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Faith communities and end-of-life care: members' perceptions of current care practices and desires for care

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FAITH COMMUNITIES AND END-OF-LIFE CARE:
MEMBERS' PERCEPTIONS OF CURRENT CARE PRACTICES
AND DESIRES FOR CARE

by

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B.A. Wheaton College, IL, 1999

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Faith communities once held significant social power to structure death and dying. However, in contemporary US society, the end of life is highly structured by institutions of medicine and a cultural framing that largely constructs death as physiological deterioration. Though faith communities have members in all stages of life, including those dying and experiencing grief and bereavement, little is known about the end-of-life care they provide members and how members consider the care provided them through their faith communities.

Using a faith community members’ survey, this study explores the care provided by faith communities in Missoula, MT to members in serious illness, through the end of life, and into the bereavement process. The study also explores what members report would be important to them if they were in one of these conditions. The data are explored for overall themes, and for differences between Catholics and Protestants, men and women, and among age groups.
PREFACE

My sincere thanks are extended to Dr. Paul Miller, the chair of my thesis committee, for his guidance and support through the many iterations of this paper and to committee members, Dr. Dan Doyle and Dr. Neva Hassanein, for their suggestions and encouragement.

My thanks are also extended to Life’s End Institute: Missoula Demonstration Project for allowing me to work with this data, to the faith communities who participated in this study, and to Dr. Kaye Norris for helping me find the story in the stats.
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CHAPTER ONE
INTRODUCTION

Every once in awhile, a [Certified Nursing Assistant] will be assigned 'one of those'—a resident whose health has declined so dramatically that it is easy to forget that they are a person. They are bed-ridden, tube-ridden, unable to speak, incontinent, vulnerable to a number of ailments, and so on. Their care is intensive; they simply require a lot of work.

I remember I was once assigned to a resident who was a classic 'one of those.' Finishing all that I had to do for her (and feeling good of myself for having done what I believed to be a good job), I noticed a little sign on the wall. It was obviously left by her family as I doubted that any one of the workers would have put so much effort into making such a fancy little sign. It read simply, "Mom’s name is Beatrice, but she prefers 'Bea'."

Having read that sign, I realized I had neglected doing what, in a greater sense, may have been the most important thing I could have done for the resident: remember her as a human being and not a list of duties. (Bernardo, 2004)

The issues and social structures that surround death and dying in contemporary American society are multi-faceted. Successes in medical technologies have greatly increased length of life while changes in family structure, religious beliefs, and managed care have transformed the ways for which dying people are cared. As the short sketch above poignantly shows, death and dying create a complex interface between many factors and competing claims. Identifiable in the above episode are the following elements: medical knowledge and values, a family’s concern for their mother, care-taking in an institutionalized setting, the competing values of efficiency and personally invested care, and human dignity. These are a few of the social elements that come together to make the contemporary structure of death and dying a multi-layered social and often difficult personal experience.

This paper explores how dying is structured in contemporary American society and looks at one small segment of how end-of-life care is provided: faith community
members’ perceptions of the end-of-life care practices of their faith communities. It also explores members’ desires for end-of-life care.

**FRAMING THE FIELD: DYING AND DEATH**

Physical death may be a fact of the human experience, but dying is, to use a Durkheimian phrase, a social fact. The processes of dying and grief and bereavement are created out of, and supported by, social structures and cultural attitudes which are not fixed but change considerably through time and place. The social constructions surrounding death and dying extend far beyond funerary rites and bereavement rituals. While these are certainly supported by social customs which inform the choices people make at the time of death, the social aspects of death and dying reach much further than these relatively obvious social rituals. The following few examples will serve to highlight the deep social embedded-ness of death and dying. First, what constitutes death has changed over time, “the old signs, such as cessation of heartbeat or respiration, are no longer sufficient. They have been replaced by the measurement of cerebral activity, the electroencephalogram” (Ariès 1981:585). Secondly, entire systems of care are dependent on a doctor’s certification that a person is not only dying, but is likely to die within six months. In order for a patient to access the palliative and hospice benefits of Medicare or most private insurers, she must have received a terminal diagnosis, a six month prognosis and foregone curative treatment. The trajectory of her dying is structured by federal law, insurance companies, and medical institutions, as well as her private decision for or against "curative" care. Other examples of the social embedded-ness of death and dying are the changes in technology, medicine, and industry which have altered the demographic of who is dying (elderly) and in what ways (chronic diseases). While, at
first glance, death may seem to be nothing more than a biological fact, this biological fact is not extractable from the multiple layers of social constructions in which it is embedded. Indeed, even to speak of it as a purely biological phenomenon reveals a certain social bent which conflates the biological and physiological with the "real."

