difference on this measure was found between the AIDS-uninvolved and AIDS-involved groups. The AIDS-involved participants, however, (1) manifested less global threat and less threat regarding meaningfulness and survival concerns, and (2) were significantly more religious, than the AIDS-uninvolved participants. Intrinsic faith, belief in God, and church attendance also associated with less global threat, threats to meaningfulness, survival concerns, and negative emotional appraisals. Literal Bible interpretations correlated positively with greater death fear, fear of personal destruction, and fear of consciousness in death.

perform. Churches are purveyors of community social values, and the prevailing levels of fear and rejection of AIDS and patients with AIDS are often internalized by these patients (Gilmore & Sommerville, 1994; Kegeles, Coates, Christopher, & Lazarus, 1989). The motivation to keep distance between oneself and AIDS is illustrated by the Muslim denotation of AIDS as a Western disease that can be best negated by complying with Islamic views and practices (Gilmore & Sommerville, 1994). Similar pronouncements by Christian ideologues are common.

The foregoing studies portray a negative role for religion in relation to AIDS, but there is research that indicates the opposite. Over the years, scientific progress has increasingly worked against the notion that AIDS is an automatic death sentence; newer treatments have provided hope. Moreover, the work of Hall (1994) with patients who have end-stage HIV disease shows that a major source of hope is religion. Hope is generated through religious beliefs and faith-related rituals that reduce death anxiety and depression on the part of those facing AIDS, as well as friends and relatives of those who have died from AIDS (Jull-Johnson, 1995).

As we have just seen, death threats from different sources may relate differently to religion in general. Belief in an afterlife is comforting to soldiers who encounter dangerous situations, but may be distressing to homosexuals with Christian inclinations who contract AIDS. Death in war usually has a religiously approved character to it, but traditional, conservative religion frowns on homosexuality.

Multidimensional Possibilities

In all of the above-described research on death anxiety, religion has been treated as a unidimensional phenomenon. One may simply speak of "religiosity," "religiousness," "religious importance," "religious beliefs," "religious practices," and "spirituality," among other conceptualizations. Each of these is treated as unitary—as one well-defined "thing" that somehow includes everything significant in the domain. By the mid-20th century, however, the complexity of personal faith became evident. The field was now faced with identifying the various forms of personal religion. This multiform approach currently dominates research in the psychology of religion.

As noted in Chapter 2, the first effort to understand religion in multidimensional terms was made by Gordon Allport. By the 1960s, his approach was operationalized into Intrinsic and Extrinsic religious orientations, a scheme that has essentially dominated religious measurement ever since (Allport, 1959; Allport & Ross, 1967).

Batson, Schoenrade, and Ventis (1993) have done yeoman service by surveying studies utilizing the measures of Intrinsic and Extrinsic faith in relation to death anxiety/fear. In this work, religion was multiform in character, while the death concern realm remained unidimensional. The findings are quite clear: An Extrinsic religious orientation was usually associated with death fear, concern, or anxiety (variously described), while an Intrinsic outlook opposed such negative outlooks. Even when controls were present for considerations such as guilt and personality, death anxiety maintained its positive tie to Extrinsic tendencies (Swanson & Byrd, 1998). A more recent effort has examined the idea of being obsessed with death, and, as above, found it to be negatively correlated with Intrinsic faith but positively correlated with an Extrinsic religious orientation (Maltby & Day, 2000).

Dimensionalizing Fear of Death

The next step in this research was to develop dimensionalized measures of fear of death. A number of schemes resulted in anywhere from five to eight forms. Minton and Spilka (1976) suggested five components: (1) lack of death fear; (2) sensitivity to death; (3) fear of the dying process; (4) awareness of the nature of death; and (5) loss of experience and control. Focusing on Christianity, Clark and Carter (1978) implied that different features of death anxiety might distinguish among persons varying in religious commitment—specifically, in Intrinsic versus Extrinsic perspectives.

Additional efforts to dimensionalize the fear of death were advanced by Leming (1979), Nelson and Nelson (1975), and Hoelter and Epley (1979); though there is a fair amount of conceptual and operational overlap among these instruments, they have proven useful in research. Nelson and Nelson (1975) identified four death anxiety factors that they labeled Death Avoidance, Death Fear, Death Denial, and Reluctance to Interact with the Dying. Scales were constructed to assess these areas, but important information was lacking, and these measures do not appear to have been used in other research. Pandey (1974–1975), also using factor analysis, found four components that he called Escape, Depressive Fear, Mortality, and Sarcasm. Again, serious questions may be raised about this work, which was not followed up. Not only are such aspects of death anxiety differentially related to religion, but curvilinear associations have also been demonstrated (Florian & Mikulincer, 1992–1993; Hoelter & Epley, 1975; Nelson & Cantrell, 1980). For example, Leming (1980) observed such relationships between overall religiosity, religious belief, experience, and ritual on the one hand and fear of death on the other. He suggested "that religiosity may serve the dual function of afflicting the comforted and comforting the afflicted" (p. 347).

In an effort to correct the shortcomings of the instruments described above, Stout, Minton, and Spilka (1976) factor-analyzed the responses of 221 people on 41 death anxiety items. Three reliable instruments somewhat similar to those of Nelson and Nelson (1975) were constructed. These were termed Lack of Death Fear, Experience in Death and Dying, and Awareness of the Potential of Death. Surprisingly, and in contradiction to other work, Intrinsic religiosity was independent of all three death anxiety scales; however, Extrinsic faith related (as expected) to death fear, to death experiences implying anxiety about how one will die, and to what being dead means.

A different approach to the issue of the complexity of death anxiety was introduced by Feifel (1974), who pointed out that both conscious and unconscious considerations should be evaluated when the death realm is examined. In other words, one's fear may be either conscious, unconscious, or both. Initially, Feifel was unable to find differences between religious believers and unbelievers with respect to these levels of death fear among persons who were either physically healthy or terminally ill. Expanding this work to three degrees of awareness, the deepest level (most unconscious) failed to relate to religion, but a midlevel fantasy approach did contribute markedly to associations with religious indices (Feifel & Tong Nagy, 1981). Employing different measures, Rosenheim and Muchnik (1984–1985) observed the influence of religion on the unconscious level, but found that it was less significant than the personality trait complex of repression–sensitization.

Other Death Perspectives

There are various other perspectives on death, which may or may not overlap with the various dimensions of death fear. This approach was initiated and refined by Hooper and Spilka (1970). Research Box 8.5 illustrates a later development of this work.

Research Box 8.5. Death and Personal Faith: A Psychometric Investigation (Spilka, Stout, Minton, & Sizemore, 1977)

Early research on attitudes and feelings toward death focused on the main emotion people express toward death. Simply put, this is fear, even though some have called it death concern or death anxiety. It soon became evident, however, that different facets of the death and dying process were being emphasized. A simple positive–negative response had to give way to more complex cognitions regarding this inevitability. Hooper (1962) originally conceptualized 10 different ways of looking at death. One could view it (1) as a natural end, (2) as pain, (3) as loneliness, (4) as an unknown, (5) as forsaking dependents, (6) as failure, (7) as punishment, (8) as an afterlife of reward, (9) with courage, and (10) with indifference. A rigorous analysis of statements in these 10 perspectives resulted in the following eight reliable scales:

1. *Death as Pain and Loneliness.* Death is viewed as painful, and is associated with loss of mastery, consciousness, and isolation.
2. *Death as Afterlife of Reward.* Death leads to eternal reward and personal justification.
3. *Indifference toward Death.* Death is of no consequence, a trivial occurrence in the scheme of things.
4. *Death as Unknown.* The end of life is an unfathomable and ambiguous mystery.
5. *Death as Forsaking Dependents.* Death involves guilt over leaving one's dependents.
6. *Death as Courage.* Death is a final test of one's highest values, strength of character, and courage.
7. *Death as Failure.* Death is personal failure and defeat—the ultimate in frustration and helplessness.
8. *Death as Natural End.* Death is the simple natural conclusion to life, with nothing beyond it.

A number of studies related these death perspectives to scales assessing overlapping religious orientations (i.e., Intrinsic vs. Extrinsic faith, and Committed and Consensual religious forms). The table below shows the differential pattern of correlations between the death perspectives in the Spilka et al. (1977) study, and a later confirmatory one by Cerny and Carter (1977). In further work, Clark and Carter (1978) obtained similar findings.

	Personal religion scales							
	Committed		Consensual		Intrinsic		Extrinsic	
Death perspective scales	Spilka	Cerny	Spilka	Cerny	Spilka	Cerny	Spilka	Cerny
Death as Pain and Loneliness	−.08	−.19**	.13	.18*	−.26**	.21*	.36**	.41**
Death as Afterlife of Reward	.35**	.77**	.20*	.51**	.37**	.72**	−.07	.05
Indifference to Death	−.09	−.38**	.18*	−.14*	−.25**	−.38**	.39**	.14*
Death as Unknown	−.24**	−.41**	.12	−.23**	−.18*	−.47**	.21**	.14*
Death as Forsaking Dependents	−.11	−.07	.14	.12	−.13	−.13*	.31**	.31**
Death as Courage	.20*	.45**	.14	.35**	.12	.41**	−.01	.10
Death as Failure	−.18*	−.15*	.17	.25**	−.23**	−.17**	.49**	.41**
Death as Natural End	.04	.11	.19*	−.03	−.13	.04	.29**	.04

Note. The higher coefficients were probably a function of the broader range of religious activity and belief observed in Cerny and Carter's (1977) larger sample.