The dying process is not a static entity, but rather is supported by a network of social arrangements and cultural attitudes which significantly structure life's end. In contemporary U.S. society, the power to frame the dying process is largely held by institutions of medicine (Ariès 1981; Seale 1998; Steinhauser et al. 2000). This has not always been the case. Rather, it developed through a combination of factors which effectively served to construct and reinforce a medical model of dying. Many of the forces which have structured the dying process are not unique to death and dying, rather they reflect broad attitudinal and social-structural shifts within U.S. society during the 19th and 20th centuries. These include increased life-expectation, changes in the family structure, shifting cultural attitudes such as increased rationality and secularization, and bureaucratization. While each of these will be explored separately, it is important to note that they are inter-related and tend to reinforce one another.

*Increased Life Expectation*

Material culture and ideological culture do not stand apart from each other but have a dynamic and mutually influencing relationship. Scientific and technological innovations can spur value changes which often drive further material transformation. Scientific and technological advances such as vaccines and surgical procedures, increased food production and security, and better housing and sanitation, brought about the greatest demographic changes in human history - a decrease in child mortality and an
increase in life expectancy – which significantly altered the processes of dying in America. With an increased life expectancy (changing from 48 years to 79.5 years between 1900 and 2000 for females, and from 46 years to 74.1 years for males during that same time period) came a sea change in the leading causes of death. In general, individuals no longer tend to die from malnutrition, childhood illnesses, and occupational hazards, but rather from chronic diseases such as cancer, heart disease, and Alzheimer’s. The importance of this difference should not be overlooked, as debilitating chronic illnesses require different systems of care and support than do more immediate on-set deaths. The systems of care which have evolved to address the needs generated by chronic illnesses – such as repeated interventions over lengthy processes of physical deterioration – include institutions such as hospitals and nursing homes, health insurance and pharmaceutical regimes, and more recently hospices.

Lower child mortality rates and life expectancy increases also changed the place of death in family and community life. In Philippe Ariès’ (1981: 560) classic work, *The Hour of Our Death*, he contends that for a thousand years of western history “death has always been a social and public fact.” He concludes, however, that over the past hundred years “society has banished death” hiding it, denying it, and moving it to the margins of society. A portion of this change came from a decrease in familiarity with death due to these important demographic changes. The comparative infrequency of death in childhood and the relatively reliable expectation that individuals will reach ages once unthinkable for the general population have been partial contributors to a disconnect between death and daily life.

The marginalization of death as a “social and public fact” was furthered by its
spatial movement from the home to the hospital, thereby intensifying the break between the dying and the living and increasing a loss of general familiarity with death. As a result, care of the dying became fixed in, and proper to, institutions of medicine. As one author notes, “When people died primarily at home, family, community and clergy assumed responsibility. As the location of death shifted to the hospital, physicians became the gatekeepers. As a result, death is now viewed through a lens of biomedical explanation and is primarily defined as a physiologic event. Most medical education and training reinforce this framework” (Steinhauser et al. 2000:828).

Changes in Family Structure

The twentieth century brought about significant changes in the structure of families. As noted earlier, this period saw a precipitous decline in child mortality, which, in turn, contributed to a decrease in the birthrate. On the whole, family size began to constrict, resulting in fewer children to share the work of caring for elderly parents. Over this same period, mobility greatly increased, often resulting in larger distances between individual family members. The combination of these two trends, resulted in smaller families that are less likely than their earlier counterparts to live in geographical proximity. These changes in family structure have had considerable effects on the dying process. As we have said, due to medical and technological advances, individuals tend to live longer but are beset by lengthy processes of deterioration complicated by multiple frailties. As individuals’ health declines, their need for daily care and help increases. A child who lives a distance from a parent in need of intense care, may be faced with difficult decisions about moving, changing jobs for more flexibility, finding an appropriate long term healthcare facility or bringing the parent to live with them. At
times where one sibling lives closer to a dying parent than others, the burden of the parent's care may be unevenly divided. This can lead to guilt, anger, and misunderstanding between siblings, and even conflicts about the trajectory of care. Caregiving is often physically and emotionally demanding; it is frequently associated with wage losses and deterioration of physical health on the part of the caregiver. Caregiving has multiple social and personal costs (The Robert Wood Johnson Foundation 2001; Berry et al. 1997).

**Shifting Cultural Attitudes**

When discussing cultural transformations which came about in the 19th and 20th centuries, it would be difficult to overstate the role that the major themes of modernity played in re-fashioning the changes at hand. The changes in the social structure of death and dying, notably the ascendance of the medical model, must be properly cast in the over-arching cultural shift towards the growth of, and dependence on, rational systems based in scientific ways of knowing. Weber's ([1921] 1978) classic characterization of the essence of modernity as an increasing rationality is evident in the transformations of death and dying noticeable during that period. As scientific advances in disease diagnosis and intervention brought about measurable differences in life expectancy and the quality of life, the positive effects of such changes garnered authority for practitioners of medicine and the treatments they offered. In effect, this accrued authority to these systems and their methodologies, steadily increasing their social power to define the appropriate place for death and dying, method of dying, and even the definition of death.

Hospitals have become the site of the “normal” death (Ariès 1981: 584). A number of social structures support dying in the hospital above any other place –
including what insurance pays for, the concentration of equipment, and even legislation.

By Montana law, an individual whose breathing has stopped and for whom emergency medical services have been called must undergo resuscitation attempts and hospital transport unless that person has obtained a state-sanctioned, doctor-ordered Comfort One, the only authorized out of hospital do not resuscitate order in the state. If such an individual does not have a Comfort One, EMS personnel must attempt resuscitation and transport to the hospital, despite any protestations or evidence of end-of-life wishes such as an advance directive. As the informational website about Montana’s Comfort One states, “Don’t be fooled by other documentation, medallions or jewelry. Unless you have the Comfort One credentials obtained directly from your health care provider, you will be resuscitated” (MHA 2005). In his book, Dying Well, Ira Byock (1997), recounts an incident where a family who had been caring for an aged grandfather in the home, brought him to the hospital at the very end. When Dr. Byock asked why they had called the ambulance the granddaughter responded, “Isn’t it illegal to have someone die in your house?” (Byock 1997: 28). As this small example suggests, death in the hospital has become so routinized that confusion exists about the legality of death in the home.

**Bureaucratization**

Medicine and the complex of institutions associated with it -- medical and nursing schools, hospitals and clinics, research institutions, and the drug industry, to name a few -- are highly bureaucratized systems, and as such, are prone to the logic of bureaucratic systems. Weber ([1921] 1978) states in his chapter on bureaucracy in “Economy and Society,”

Bureaucratization offers above all the optimum possibility for carrying through the principle of specializing administrative functions according to
purely objective considerations. Individual performances are allocated to functionaries who have specialized training and who by constant practice increase their expertise. "Objective" discharge of business primarily means a discharge of business according to *calculable rules* and "without regard for persons." (p. 975)

This characterization of bureaucracies holds true for the systems which largely structure death and dying in America. Individuals trained in specialized fields -- surgeons, nurses, x-ray technicians, pharmacists, admissions staff, phlebotomists -- might all have dealings with the same patient whose information is passed along from one department to the next in the form of written directives and charts. The "'objective' discharge of business," as Weber calls it, is carried out by individuals following their training, institutional rules and protocols. As a result, patients' care is often disjointed as they move from specialist to specialist, from the ICU to the oncology floor. Patients are followed by a chart and discussion with medical personnel may be limited to topics that are reimbursable. As one doctor writes, "People with widespread cancer might ... be seen by whichever resident happened to pick their chart from the rack that day" (Byock 1997:28).