*$p < .05$. **$p < .01$.

continued

Research Box 8.5. *continued*

It is noteworthy that this table shows only one instance of disagreement in the direction of a relationship where both correlations were statistically significant. Full agreement in both direction and significance occurred in 22 of the 32 coefficients. In addition, of the nine correlations that attained significance in only one of the studies, eight occurred in the Cerny and Carter research. As the table footnote indicates, this could have been a function of the larger sample, as well as the use of less stringent criteria to denote religiosity. These would have permitted greater meaningful variance, and hence more significance.

The pattern of correlations was as expected. Scores on the scales for Intrinsic and Committed religious orientations related positively to scores on scales indicating favorable outlooks on death (e.g., Death as Afterlife of Reward and Death as Courage). Negative associations were obtained with scales indicating undesirable death perspectives, with one exception (Intrinsic religion with Death as Pain and Loneliness). The latter may simply have been an "artifact" (a chance occurrence). Again, we note that religious commitment endows the individual with strength and reason not to fear death. There is obviously considerable potential to understanding both death and religion in multidimensional terms.

RELIGION, DEATH, AND AGE

When we look at death, our understandings primarily encompass the period from adolescence to old age—in other words, young and middle adulthood. There is a popular aversion to associating death with children; although children do encounter death, and sometimes even die themselves, we acknowledge these facts with reluctance. In contrast, old age and death naturally seem to go together. Religion, however, is pertinent to both extremes of the age continuum.

Religion and Death in Children

Children's Views and Knowledge of Death

Before religion can exercise its influence on children, we need to know something about their views and knowledge of death. Using primarily Piagetian developmental concepts, a number of researchers have made efforts to determine how children learn about death and conceive of it as they develop (Anthony, 1940; Nagy, 1948; Wass, 1984). Even though possibilities of death awareness are implied as early as the age of 2, by the time children reach age 5 or so, they no longer regard death as a temporary and reversible phenomenon. For about the next 4 years, death is embodied as a person, and a child may feel that this personification can be avoided. After ages 9 or 10, death becomes understood as a universal and inevitable process that affects everyone (Nagy, 1948).

Also at about the age of 5, religious ideas become associated with death. Concepts of God, angels, heaven, and the like are introduced, probably reflecting the influence of parental faith, and instruction in church and Sunday school. For example, 5-year-olds are well acquainted with the deaths of animals and elderly people, particularly grandparents

(Goldman, 1970). Religious explanations of such experiences are commonly provided by teachers and parents, in an effort to reduce the anxiety and fear that may result as children attempt to comprehend what has occurred.

During these early years, religious language is anchored in tangible, concretistic notions. For example, Tamminen's (1991) young subjects generally stated that dead people and possibly pets go to heaven, which is located in the sky, and that they remain there with God. The relationship between death and religion follows Piagetian developmental concepts quite well (Hyde, 1990; Wass, 1984).

Employing galvanic skin responses (GSRs) with a word association test, Alexander and Adlerstein (1958) attempted to determine emotional correlates of death-related terms among children ranging in age from 5 to 16. The middle group (those aged 9–12) displayed the lowest GSRs. The youngest group (aged 5–8) came in second, while the oldest respondents (aged 13–16) evidenced the highest GSRs. Death-related words elicited significantly longer response latencies than neutral terms did over all ages, implying that death concepts do arouse emotion. This effect was greatest for the youngest children and least for the oldest group.

Childhood Spirituality and Death

Even though he recognizes the pervasive influence of religion in the lives of children, psychiatrist Robert Coles (1990) feels that the notion of "spirituality" better describes the holistic quality and innocent purity of how children treat religious ideas. Death is one of those realities that affect children deeply. Using primarily interview methods, Coles has simply inferred that "death has a powerful and continuing meaning" (p. 109) for children. Both actual death and potential death are profound mysteries that often call forth images of God and Jesus in children. Death is a puzzlement, an awesome phenomenon, a challenge to understanding, a stimulus for contemplation, and a source of emotional turmoil. Formal religion is put aside as children seem to marshal their defenses against death's finality. However, personal prayer is frequently employed as death is largely concretized in specific experiences and observations—the loss of grandparents, the accidental deaths of strangers, the death of friends, and thoughts of personal death. The idea that heaven is nearby mutes the fear and horror of dying. When one reads what Coles's children say, an individuality shines through, making his attribution of spirituality most appropriate. This is rich material, and even though we would like to analyze it in a more objective manner, it shows that our generally preferred method has limits.

Death apparently becomes increasingly important as individuals leave childhood and adolescence. Still, there is a dearth of solid research relating faith to death fear, anxiety, and attitudes among children and young people. The role of specific religious forms has also been overlooked. Anecdotal descriptions are useful, but objective research is necessary.

Religion, Death, and Elderly People

Death is too far from young persons and too near elderly people, both in fact and perception—but not always, as one might expect. As of 1997, persons over the age of 65 did account for 75% of the deaths in the United States; therefore, the reality of death grows as one ages, and this invariably becomes a coping issue (Kearl, 1989; U.S. Bureau of the Census, 2000). The average U.S. resident actually lived 75.4 years in 1991, the last year this information was presented (U.S. Bureau of the Census, 2000). Preliminary data for 1998 show that

life expectancy at birth for the U.S. population was 76.7 years. The projection for 2010 is 78.5 years (U.S. Bureau of the Census, 2000). This number has increased 5.9 years since 1970; the process of increasing longevity is thus apparently slow but sure.

Death Concern among Elderly Persons

Erikson and his associates have claimed that "those nearing the end of the life cycle . . . [struggle] to balance consequent despair with the sense of overall integrity that is essential to carrying on" (Erikson, Erikson, & Kivinick, 1986, p. 8). The expectation of an association between increasing age and despair is probably overdone, however, and may be a view held by more younger people than older people. In one study of those over the age of 65, only 4% were troubled by their own relative temporal proximity to death (Munnichs, 1980). Other research reported that only 10% of an older sample indicated fear of dying, while 45% claimed a "forward-looking attitude toward death" (Swenson, 1965, p. 108). The same percentage were said to be evasive, preferring not to think about death; this does imply some degree of death anxiety.

Regardless of age, death anxiety may be essentially irrelevant when a person is healthy. A study of patients suffering from terminal cancer and heart disease plus a healthy control group found that most of those who were ill denied fears about death (Feifel, Freilich, & Hermann, 1973). No differences were observed between the patients with heart disease and those with cancer. Since clinically sophisticated interviewers gathered the data, conscious and unconscious indicators of death fear were distinguished. The results just described applied only to conscious fears; significant evidence of differences between the healthy and ill groups in unconscious fears were noted, with both ill groups revealing higher levels of unconscious death fears.

Another possibility is that thoughts of death and dying are replaced by "more optimistic life-affirming involvement" (Munnichs, 1980, p. 63). In a personal contact, a centenarian responded to a question about whether she thought about death with the response, "Of course, but I'm too busy to die."[2] She was indeed, and survived for another 3 years. Hers is not an isolated perspective. The notion of not wanting to die because of "unfinished business" may be quite common (Tobin, Fullmer, & Smith, 1994). This view challenges the most popular social science perspective on aging—namely, "disengagement" theory, which suggests that people are supposed to lead themselves toward death when they are old by slowly withdrawing from their worldly attachments (Kearl, 1989). In cases where such withdrawal occurs, it is usually accompanied by health problems.

The question of what constitutes "withdrawal" is controversial. The recent proliferation of senior centers and senior housing with exercise programs and a variety of intellectually stimulating courses is working increasingly against disengagement. In addition, older people are also often involved with religious institutions, and to regard such involvement as "disengagement" may be more pejorative than accurate. The constructive aspect of this behavior is most evident: Elderly persons who are religious generally reveal low levels of anxiety and concern about dying (Koenig, 1988). Though a minority of studies show no relationship between these variables, none show a positive association (Koenig, 1994a).

2. This response was given by Dr. Ruth Underhill in a 1977 course on the psychology of death and dying, which was taught by Bernard Spilka. Dr. Underhill was then almost 100 years old, and was still both mentally and physically active.