Bureaucratic systems also reinforce their own authority. Through research institutions and medical and nursing schools, aspiring healthcare providers are trained by the gatekeepers of the medical field. Due to practical constraints and the large corpus of material they must learn, the range of instruction must be limited to the "medical" field which is primarily comprised of learning material interventions. The field is, after all, based on the body and decisions about necessary course content must be weighed against the amount of time students have to complete their degrees (Institute of Medicine 1997). The material bias of the medical education is perhaps inevitable and while this bias may not make a difference when a person is having a wart removed, it will make a great difference when that person is dying, as dying is enmeshed in multiple social and
personal realities of which the state of the body is only one.

Bureaucracies also tend to follow their own logic to its end point. In death and dying this takes the form of aggressive interventions even when there is no hope of cure and comfort care might be more appropriate for the patient. Contemporary medicine is often critiqued for portraying death as a failure. As Ariès (1981) notes,

Sometimes this prolonging of life becomes an end in itself, and hospital personnel refuse to discontinue the treatments that maintain an artificial life...What interests us is that medicine can cause someone to remain alive almost indefinitely: and not only medicine but the hospital itself, that is, the whole system that turns medical activity into a business and a bureaucracy that obeys strict regulations regarding method and discipline. (p. 585)

This statement from Ariès highlights the irony at the heart of the bureaucratic enterprise: that in following rationality to its end, a bureaucracy becomes irrational.

**Changes in Death: Definition and Denial**

Montana Legal Code includes a determination of death statute which reads, "An individual who has sustained either irreversible cessation of circulatory and respiratory functions or irreversible cessation of all functions of the entire brain, including the brainstem, is dead. A determination of death must be made in accordance with accepted medical standards" (Montana Code Annotated, 2003). This code is a direct adaptation of the Uniform Determination of Death Act (UDDA), a model bill resulting from a 1981 study on brain death by the President's Commission. The Montana code, like the UDDA, allows for an individual to meet either of two conditions in order for death to be determined, the cessation of circulatory and respiratory function, and/or the cessation of brain activity - i.e. "brain death." This definition of death is sociologically important for a number of reasons. First, its mere existence suggests that there has been disagreement
about what is and is not death. An enactment of the determination of death serves to
create a concrete legal frame for death. Second, the UDDA uses criteria which can be
only decisively determined by medical professionals using technologically advanced
monitoring equipment, further reinforcing a medical definition of death by incorporating
it in legal code.

A reinforcement of the medical definition of death can also be seen in the
requisite certification of a death. To be dead in the eyes of the state, one must be
proclaimed dead by someone who is invested with authority in the eyes of the state, a
physician or coroner. Seale (1998: 79) notes the change in what is found on death
certificates from the beginning of the 20th century to its end as an example of the growth
of the medical definition of death.

...no longer do we find ‘intemperate living’, ‘want’, or ‘cold and whiskey’
written on certificates. Of more contemporary relevance, neither do we
find death from a rubber bullet in a street disturbance, or from structured
class inequality, or poverty...as legitimate cause of death at the
certification stage, since [these] do not describe a bodily event.
Certification removes human agency, and is a pure assertion of the bodily
containment of death.

This change from “intemperate living” as a certifiable cause of death to
“myocardial infarction,” illustrates the rise in the power of medicine as the culturally
legitimate authority in defining death.

Shifting cultural attitudes can also be seen in the change of the method of dying.
In a characterization that has become largely accepted, though with a few notable
detractors (Parsons 1963; Seale 1998), Ariès (1981) spoke of the death “denying” culture:

It is quite evident that the suppression of mourning is not due to the
frivolity of survivors but to a merciless coercion applied by society.
Society refuses to participate in the emotion of the bereaved. This is a
way of denying the presence of death in practice, even if one accepts its
reality in principle.... For some time this denial had been rising from the depths...from the fear of apparent death, to the time when one concealed the death of the other out of love and concealed the sick person from others out of disgust. From now on, the denial of death is openly acknowledged as a significant trait of our culture. (p. 580).

For Ariès and others the denial of death is manifest in a number of ways – refusal to acknowledge others’ grief, lack of popular media that substantively explore issues of death and dying, resistance to end of life planning, reluctance to discuss issues of death and loss, lack of end of life care curriculum in medical and pastoral training, removal of the dying to hospitals and nursing homes, the placement of cemeteries on the edge of town.


Apathy need not mean basic indifference to problem areas but is rather a manifestation of a conflicted state. And since conflicted states are especially likely to be widespread in periods of rapid change, it may therefore very well be that some of our tendency to be silent about problems of the meaning of death is related to phenomena of conflict. (p. 63).

Parsons’ cultural appraisal recognizes the possibility that cultural attitudes towards death and dying are undergoing a process of significant reframing necessitated by the considerable restructuring of the dying process. The instability produced by this restructuring and reframing has created a period of ambivalence towards death which is different than, though mistaken for, denial.

Language and Power

While it is necessary and helpful to examine the historical-cultural processes which brought about the medical model of death and dying, it is also important to explore the dynamics of power which lie behind, and continue to play within, any “social fact.”
As stated earlier, the power to define the appropriate course (and meaning?) of death and dying became centered largely in institutions of medicine and the types of knowledge (rational-scientific) and methods (physical interventions such as surgeries and drug therapies, removal to the hospital) that undergird these institutions' authority. Though institutions of medicine hold power in the field, there are other groups which are actively and consciously trying to reform the cultural structures and reframe the discourse surrounding the end of life.

An examination of some of the language commonly employed when speaking and writing about death in America tells of a dynamic of unequal power relationships that goes almost unnoticed. Even those who work to change these dynamics are often caught in the position of using language that still operates within a medical framework. For example, a patient's decision to refuse CPR is written by a doctor as a "do not resuscitate" (DNR) order. There are some who try to reframe the thinking about this situation by using the term "allow a natural death" (Meyer, 2000) This difference, while outwardly minor, underscores a host of complex issues. In the first phrase resuscitation measures are the assumed standard, in the second a "natural" death is the starting point; the movement from one phrase to the other changes the frame of reference. And yet, hanging behind both are those to whom the imperative is directed, the medical providers that will resuscitate or not resuscitate, allow or disallow a natural death.

Two other examples of attempts to frame the social constructions of death and dying by harnessing the power implicit in language can be seen in recent events. In January of 2004 a bill was introduced into the South Dakota state legislature that, had it passed, would have significantly limited the powers of a surrogate decision maker’s
ability to decide to have a feeding tube, typically referred to as "artificial nutrition and hydration," removed when a patient was beyond hope of recovery. In the bill that was introduced, each instance of the word "artificial" preceding "nutrition and hydration" was tellingly removed from the existing law. The point, of course, is that labeling a medical procedure "artificial nutrition and hydration" succeeds in framing the intervention in a certain light – mechanical, not-natural – while calling it "nutrition and hydration" frames the same practice very differently – natural, essential.

In March of 2004 Pope John Paul II released a statement similar to the provisions of the South Dakota bill – declaring it immoral for anyone under any circumstance to remove artificial nutrition and hydration even when the patient is declared to be in a persistent vegetative state. In the statement the Pope implied that the term "persistent vegetative state" is degrading as it implies a person is vegetable or animal like (Pope John Paul II 2004). The Pope’s aversion to these words points to the constitutive power of language and the legitimacy accrued to those whose use of language gains popular employ.