Faith apparently buttresses older people against the idea of impending death; it may accomplish this protective and beneficial function not only by its assurance of an afterlife, but also by currently affirming one's worth and dignity. Koenig (1988) suggests that religion plays a buffering role against death anxiety, because it offers hope that death is not a final end. As in Swenson's (1965) study, highly religious people may perceive death as a doorway to a future life of reward. Koenig further reinforces the idea that religion may support the mechanism of denial—a kind of cutting off of such negative emotions as fear and anxiety. Lastly, we should not underestimate the role of the church in bringing together groups of elderly devout individuals, so that anxieties about death may be lessened through discussions and social reinforcement of doctrines and beliefs that neutralize concern about death.

Even in cases where aging people do reduce their social and occupational roles (i.e., where disengagement occurs), religious involvement may be substituted for other lost positions. Church activities offer a number of social possibilities by sponsoring the acquisition of new contacts and opportunities, to demonstrate that one is still effective and has worth. Blazer and Palmore (1976) thus noted that "religious activities . . . were correlated with happiness, feelings of usefulness, and personal adjustment" (p. 85) among those over 70 years of age. The emotion-controlling and directive roles that ritual plays should also be considered here. Not a few of the elderly regard religious ritual as reassuring (Erikson et al., 1986).

Old age is a time, as Erikson et al. (1986) have put it, of dealing with the issue of basic meaning. As we have noted in a number of chapters, this is one of the most fundamental of religious purposes. Facing death implies the attainment of integrity and what Erikson and colleagues call "wisdom." The task for the individual is to gain a sense of place in the universe—a religious function if there ever was one. The last years of life are thus a period of taking stock, coming to terms with the past, and looking into a questionable future. In a rather straightforward study, Jeffers, Nichols, and Eisdorfer (1961) interviewed 269 community volunteers 60 years of age and older about their afterlife beliefs and fear of death. Table 8.3 summarizes the main findings in relation to religion. The data in the table are simple and clear: Religion negates fear of death among older persons.

TABLE 8.3. Fear of Death and Belief in an Afterlife in Relation to Religious Variables in an Older Sample

Fear of death was associated significantly with . . .
Less belief in life after death.
Less frequent Bible reading.
Belief in an afterlife was associated significantly with . . .
Less fear of death.
More frequent church attendance.
More frequent Bible reading.
Involvement in more church activities.
More favorable attitudes toward religion.
Greater personal importance of religion.

Note. All of these relationships attained statistical significance at the .05 level. Data from Jeffers, Nichols, and Eisdorfer (1961).

Religion, Elderly People, and Longevity

In the late 19th century, Francis Galton rejected the idea that piety and longevity may be positively correlated. Focusing on individuals who prayed the most or who were prayed for the most, he showed that neither group benefited from prayer (Mccullough, 2001). People have often been reluctant to accept such a judgment. Where research has dealt with this issue, either directly or indirectly, the results have not been either clear or consistent. A. H. Richardson (1973) studied over 1,300 octogenarians and found religion to be unrelated to 1-year survival rates. More recent work by Koenig (1995) confirmed this finding. Idler and Kasi (1992) also found that neither public or private religiousness predicted mortality; however, for both Christians and Jews, there were significantly fewer deaths in the 30 days prior to a major religious holiday than for the same period afterward.

Other research on a sample of institutionalized, chronically ill elderly people claimed that those who die within the year were less religious (Reynolds & Nelson, 1981). This picture is muddied by the fact that they also had poorer prognoses and were more cognitively impaired. In a similar vein, Zuckerman, Kasl, and Ostfeld (1984) reported that religion was positively correlated with longevity, but only among elderly individuals who were in poor health.

McCullough (2001), in a truly major effort, has attempted to resolve the many contradictory investigations in this area. He and his associates undertook a meta-analytic review of the research in this area, and came up with 42 independent estimates of the relationship between religion and mortality. ("Meta-analysis" is basically a methodological/statistical procedure in which one gathers together a great deal of data that are thought to be comparable, and analyzes these data in order to resolve discrepancies, disagreements, and conflicting findings). Even after considering some 15 possible confounding factors, McCullough (2001) found that religious involvement and longevity were positively related. The association was, however, rather weak. For example, if we had two groups of 100 people each—one group being high in religiosity, the other less religious—we could expect to find in a later follow-up that 53 people in the less religious group had died, while only 47 in the more religious group had died. This outcome would apparently hold for public religious activity (e.g., church attendance), but not for private devotions. The association between religion and mortality was also found to be stronger for women than men. McCullough (2001) offers a number of possibilities to account for these observations, opening the door to further research. This is an area that merits more rigorous study, along with theory that offers reasons why faith and mortality should be related, especially among elderly people.

RELIGION AND EUTHANASIA

Euthanasia is a troubled realm. Not a few seriously or terminally ill patients have appealed to be euthanized, and have even sought relief through the courts. Behind the scenes, however, such desires are surprisingly common.

This is an issue that is often simplified and euphemized by such terminology as "mercy killing," "assisted suicide," "right to die," and "death with dignity." A distinction must, however, be made between "passive" and "active" euthanasia. The former usually implies the withholding of heroic measures to sustain life when death is imminent and the quality of life is very poor. In contrast, active euthanasia is the intentional termination of life under

the same conditions, especially when great pain and suffering are present. This is probably practiced more often than we think when the patient makes impassioned pleas to die.

Support for Euthanasia: Medical and General

Though active euthanasia is illegal in most jurisdictions, the overwhelming majority of medical professionals favor passive euthanasia. Surveys reveal that from two-thirds to over 90% of health care practitioners approve passive approaches, whereas only 17% of physicians and 36% of nurses take positive views of active euthanasia (Carey & Posavec, 1978–1979; Hogg & Spilka, 1978; Lavery, Dickens, Boyle, & Singer, 1997; Rea, Greenspoon, & Spilka, 1975). It should not come as a surprise that in 1993, a Gallup Poll reported that 43% of U.S. residents approved the "assisted suicide" actions taken by Dr. Jack Kevorkian (*The Gallup Poll Monthly*, 1993, p. 47); a slightly greater number (47%) disapproved. The Gallup Poll organization has taken a sophisticated view of the euthanasia issue, revealing how attitudes are dependent on a number of factors. Table 8.4 illustrates some of these considerations.

TABLE 8.4. Attitudes toward Euthanasia in the United States

Do you think a person has the moral right to end his or her life under these circumstances?[a]

	Yes	No
When the person is suffering from incurable disease	58%	36%
When the person is suffering great pain with no chance of improvement	66%	29%
When an otherwise healthy person wants to end his or her life	16%	80%

A terminally ill person wants treatment withheld so that he or she may die. The patient has the right to stop treatment . . .[a]

	Yes	No
If the doctor agrees	75%	22%
If the person is in great pain	78%	18%
If the family agrees	76%	22%
Under any circumstances	59%	4%
Under no circumstances	11%	87%

If you yourself were on life support systems and there was no hope of recovering, you would prefer to . . .[a]

	Yes
Remain on life support	9%
Have treatment withheld	84%

Do you think a doctor should be allowed by law to assist a person to end his or her life?[b]

	Yes	No
When the person is suffering from incurable disease	52%	42%
When the person is suffering great pain	64%	31%
When the person is a burden on the family	22%	71%
No reason	8%	88%

[a]Data from Gallup (1992, p. 4).

[b]Data from *The Gallup Poll Monthly* (1992, p. 34).

Religious Perspectives on Euthanasia

Though scripture and theology are usually interpreted as opposing euthanasia, there is much deviation from such a position. If euthanasia is approved by a physician, 61% of Protestants, 62% of Catholics, and 78% of Jews agree with such a stance (Kearl, 1989). The strength of one's religious position affects these findings, as the comparable data for "strong" Protestants, Catholics, and Jews are 49%, 51%, and 67%, respectively (Kearl, 1989). It is abundantly evident that euthanasia under certain circumstances is supported widely regardless of religious affiliation, but that this support decreases with an increasing degree of religiosity. In addition, for the last 50 years, the tendency has been for approval of euthanasia to increase slowly and steadily among moderate and liberal religionists (Kearl, 2002). Such approval is also a positive function of belief in an afterlife (Klopfer & Price, 1979).

Religion and Physician-Assisted Suicide

A conceptual variation on active euthanasia is "physician-assisted suicide" (PAS). Needless to say, sometimes the distinction between the two is tenuous. PAS takes one of two forms: (1) The physician may offer the individual the means (pills, injections, or equipment) to induce death; or (2) the doctor may accede to the patient's wish to die by actively causing the person's death (Koenig, 1994a). Though PAS is against the law in the Netherlands, the law is evidently not enforced, and it is estimated that up to 10,000 persons utilize PAS annually in that country. Despite the fact that these procedures are also illegal in the United States, there is much tacit approval of their use, and in a number of states efforts to pass laws permitting PAS are pending. Illustrative of this trend, in 1994, a federal district court in the state of Washington struck down the state's 140-year-old law that made assisted suicide illegal (Kearl, 2002). In states where the electorate has acted on such proposals, they have usually been narrowly defeated (Koenig, 1994a). Oregon, however, did pass such a law in 1997, and a number of terminally ill people have utilized their right to die under this statute. It is currently being challenged in the courts.