**FRAMING THE FIELD: THEORY**

Bourdieu (1987) sees the struggle for the power of constitution, the power to frame a dialogue, as operating within a field. In this case, we are concerned with what might be called the field of dying. Within the field of dying the struggle for the legitimacy to define what constitutes dying well is waged. For Bourdieu (1987) the task of the sociologist is to:

strive to speak the truth about struggles whose stakes include, among other things, truth... the sociologist works to establish the specific logic of this struggle and to determine, through an analysis of the state of the balance
of forces involved and the mechanism of its transformation, the chances of
the various contenders. (p. 181).

Generally, then, the task at hand for the sociologist interested in the discourse
surrounding present day constructions of dying is to understand the strategies employed
in this field to articulate a vision of dying well. A Bourdieuan analysis of any "social
fact" will be comprised of several features – the field and players, and an analysis of the
distribution of resources such as economic, cultural, social and symbolic capital among
these players. For our purposes we have added to the analysis of the state of death in
contemporary America an historic dimension as well.

An analysis of two quotations from Bourdieu (1987) will suffice to sketch the
meaning he attaches to the term "field."

I am trying to develop a genetic structuralism: the analysis of objective
structures: – those of different fields – is inseparable from the analysis of
the genesis, within biological individuals, of the mental structures which
are to some extent the product of the incorporation of social structures;
inseparable, too, from the analysis of the genesis of these social structures
themselves: the social space, and the groups that occupy it, are the product
of historical struggles (in which agents participate in accordance with their
position in the social space and with the mental structures through which
they apprehend this space). (p. 14).

It is the structure of the relations constitutive of the space of the field that
governs the form that relations of visible interaction may take and the very
content of the experience that agents may have of them. (p. 192).

In the first quotation, Bourdieu outlines his concept of field: a social space
composed of social structures which must be understood in light of the history that has
brought them about in the particular forms they take at this place and time, and in light of
the constituent groups, or players, who assemble in this field and the mental structures
which these groups in turn bring to bear on the issue at hand. To analyze the field of
death and dying in America, one would look at the historical factors that have brought
about the particularities of the present social-structural handling of death, the groups who have a stake in this handling, and the "mental structures" or frames and types of knowledge embedded in these groups’ approaches to death and dying.

In the second quotation, Bourdieu restates his position that the content of a person’s experience with any given social phenomena is governed, in part, by the "structure of relations" that constitute a field. In other words, an individual’s experience of death, dying, caregiving, grief, or bereavement, is necessarily embedded in, and indivisible from, the present manifestation of the field of dying and the particularities of the present structure of relationships between the groups that make up the field. Not only do constituent groups act as the players in the field – making moves to improve their position or maintain their power – but they also serve as the terrain of the field, setting the parameters, the definitions, the choices that will frame non-players’ experience in the field. One who is faced with a terminal illness will experience the end of their life in a way significantly structured by the relations between the constituent players: institutions of medicine, insurance and pharmaceutical companies, hospices, faith communities, and government regulators to name a few.

In an analysis that echoes Bourdieu’s concept of players competing for the ability to structure, define, and control a field, Sociologist Clive Seale (1998: 172) maintains that there are two major “cultural scripts” available in late modernity to people at the end of life: “medicine” and “revivalism.” The medical script that Seale describes is analogous to what has been put forward already in this paper – technological interventions broadly proper to bureaucratic institutions that follow a particular logic of treatment. In contrast to this Seale sketches the parameters of what he calls, “revivalism.” Revivalism is a
critique of modern medicine’s promises, which nevertheless, borrows from a modern
psycho-therapeutic concept of the self. Revivalism frequently invokes some unspecified
past where deaths were “natural” and works to refashion the present state of death and
dying in the image of this constructed “natural.” Revivalism also places a high value on
“the role of confessional talk in encouraging the self to be spoken into psychological
discourse, and thereby shaped into an heroic quest narrative” (Seale 1998: 92). Seale
places proponents of hospice and palliative care and writers like Kubler-Ross¹ squarely
within the revivalist framework. Noting the tensions between these two cultural scripts in
a statement strongly reminiscent of Bourdieu, Seale (1998) states,

What we see here is an interplay of discourse, and it would be a mistake
for the sociologist to side with one or the other. A more analytic approach
lies in seeing how these discourses, or great meta-stories, are appropriated
by people as they seek to understand their experience in care settings.
That is to say, we need to see how the people who work in these settings
think about their work, what they do on an everyday basis, and how they,
as ‘system representatives’ seek to mould the subjectivities of the people
for whom they care. (p. 117).