Opposition to PAS has come more from formal religious organizations than from their individual members. Still, the more liberal Christian and Jewish groups are slowly increasing their support for PAS. The United Church of Christ already formally backs such action (Koenig, 1994a).

Indications that it is probably just a matter of time before more religious bodies justify euthanasia and PAS come from the increasingly favorable positions taken by clergy. In one investigation, Carey and Posavec (1978–1979) found that 96% of the clerics they sampled advocated passive euthanasia, and that 21% espoused its active form. Support for passive euthanasia varies with the reasons advanced for such action, however (Nagi, Pugh, & Lazerine, 1977–1978). Depending on the justification, Carey and Posavec (1978–1979) found that support was offered by anywhere from 34% to 73% of Protestant clergy; for Catholic priests, the comparable percentages ranged from 30% to 69%. In regard to active euthanasia, the percentages were significantly lower: Only 13–25% of the Protestant clergy, and only 1–3% of the Catholic priests, countenanced such action. Even though Carey and Posavec's investigation failed to designate the Protestant denominations sampled, approval of euthanasia grows with liberality of a cleric's theological position and group. Conservative clergy balance their opposition with strong beliefs in a rewarding afterlife (Spilka, Spangler, & Rea, 1981).

Despite the fact that a study by Gillespie (1983) did not bear directly on the question of euthanasia, he demonstrated clerical differences on a variety of death perspectives across religious groups. This research implies that pastoral outlooks on euthanasia may be dependent on other factors than denominational conservatism and afterlife beliefs. It opens a significant door to further study.

A word is in order regarding why there is religious opposition to euthanasia and PAS. In brief, a position derived from scripture simply avers that both life and death are in "God's hands." That is, life can only be given and taken away by the deity. Other considerations are that the pain and suffering of the ill person is supposed to be experienced by that individual, and may benefit all concerned in the long run.

RELIGION AND SUICIDE

The tragedy of suicide is usually difficult to understand. In nations such as the United States and Canada—with so much to offer, with medicine making almost unbelievable progress, and with science and technology opening a future that points toward an easier and better life for all—suicide remains a mystery for most people. Psychological explanations such as depression abound, but these often mean little more than that a word has been substituted for a reality that can't be grasped. Death itself is enigmatic, but suicide remains the ultimate conundrum.

In 1998, 29,300 people in the United States committed suicide; the National Institute of Mental Health tells us that approximately another half million people entered hospital emergency rooms as a result of attempting suicide (Hoyert, Kochanek, & Murphy, 1999; U.S. Bureau of the Census, 2000). Though women attempt suicide more often than men, the latter "are four times more likely to die than are females" (U.S. Office of the Surgeon General, 1999, p. 1). Among whites, depending on age, male suicide rates range as high as six times those for women (U.S. Bureau of the Census, 2000, p. 93). The incidence of suicide is fairly level until age 59, after which it sharply increases from 23 per 100,000 to 65.3 per 100,000 for men 85 years and older (U.S. Office of the Surgeon General, 1999). After age 65, men account for 84% of all suicides. The suicide rate for elderly divorced or widowed men is 2.7 times that for their married peers and over 17 times the incidence for married women (National Center for Injury Prevention and Control, 2003). The fact that 85 people commit suicide each day in our country portrays a true national tragedy (U.S. Public Health Service, 1999).

Views of Suicide in Institutionalized Religion

Institutionalized religion has rather uniformly treated suicide in negative terms. The Judeo-Christian tradition has taught that suicide is immoral and therefore sinful (Kastenbaum, 1981). Those who commit suicide may not be allowed burial with the faithful in religiously sponsored cemeteries, and may be consigned to certain sections that imply severe condemnation and rejection. Because of the stigma that has traditionally been (and often still is) attached to suicide, medical, religious, and civil authorities commonly identify a death as a suicide with reluctance. The more modern religious perspective is to consider these individuals as mentally disturbed—a diagnosis that removes the burden of sin, and mitigates the opprobrium that members of the surviving family have often received from the religious community. The influence of religion on attitudes toward suicide has lessened con-

siderably in the contemporary world, especially in the United States (Wasserman & Stack, 1983).

That institutionalized faith can affect the incidence of suicide has been well documented for over a century (Dublin, 1963; Kastenbaum & Aisenberg, 1972). Cross-national studies suggest a weakening of the impact of religion, such that the inverse relationship between faith and suicide may no longer hold for men, but this is questionable. It continues to exist among women (Stack, 1983). The classic finding that religious commitment and conservatism oppose suicide nevertheless persists; hence church attendance remains negatively correlated with suicide rates (Martin, 1984).

Religion and Suicide among Elderly Persons

We have noted above that people over 60 are at much greater risk of suicide than younger cohorts are. Kearl (1989) suggests that "for some elderly individuals, suicide is preferable to loneliness, chronic illness, and dependency" (p. 145). This may be especially true for physically ill older men, the group with the highest suicide rate in the United States. Again, however, among elderly individuals, religion plays its traditional role in opposing self-destruction. Koenig (1994b) suggests that faith suppresses suicidal thinking in this group. He found that 18% of his sample of physically ill older men experienced suicidal thoughts, and that these were negatively related to religious coping.

This last observation may reflect a generation effect. Elderly religious individuals were reared at a time when religion was a stronger cultural influence than it is today. Because of this, they may identify with their faith's opposition to suicide, as well as with the promise of a happy afterlife. A related finding is that the recovery from bereavement of those who lose a loved one via suicide is enhanced by high belief in an afterlife (Smith, Range, & Ulmer, 1991–1992). We need to know whether this is true for those who committed suicide. Also, were they more isolated prior to their action? Direct research relating suicide to belief in an afterlife with this group would make a noteworthy contribution to this literature. Obviously, such information would have to be obtained indirectly.

Another answer may lie in being socially integrated into the community, especially a religious community. The data tell us that the highest suicide rates are among older, single, socially isolated men (Dublin, 1963; Stengel, 1964). Dealing with suicide ideology—namely, attitudes toward suicide—Stack and Wasserman (1992) have noted three possibilities: (1) Religion fosters general social integration, which opposes suicide; (2) specific religious views, such as belief in an afterlife, may contravene self-destructive impulses; and (3) religious organizations foster networking and social support, which should thwart suicidal inclinations. Using sophisticated statistical techniques on national data, these researchers found evidence supporting all three views, especially for conservative religious bodies. Focusing on church attendance, Stack and Wasserman concluded that the social connections a common faith may create and reinforce could be the main elements hindering suicide.

Apocalyptic Suicide

Recent years have witnessed a spate of mass suicides among members of religious cults. The cases of the Jonestown People's Temple, the Branch Davidians, and Heaven's Gate (among others) have shocked the world, and have left most of us without a satisfying explanation for these tragedies. There is a considerable literature on doomsday cults, and the classic study

When Prophecy Fails (Festinger, Riecken, & Schachter, 1956) offers an entry into this topic, even though it does not deal with death except as a fantasy possibility.

The rather bizarre forms religion took in several cults in which there were mass suicides has been analyzed by Dein and Littlewood (2000). The inclination of scholars who have studied these groups has been to examine their leadership and group structure. Searching for common personality factors or various forms of mental disorder has not been productive. The lack of hard data—specifically, too much clinical subjectivity and a dearth of confirmatory efforts—makes inferences in the realm of the individual rather tenuous. Vague allusions to paranoid traits, poor reality contact, or distressing early life conditions also do not appear useful. Previous work on mental disorder among cultists indicates the incidence of such problems to be no higher in cults than in the population at large (Needleman & Baker, 1978; Richardson, 1980; Wright, 1987).

If generalizations can be offered, a number of possibilities seem in order. Cults are groups that center about charismatic leaders who work to see that their members are separated from society in general, from family members, and from anyone who might offer divergent views. Absolute devotion to the leader's beliefs and teachings is reinforced in every manner possible. These doctrines may include the notions that death is invariably a door to a future life; that the physical body is a hindrance; and that even if people commit suicide, they never truly die in the sense of total termination, but continue on toward an ideal realm, a heavenly existence. These groups create the conditions that make suicide appear to be the only means of achieving ultimate happiness. The chapters in this volume on conversion and religious organizations (Chapters 11 and 12) go into these considerations in much greater depth.

Religion and Suicide: A Cross-Cultural Note

In Chapter 1, we have regretted the fact that little research has been undertaken on other than Western societies and cultures. However, comparisons are possible between Hindus and Muslims in regard to religion and suicide. Though Ineichen (1998) points out that Hindu religious writings are ambivalent about ending one's life, ultimate salvation is denied those who commit suicide. Strongly contrasting with this stance, the Koran and Islamic interpretations explicitly condemns suicide. The result is that Hindus manifest much higher suicide rates than Muslims (Ineichen, 1998). A very recent survey of national suicide statistics reveals a much higher rate of suicide for India than for Muslim nations that report such data (World Health Organization, 2001).

These data may be questioned, however. It is often difficult to be sure that a deceased person committed suicide, and, as noted earlier, there is great resistance to making such an identification in a cultural/religious milieu that strongly opposes suicide. When nations such as Jordan claim that no suicides at all took place in 2001, and Egypt gives a rate of 0.1 per 100,000 (World Health Organization, 2001), there is good reason to question these reports.

RELIGION, GRIEF, AND BEREAVEMENT

Living means that we will experience the deaths of loved ones, for there must always come that time when a beloved person "goeth to his long home, and the mourners go about the streets" (Ecclesiastes 12:5). When someone dies, the likelihood is high that family and friends

will turn to religion for solace and understanding. Faith is often a basic part of the coping process, and death is frequently confronted and conceptualized in religious terms.

The process of grief and bereavement is surprisingly complex. "Grief" is an emotional process. "Bereavement" is not unambiguously defined as separate from "grief," though it emphasizes the sense of loss that leads to grief. Another overlapping concept is "mourning," which refers to the combination of cognitive, emotional, and behavioral responses that one manifests in bereavement.

The literature offers discussions about stages of grief, models of grief, degrees of grief, ritual in grief, religion as a resource in bereavement, the grief of parents and grandparents for deceased children and grandchildren, the grief of spouses for deceased mates, and grief for other family members and loved ones. In all of these areas, the role of faith is significant. For example, Flatt (1987) suggests some 10 grief stages that range from "initial shock" to what he terms "growth." In most of these stages, God is given a role—whether it be a questioning of how the deity could let someone die or how the divine actively brings about a death, to a place for "God's grace" in recovery from the depression resulting from grief. Another possibility is that the recovery from grief may move the person along to new stages and tests, such that the deity is seen to care as the person is reintegrated into "God's world." This means that the bereaved gains new strength to realize "God's purpose" in his or her remaining life (Flatt, 1987). Here we observe how significant attributions to God may be when death is confronted.

The central issue is "making sense" out of the loss, and religion seems to be the main source of meaning available to the survivors. Whether it is the loss of a spouse, a child, or another loved one, religious/spiritual commitments, doctrines, and ideas offer the meanings that reduce symptoms of distress and engender hope (Dahl, 1999; Golsworthy & Coyle, 1999).

Though the majority of research on religion and bereavement points to the beneficial role of faith in such distressing circumstances, it should be noted that not all work in this area supports such inferences and observations (Sanders, 1979–1980). This is indeed an involved realm—one that requires more sensitivity to theory and the possibility of confounding factors.

Sanders (1979–1980) undertook an interesting study in which she compared grief reactions to the death of a spouse, a child, and a parent. Though the most intense responses occurred when a child died, church attendance was related positively to optimism, less anger, and a better appetite. When church attendance and family interaction were treated together, the findings even more graphically favored the religion–family combination. This may imply the significance of religion not only in terms of meaning, but in regard to a broader beneficial basis for social support from one's kin.

There is evidence that bereavement may vary as a function of the kind of death that occurred—in other words, whether the death was natural, accidental, a result of violence, or a suicide (Morin & Welsh, 1996; Sheskin & Wallace, 1980). Morin and Welsh (1996) interviewed urban and suburban adolescents. The urban adolescents were in a facility for adjudicated youths, and had experienced more violent deaths than the suburban groups had. Their views of death involved violence and religion to a greater degree than those of the suburban teens did. The latter emphasized the experience of suffering, while the urban youths were more concerned with the loss of loved ones. Both groups found that their grieving benefited from talking about their feelings and concerns.

Sheskin and Wallace (1980) studied widows, and observed that, regardless of the nature of their husbands' deaths, they usually needed to "unburden themselves" to good listeners.

Theoretically, one might expect clergy to fulfill such a role, but this was not found. According to the studies reviewed by Sheskin and Wallace (1980), the clergy were found to be particularly unhelpful by widows whose husbands committed suicide. The implication is that since organized religions strongly oppose suicide, their representatives (i.e., the clergy) will have difficulty counseling the survivors of those who have committed suicide. Accordingly, the clergy, who should be highly knowledgeable, understanding, and sympathetic regarding death, may not be very helpful in such cases. Clerics could be responding like others who relate to the surviving Family members of those dying by suicide. This group feels that they are less accepted by their communities than others whose relatives died accidental or natural deaths (Smith et al., 1991–1992).

Another consideration brings us back to the issue of meaning. Even though the meaning of death in the religious/spiritual sense is enhanced by devotion to one's faith, suicide poses additional explanatory problems, compared to accidental or natural deaths. We may try to play word games and attribute the death to depression or some "psychotic break," but then we face the question of why this mental state was present. We struggle to make sense out of the tragedy, for our social order stresses individual worth and dignity, and taking one's own life often poses a deep and troubling dilemma.

Religious Schemas and Bereavement over Child Loss

A creative and useful theoretical treatment of bereavement has been advanced by Daniel McIntosh and his colleagues (McIntosh, Silver, & Wortman, 1993). McIntosh (1995) has also extended this approach to religion in general and its role in life. Noting that "a schema is a cognitive mental structure or representation containing organized prior knowledge about a particular domain, including a specification of the relations among its attributes" (1995, p. 2), McIntosh further notes that "people have different schemas for many domains." Schemas influence what is perceived, speed up cognitive processing of information, and offer meaning in difficult situations by filling in the gaps in our knowledge. In sum, they orient us to the world and to the problems with which we must cope; they therefore influence our behavior, and can help us adapt to problematic circumstances. With respect to death and bereavement, one salient aspect of a religious schema might be belief in an afterlife. Apparently such belief is "associated with greater recovery from bereavement regardless of the cause of death" (Smith et al., 1991–1992, p. 222). In contrast, bereaved persons with low belief in an afterlife evidence less well-being in general, and poorer recovery from the bereavement in particular. Such people also make greater efforts to avoid thinking about the death in question.

For many reasons, primarily culturally based, most people possess religious schemas that are often called into play when ambiguity and threat become troublesome. In their significant work on how parents cope with the death of an infant from sudden infant death syndrome (SIDS), McIntosh et al. (1993) demonstrated how parents' faith, through the use of religious schemas, indirectly facilitated their adjustment—both cognitively and behaviorally. The schemas both made the death meaningful and also supported efforts to come to terms with the loss. Religious participation and social support promoted the acquisition of helpful religious explanations. Cognitively, religious importance contributed to constructive mental processing and helped reduce distress.

McIntosh et al.'s work explains similar findings in other studies that have dealt with parental and grandparental bereavement (Bohannon, 1991; De Frain, Jakub, & Mendoza, 1991–1992). Studying the influence of church attendance, Bohannon (1991) was able to show

that it was inversely related to anger, guilt, helplessness, obsessive thoughts about a child's death, somatic complaints, and death anxiety on the part of the grieving mothers. Similar effects were found for paternal anger, guilt, and death anxiety. De Frain et al. (1991–1992) found that religious beliefs were strengthened for 46% of the grandparents of children who died of SIDS, and 90% felt that their faith aided them in coping with the SIDS death.

Further work by Gilbert (1992) stressed the perceived role of God in this situation. She found that when religion was employed as a resource, bereaved parents felt that (1) God did not do bad things; (2) God was in control and could be relied on to make the wisest decision; (3) God had good reasons for the child's death; (4) God inflicted this tragedy upon the parents because they had the strength to deal with it; (5) God wanted them to appreciate life more; and (6) God desired that they change their lives for the better. Interestingly, those who claimed that religion was not initially helpful acquired a more positive outlook over time. Lastly, those who claimed that religion was irrelevant tended to be extrinsically oriented. The implication is that for faith to be of significance in this kind of tragedy, it must have an intrinsic, not superficial or utilitarian, quality. An excellent example of theoretically guided and methodologically sophisticated work in this area is presented in Research Box 8.6.

Conjugal Bereavement

The demise of a spouse is extremely distressing to the widow or widower. No one has yet assessed all of the factors that may affect the surviving mate. For an older couple, separation

Research Box 8.6. The Stress-Buffering Role of Spiritual Support: Cross-Sectional and Prospective Investigations (Maton, 1989)

Maton has theorized that religion may mitigate the effects of stress through the use of cognitive and emotional pathways. Specifically, he has defined these as "cognitive mediation" and "emotional support." The former implies a positive reframing of negative life events, while the latter comprises perceptions of God as valuing and caring for the distressed individual. Treating these as independent, Maton assessed the contributions of each with two samples: (1) bereaved parents who had lost a child, and (2) college students. In the first sample, 33 parents who had been bereaved within the preceding 2 years constituted a high-stress group, and 48 whose child had died more than 2 years previously made up a low-stress group. Measures of spiritual, social, and friendship support plus depression were completed by the respondents.

Spiritual support correlated negatively with depression and positively with self-esteem for the high-stress group, but not for the low-stress sample. A similar pattern was noted for support provided to the high-stress group, but not to the low-stress group. A prospective study with college students ruled out the likelihood that spiritual help followed rather than contributed to well-being. Maton concluded that "spiritual support may influence well-being through directly enhancing self-esteem and reducing negative affect ('emotional support' pathway) or through enhancing positive and adaptive appraisals of the meaning of a traumatic event ('cognitive mediation' pathway)" (p. 320). He went on to theorize various forms of spiritual support, and to suggest various research possibilities for exploring this domain further.

after a half century or more of living together may be the most wrenching and distressing factor. (Often we read that the passing of an elderly husband or wife is shortly followed by the death of the other, as if their link in life must continue indefinitely.) The issue of an expected death versus an unexpected one must also be considered. If a wife's death is not anticipated, the level of somatic symptoms and depression is greater in the husband than if the death has been expected for some time (Winokuer, 2000). In the latter instance, anticipatory grieving may take place and reduce the overall amount of physiological disruption that occurs.

The classic work of Glick et al. (1974) stresses the benign effects of faith on bereavement when a spouse dies (see also Parkes, 1972). In this research, to the extent that the widows were devout, they were described as turning "to the formal doctrine of their religions for explanation" (Glick et al., 1974, p. 133). Again we see the significance of spiritual meaning and understanding in alleviating depression and the sense of loss. In other work, social and religious support appeared to operate independently, both working to counter depression and subjective stress (Levy, Martinkowski, & Derby, 1994). Study after study confirms these findings: Personal adjustment and religious commitment and activity go together. As might be expected, religious involvement is likely to increase following the death of a spouse (Bahr & Harvey, 1980; Haun, 1977; Loveland, 1968).

The Significance of Ritual

In Chapter 3, we have shown that ritual has roots deep within our human and animal past. It performs many functions, not the least of which is to establish and maintain control over our personal world and ourselves, especially when we feel pressured. Rites and ceremonies are integral to religion; they bring us psychologically closer to others and to our common cultural heritage. These confirm our oneness with the perceived source of all good and strength, and allow us to feel that we can overcome even death. Ritual is a core aspect of faith that plays a constructive role in grief. Variously said to create a sense of safety and impart new constructive meanings, it may also be "constructively self-alienating." In other words, ritual distances a person from emotions and permits him or her to return to the world—a process that obsessive self-concern hinders. Reeves and Boersma (1989–1990) thus maintain that "rituals can provide a sense of positive personal power for an individual who is feeling out of control and clarify and provide meaning to an issue so that it is easier to work on" (p. 289).

On another level, rituals introduce structure, elicit social support, and not infrequently serve as a distraction from the grief itself. Formal ceremonies allow bereaved individuals to work through the pain of loss. Death is a disruption in the survivors' lives, and religious ideology and ritual can function to restore stability to those who are bereaved (Honigmann, 1959).

Illustrative of this principle is the Jewish practice of *shiva*, a 7-day, repetitive set of mourning rites that evokes community support in the form of a group. Group members often bring food to the griever's home and participate in a well-established set of ceremonies. It has been compared to group therapy (Kidorf, 1966). Gerson (1977) describes in depth the formalized mourning process in Judaism, and notes how it is designed to thwart the development of pathological grief by specifying degrees of return to normal social interaction. For these reasons, the symbolic power of religious rituals has recently become part of the psychotherapeutic armamentarium of pastoral counselors.

Memorial rituals frequently follow the more immediate funeral ceremonies. This is particularly true of highly regarded community members, or of great and famous individ-

uals who may be formally remembered through rites on their birth or death days for years following their demise. These rites may also be incorporated into one's faith. On the anniversary of the death, specifically for family members, specific prayers are often mandated. In Catholicism, there are votive Masses to aid the deceased in the afterlife. Judaism has its *Jahrzeit*, the time of year on the Jewish calendar for remembrance. In Japanese Buddhism, here is a kind of ancestor worship, *mizuko kuyo*, that allows one to maintain a ritualistic nteraction for 35 or 50 years with those who have died. A variation of this ceremony has een created for abortions (Klass & Heath, 1996–1997). Women who have aborted fetuses se this rite to achieve a number of goals (to resolve guilt, maintain connections with the pirit of the aborted child, express regrets over having had the abortion, ask for forgiveness, pologize, etc.).

The San Francisco gay community has recently created a set of rituals to commemoate those who have died of AIDS (Richards, Wrubel, & Folkman, 1999–2000). Though many f these ceremonies are privately designed, the majority (69%) contain formal or informal eligious content. Multiple rituals may be carried out over a number of months, and possily years.

All known societies have their death rituals. Whatever biological resonances these epesent, their significance is buried in cultural practice. Rituals do, however, reflect much elefental psychology—communication, emotional control, and the fostering of group coheion (Lorenz, 1966; Wulff, 1997).

DEATH AND THE CLERGY

Inlike the rest of us, the clergy are commonly called upon to deal with death and dying. They re also trained in pastoral skills to deal with terminally ill patients and their families. Furiermore, once death has occurred, the clergy conduct the final rituals that consign the souls f those who have died to their ultimate divine destiny. Concurrently, they turn their attenon to grieving family members and friends, attempting to bring solace to them. This may iclude such practices as praying with bereaved individuals, reading Scripture with them, iterpreting theology, discussing spiritual and practical matters, conducting home visits, and hatever else may help to situate death in ultimate perspective. The pastoral goals are to igender hope in the face of death, and to assist the bereaved persons through the process f recovery from their loss.

Given these responsibilities, it is understandable why White (1991) perceives clerics as primary caregivers" (p. 4). Leane and Shute (1998) define the aiding clergy as "gatekeepers," first line of help to those who grieve.

The relatively recent development of the modern hospice program or facility has greatly ttended the role of clergy in the predeath period. In the hospice context, a cleric provides iendship, and becomes a good listener to the patient and to visiting family members and iends (Dubose, 2000). The need for psychological understanding and clinical skills is overhelmingly evident in these situations.

Three aims may be posited in work with dying persons and their survivors: (1) to make ie death meaningful in terms of the perspective of a religious or spiritual system; (2) to transrm the distress of the death and dying process into a vista of personal strength, self-identy, and a natural closing to an existence in which one has contributed to a better future; id (3) to attempt to convince all that death is not an end, but a new beginning, a doorway

to immortality, a personal permanence, a new kind of life (Cook & Oltjenbruns, 1989). We have already shown how clergy may do these things by strengthening spirituality, offering hope, and enhancing the sense of death as meaningful beyond the immediate situation.

Training the Clergy to Deal with Death

The years since 1970 have witnessed a new sensitivity to death and dying that has profoundly affected clerical education. Programs to develop pastoral skills in this area have proliferated, along with a plethora of books and articles that detail the complexities of the tasks the clergy must confront (Bendiksen, Hewitt, & Vinge, 1979; Clemens, 1976; Jernigan, 1976; Kalish & Dunn, 1976; Malony, 1978; O'Brien, 1979; Wood, 1976).

Even though the clergy overwhelmingly feel that they have a responsibility to deal with those who are dying (91%) and bereaved (89%), they find performing these duties difficult and anxiety-producing (White, 1991). The fact that many clerics also feel deficient in this area is illustrated by one study of priests, ministers, and rabbis, which revealed that only 15% felt themselves educationally prepared to deal adequately with death and dying. Forty percent considered themselves poorly trained to do death work (Spilka, Spangler, & Rea, 1981). Though there is much variation in these feelings, more recent surveys continue to find that one-third to two-thirds of ministers still question their education in regard to dealing with terminally ill patients and their families (Missoula Demonstration Project, 2001).

In contrast, an increased emphasis on death education for prospective clergy has sometimes imparted a heightened sense of competence in dealing with terminality. In one study, 64% felt moderately to well educated in this area (Spilka, Spangler, & Rea, 1981). In contrast, older clergy had to learn about death and dying through direct experience in the pastorate. Today, these important skills can be acquired both in seminaries and through internships prior to ordination. Opportunities are currently provided for neophyte clerics to model themselves after mentors who have been engaged with dying people and their families for long periods of time.

With relatively little variation, those to whom the clergy provide their services are pleased with the pastoral efforts of hospital chaplains and "home pastors" (i.e., people's regular clerics making home visits) (Brabant, Forsyth, & McFarlain, 1995; Johnson & Spilka, 1991; Spilka, Spangler, & Nelson, 1983). An interesting exception occurs for patients with breast cancer: Both male and female clerics usually avoid discussing some of these women's central concerns about their identity as female and the surgical mutilation of their bodies (Johnson & Spilka, 1991). Obviously, there is still a need for pastoral training to deal with such sensitive personal issues.

Another approach revolves around the concept of a "good death." Utilizing focus groups of clergy and congregants, Braun and Zir (2001) found agreement on a number of criteria that pastoral education might emphasize for a terminally ill patient to have a "good death." The implication is that clerics should (1) be involved in pain management; (2) see that the dying process is not inappropriately prolonged; (3) work to encourage a supportive family atmosphere at the bedside; (4) try to resolve conflicts and introduce the potential of forgiveness, when desirable; (5) aid not only the terminally ill patient, but grieving family members; and (6) where proper, bring in theology and rituals to lighten the burden of mourning and bereavement.

Other troubling areas for which clergy feel unprepared are infants' deaths and youth suicides (Strength, 1999; Thearle, Vance, Najman, Embelton, & Foster, 1995; Leane & Shute, 1998). With regard to adolescent suicide, an Australian study revealed low levels of knowl-

edge about risk signs for such an eventuality. This is believed to handicap clerical efforts to counteract such suicidal inclinations (Leane & Shute, 1998).

Pastoral education might also look more closely at the problems children have when loved ones die. The problem of inaccurate, distorted, and troubling magical fantasies needs to be confronted in order to resolve a child's grief (Fogarty, 2000).

Clerical Feelings about Death and Dying

Even though most clergy appear to buffer themselves against death and dying with strong beliefs in a life after death, the more theologically liberal they are, the more they see death as a natural end to life or simply as a mystery (Spilka, Spangler, & Rea, 1981; Spilka, Spangler, Rea, & Nelson, 1981). None of these perspectives implies that the clergy are not afraid of death. The evidence is that, like everybody else, they too manifest anxiety about death and dying (Kierniesky & Groelinger, 1977; Yudell, 1978). The theory has been proposed that this is one of the reasons why individuals become clerics. If this is so, the evidence suggests that the clergy's considerable personal experience with death does not help them come to terms with the prospect of their own deaths (Angelica, 1977).

A more serious and immediate likelihood is the development of clergy burnout or posttraumatic stress disorder. Echterling. Bradfield, and Wylie (1992) conducted a 6-year follow-up on the effects of a major disaster, a flood. This work is detailed in Research Box 8.7.

Research Box 8.7. Six Years after the Flood: Clergy's Long-Term Response to Disaster (Echterling, Bradfield, & Wylie, 1992)

For 16 months after a major flood, these researchers gathered data on 44 clergy who were deeply involved in all aspects of flood relief, including rescue, cleanup, and offering both physical and emotional aid to the victims. Six years later, extensive follow-up interviews were conducted with 42 of the original clerics.

Even though considerable time had elapsed since the flood disaster, almost three-quarters of these 42 clerics were still discussing it in their sermons, and close to half held memorial services for the losses experienced. The dominant images of God presented by the clerics were of a loving deity rather than a punitive one: God wanted to provide an opportunity for those affected by the flood to re-establish basic human values and concerns. There was considerable evidence that the impact of the flood was a continuing issue to be resolved, however. A positive relationship was observed between a congregation's losses and the amount of flood relief in which its cleric was involved.

The authors interpreted many clerical responses as symptoms of posttraumatic stress disorder. From 10% to 25% cited continuing worries about the weather, illness, guilt about surviving, poor concentration, changes in appetite, dreaming about the flood, somatic complaints, avoidance, and reexperiencing the flood. Fewer than 10% showed signs of more serious disturbance. On the positive side, more than 90% of these clergy felt that their congregations had become more capable of handling similar crises in the future.

This study shows that the effects of a major disaster may persist and have religious repercussions for far longer than one might imagine. The researchers concluded, "In their struggle to face and meet the needs of a traumatized community, the clergy themselves became wounded healers" (p. 6).

Clerical Involvement and Effectiveness in Death-Related Situations

Spilka has participated in a number of workshops designed to aid clergy (and others who work with death) in their interaction with dying persons and their families. The growing hospice movement has also undertaken such training. Unfortunately, the proliferation of similar efforts has not been accompanied by research to evaluate the effectiveness of these programs. Still, in two studies of over 400 clergy, about 60% claimed that they deal often or very often with terminality; only 1% were not involved in this kind of work (Spilka, Spangler, & Rea, 1981).

But what do home pastors and hospital chaplains do when they interact with dying people and their kin? Over 90% of the clerics surveyed by Spilka, Spangler, and Rea (1981) claimed that they made two or more calls to the home of a bereaved family in the year following a death. Table 8.5 gives us some idea of the variety of actions that may take place in both home visits and hospital encounters.

Table 8.5 reveals a number of interesting differences between home pastors and hospital clergy, some of which may be due to the longer personal history of contact between the recipients and their regular clerics. In most instances, especially for patients with cancer, hospital chaplains were not likely to be as pastorally involved with the patients as home clergy were. This was less true when the clerics were dealing with the families of children with cancer. Still, for both groups, there was considerable reluctance to discuss the future. There may be a number of critical interactive subtleties in this process that call for additional research. Certainly, we still need to know the characteristics and behavior of successful pastors—that is, successful from the recipients' viewpoint.

Theology, Personal Faith, and Clergy Effectiveness

Spilka, Spangler, Rea, & Nelson (1981) found that among clergy dealing with death and dying, two-thirds claimed that the theology of their church was "very helpful," while only 2–3% felt it was of little or no use. Surprisingly, these numbers held whether the clerics were affiliated with a conservative or a liberal religious body. An interesting variation on this theme

TABLE 8.5. Activities of Home Clergy and Hospital Chaplains, According to Patients with Cancer and the Families of Children with Cancer

	Patients with cancer		Families of children with cancer	
Activity	Home clergy	Hospital chaplains	Home clergy	Hospital chaplains
Offering to pray for	43%	47%	42%	44%
Offering to pray with	42%	35%	51%	44%
Actually praying with	46%	22%	56%	48%
Reading religious material	17%	14%	20%	20%
Counseling	21%	16%	20%	24%
Talking irrelevancies	21%	18%	34%	36%
Seeming to understand	44%	28%	44%	44%
Talking about church matters	15%	6%	7%	12%
Talking about family	47%	12%	46%	40%
Discussing the future	15%	8%	15%	12%
Other	9%	22%	17%	8%

Note. Data from Spilka and Spangler (1979). Percentages add to more than 100, because clergy engaged in more than one activity per contact.

suggests that clerics' own personal faith is of greater importance than their church's theology, as 83% regarded the former as providing them with the most support in their death work (Spilka, Spangler, & Rea, 1981). Apparently, as important as formal theology is, the crucial issue may be the degree to which a cleric identifies with the official position.

There is little doubt that working with terminality is a very trying experience for clerics. Almost 70% of those surveyed by Spilka, Spangler, and Rea (1981) were less than "very satisfied" with their efforts, and 11–14% were quite unhappy with themselves. Some 43% of these pastors described themselves in this work with qualifying adjectives such as "frustrated," "inadequate," "apprehensive," and the like. In addition, Parkes (1972) observed that clergy "are often embarrassed and ineffectual when face-to-face with those who have been or are about to be bereaved" (p. 169).

At least in work with the families of the dying, however, theological conservatism implies more personal satisfaction; this may be a concomitant of afterlife beliefs that are more strongly held and more clearly defined by orthodox than by liberal institutions. Research further suggests that clergy from the liberal end of the theological spectrum are usually more concerned with their own psychological state than with that of patients and families when they are doing death work. (Spilka & Spangler, 1979). In these circumstances, the more conservative clerics emphasize religious, scriptural, and spiritual referents, and convey such to those to whom they minister. It is not amiss to note that terminally ill patients and their kin prefer these kinds of support, rather than what might be taken as strictly psychological pastoral actions. As important as the latter are in these situations, the appeal is clearly to God, not to psychotherapy (Spilka & Spangler, 1979).

That bereaved people consider the clergy helpful at this troubled time is abundantly evident. Carey (1979–1980) compared the satisfaction of widows and widowers with physicians, nurses, chaplains, social workers, and family members. Although family members were viewed as most helpful, the hospital chaplains came in a close second.

Like virtually everyone who confronts death, the clergy probably never become immune to the feelings that death and dying engender. They have entered a profession in which they must continually confront these hard realities. Undoubtedly, pastoral effectiveness is a function of experiences that force clerics to face their own mortality while expressing the empathy and humanity these situations call for. Fortunately, most clergy acquire the skills, compassion, and understanding to handle these trials. Additional comprehension of these difficulties from the consumers' viewpoint is offered in Research Box 8.8.

DEATH IN THE RELIGIOUS–SOCIAL CONTEXT

Though we emphasize the psychological aspects and influence of religion, we have also stressed the idea that individual behavior is embedded in various contexts—biological, social, and cultural. This principle is nowhere clearer than when death is confronted. People's perceptions and responses are commonly shaped by their group's heritage and ceremonial practices. For example, in the Jewish custom of *shiva* (see above), friends and relatives gather in the home of the deceased for 7 days following a funeral to offer their prayers, and family members are given emotional and social support. The idea that they are part of a long tradition is dutifully conveyed. Efforts are thus made to short-circuit deleterious mental and physical possibilities. In fact, Judaism exactingly defines the mourning process with regard to time, stages, and duties.

Research Box 8.8. Spiritual Support in Life-Threatening Illness (Spilka, Spangler, & Nelson, 1983)

In the last analysis, the effectiveness of clerics must be determined by those to whom the clergy demonstrate their skills. This was assessed in a study of 101 patients with cancer and 45 parents of children with cancer. All were questioned about their interactions with home pastors and hospital chaplains. The participants were generally quite religious. All respondents were administered a 45-item questionnaire, in which 6 items were open-ended, permitting a free response.

Twenty-nine percent of the patients were visited at home by their pastors, and 66% received hospital visits. With regard to the families of the children with cancer, 42% had home visits and 56% hospital visits. About 55% of both the patients and parents saw hospital chaplains. From 78% to 87% of the patients and parents were satisfied with the home and hospital visits. (Table 8.5, earlier in this section, has indicated what went on during these contacts.) The respondents expressed most satisfaction with situations where the home clergy actually prayed with the patients and the family. Engaging in religious reading was also positively regarded. In the hospital, the families approved discussions of the future by the chaplain. Finally, the willingness of a cleric simply to be present and to devote time to this troubling situation was considered most desirable.

As is so frequently true, the respondents were often clearer about the undesirable characteristic of clerics than about those they found positive. Most that was displeasing was broadly attributed to poor communication and lack of understanding by a pastor. Specifically, conveying the impression of visiting out of a sense of duty alone, or failing to appreciate or to be sensitive to the pain of the circumstances, was upsetting to these people. Extremely distressing were efforts (fortunately rare) to effect "deathbed conversions." For example, one cleric harangued a patient to "change his pagan ways." Much more common were indications of the pastors' own discomfort—looking at their watches, acting "nervous," verbalizing clichés, standing at a distance from patients, being painfully silent and unresponsive, and finally being in a rush to leave.

Pastoral identity was also a problem. A fair number of patients reported difficulty discovering who was and was not a chaplain. This resulted from the wearing of informal sports clothes, the absence of a badge that defined one as a chaplain (or the use of a badge too small to read at any distance), and/or a person's failing to state that he or she was a chaplain.

The many things pastors do and may represent can bring comfort and solace to those greatly in need of such aid. In most instances, this is what takes place. Still, clergy sometimes convey a lack of feeling and compassion without intending to do so. There is clearly a need for "on-the-job" training in these critical situations.

When cultural settings and religious rites are coordinated, their combined power is often quite compelling to all who are affected by the loss of a loved one. Death has always been circumscribed by rites that are usually quite meaningful to believers. The Mormons and the Amish offer excellent illustrations of the power of religious regulations and traditions concerning death.

The Mormons: Religion, Health, and Death

It is no accident that the lowest death rates in the 48 contiguous United States are found in Utah, the "Mormon state." These numbers hold for deaths from cancer, cardiovascular problems, and a variety of other diseases, as we have discussed in Chapter 3.

The Church of Jesus Christ of Latter-Day Saints possesses an extensive theology associating health and life with doing good, and evil with illness and death (Hansen, 1981; O'Dea, 1957; Vernon & Waddell, 1974). Kearl (1989) further tells us that "the Mormons baptize the dead, procreate to provide bodies for spirits caught in preexistence, and theologically reinforce the physical fitness ethos . . . to minimize premature deaths" (p. 171). This is an excellent example of how a strong and pervasive religious system that is well integrated with the sociocultural context can influence nutrition, health, and longevity.

The Amish: Religion and Family Support

Like the Mormons, the Amish have been able to blend the social setting in which they live with their religious ideology. To do so, they have been quite successful in preserving their religious and cultural unity by creating relatively isolated communities. Under such conditions, daily life is often inseparable from one's spiritual existence.

The Amish illustrate well what occurs when a distinctive faith group maintains its separation from others with variant beliefs and practices. Similar behavior is found among Orthodox Jews, Mormons, and a variety of sects and cults. A situation is created in which people rely primarily on their relations and close neighbors, and death is first a familial–religious obligation that is rapidly and willingly embraced by the community (Bryer, 1979). In essence, illness and death are community events. A dying person and a bereaved family are the recipients of extensive visits not only by friends and relations, but by any and all church and community members (Hostetler, 1968). This kind of support continues through the funeral, the burial, and thereafter, formally concluding with a meal that signifies the necessity of a return to everyday life. Hostetler (1968) uses the German term "*Gemeinsamkeitsgefuele*" (p. 188), which conveys the sense of a general community feeling of togetherness. A semiformal organization develops to provide mutual support and to perform various ceremonial functions, such as preparing the deceased for burial. In this way, the Amish view of "death as a spiritual victory over temporal life" is reinforced (Bryer, 1979, p. 259). Other families who have also lost members visit and aid the newly bereaved family to work through the grieving process. Death is not denied, but openly accepted as a necessary and essential fact of life, every aspect of which is encompassed by theological doctrine and meaning.

Under such circumstances, one may reasonably hypothesize that death, rather than diminishing the community and family, strengthens its ties and enhances religious commitment. In addition, this kind of religious–social support may be very effective in resolving the grief process, so that the likelihood of developing undesirable psychological aftereffects may be low.

Other Groups

The foregoing examples of how the Mormons and Amish deal with death can be easily extended to other, primarily nonmainstream religious groups. In 18th and 19th Century North America, for example, the Shakers developed their own unique theology relating to dying and the afterlife. To some degree they modeled themselves after the Quakers, circumscribed

the care and dressing of the deceased, and denoted who might or might not attend funerals and burials (Andrews, 1963).

Scheffel's (1991) research on the Old Believers of Alberta describes the burial process, and specifies in great detail every aspect of body preparation, clothes, symbols, artifacts, body position, and activities that must take place at various times following the burial. The important thing is that the role of ceremony is made very clear, and ritual can be viewed in its structuring and emotion-controlling function. Considerations of meaning and control are ever-present, and one can easily see how well religion performs these functions. A similar situation exists in Hutterite society (Hostetler & Huntington, 1967) and undoubtedly in many other faiths. Death is thus an individual concern and a cultural matter—both of which are important to the psychology of religion, which recognizes that the person must always be understood in sociocultural context.

The fundamental factor here is group culture, but quasi-religious elements may go beyond religious bodies, as noted earlier in the practices of those who mourn the deaths of individuals from AIDS (Bivens et al., 1994–1995).

OVERVIEW

This chapter tells us that death and its relation to religion are far more complex than one might initially believe. Behind every obituary there is a life, and in some way this existence has included religious beliefs, experiences, and behavior. They may have also influenced the way the person died, and also what took place afterward.

With respect to religion, the psychology of death has not resolved the problem of theory—basically, how people explain and handle death and dying. Florian and Kravetz (1983), stating that this is an area that "may require a theoretical model that is more descriptive than valuative" (p. 602), suggest an attributional approach in which one searches for causal explanations that both reflect and shape thinking and behavior. To what do people attribute death? Is it simply the way nature works, or should they invoke faith-based notions of "original sin" or the penalty for not living a good life? Psychological coping theory also looks as if it may be quite productive, for death is, without question, a problem with which people must deal many times in life (Maton, 1989; Park & Cohen, 1993; Park, Cohen, & Herb, 1990; Pargament, 1997).

Sociological thinkers may have an advantage over psychologists as they can relate individual responsivity to sociocultural referents and to the social construction of ideas and attitudes about death. Leming (1980) thus utilizes the sociologist Homan's notion that religion both creates and resolves death-related anxiety. Another sociologist, Emile Durkheim (1897/1951), integrated suicide into the social order, recognizing bases for variation in suicide rates as a function of the primary religion in a society.

Overall, we have seen a major development in research in this area—namely, from the use of simplistic and unitary notions of death fear and religiousness to multidimensional conceptualizations in both domains. Even though more sophisticated instrumentation is now available, it does not seem to be employed as much as it should be in current research. Too much work still relies on unidimensional measures of death fear/anxiety. Part of this may be due to the fact that researchers are much more knowledgeable in the coping realm than they are with advances in the psychology of religion. Convenience samples in which testing must be kept to a minimum may also be impeding the use of more sophisticated measure-

ment of religious perspectives However, we now see multidimensional trends in work on religiosity in relation to coping with AIDS, bereavement, and euthanasia.

Our position is that the deaths of others and the prospect of one's own death raise for each individual two very basic coping issues we have often referred to in this volume—that is, the issues of meaning and control. Death arouses these concerns in their most intimate and ultimate forms. It is here that faith probably makes its greatest adaptive contributions.

The contemporary world has united death more strongly with moral and religious considerations than ever before. Vacuous platitudes such as "God works in mysterious ways" and "The good die young" are highly likely to elicit rapid and vehement rejection in a time of AIDS, high suicide rates for adolescents and elderly people, the delaying of death indefinitely by leaving mortally ill individuals in an almost permanent vegetative state, and many calls for active euthanasia. Simple, easy, dichotomous yes–no answers must give way to deeper, more thoughtful considerations in which institutionalized religion plays a significant and central role. Death in the modern world has been become increasingly complicated; it challenges faith and the role of the clergy more and more, on both the individual and societal levels.