The revivalist and medical scripts are simply ideal types that often interface with
each other in any one patient’s care. Palliative care units exist in hospitals just as
pain management through medical intervention is used by hospice patients dying
in their own homes. These ideal types are helpful in creating a framework for
social exploration and analysis; however, the field is, of course, more complex
and varied than these types suggest.

With Bourdieu’s ideas of field, players, and strategies, and Seale’s ideas of
competing cultural scripts framing this analysis we can define our task as the following:

¹ Elisabeth Kubler-Ross, M.D. was a formative influence in the move to “humanize” death and dying. Her
book, “On Death and Dying” (1969), outlined the five emotional stages which, she contended, a person
would pass through in the dying process.
to understand one constituent set of players on this field, faith communities, and to understand what faith community members think about their faith community’s performance in this field. In this way, this study is essentially descriptive, highlighting one small segment -- faith communities in Missoula, Montana -- of this vast field.

**FRAMING THE FIELD: RESEARCH ON DEATH AND DYING**

As has been stated repeatedly in this paper, dying is significantly structured by the institutions and interventions of medicine. We have outlined the process by which this came to dominance and now will turn to a review of the research that more fully explores these structures of care for the dying. We will review a number of articles that explore what people conceive to be the elements of a “good death.” And finally, we will turn to literature that reviews faith communities’ involvement in end of life care.

**Good Death**

In response to the repeated assertion that care for the dying in contemporary US society is fragmented, institutionalized, and materially biased, a number of research projects explore concepts of a “good death.”

Steinhauser et al. (2000) conducted focus groups comprised of “a full spectrum of persons involved with end-of-life care – physicians, nurses, social workers, chaplains, hospice volunteers, patients, and recently bereaved family members” (Steinhauser 2000: 825). From these focus groups researchers were able to identify components of a “good death” including: “pain and symptom management, clear decision making, preparation for death, completion, contributing to others, and affirmation of the whole person.” These components are notable for the multi-dimensional needs expressed by them. Only
pain and symptom management falls largely in the "medical camp" and yet it also has non-physiologic concerns associated with it. As Steinhauser et al. (2000) conclude:

A strictly biomedical perspective is incomplete. For most persons involved with care at the end of life, death is infused with broader meaning and is considered a natural part of life, not a failure of technology. All focus groups, except physicians, spoke extensively about the need for life review and subsequent completion. This is not to suggest that these themes are unimportant to physicians; rather, they are not a usual focus of treatment. It may be useful to recognize that for most patients and families who are confronting death and dying, psychosocial and spiritual issues are as important as physiologic concerns. (p. 825).

Another group of researchers also used focus groups comprised of participants from Christian faith community, both laity and leadership, to explore concepts of a good death. They found that the following characteristics were elements of a "good death" according to subjects, "pain and symptoms are managed, inappropriate prolongation of dying is avoided, family presence and support, conflict is resolved, spiritual and existential issues are addressed" (Braun and Zir 2001: 693). These components clearly echo those put forward in Steinhauser et al.'s (2000) research, again suggesting the importance of forms of care at the end of life that are not strictly physiological.

**Faith Communities and the End of Life**

In 1963, Talcott Parsons published a working paper called, "Death in American Society." In the conclusion, which suggested areas of further study he wrote, "Finally, an important set of problems concern study of the special occupation groups which have occasion to deal with situations of death. In the ordinary course of events three are especially involved, namely the physician, the undertaker and the clergyman" (Parsons 1963: 65). While Parsons explicitly suggested study of the clergy's, and by extension faith communities', role in end-of-life care, there have been surprisingly few studies that
have taken up this very question.

While there is a growing body of literature both in medical and social science journals that forwards the necessity for incorporating spirituality and making room for religious practice in the clinical setting, few articles address the role of a faith community in providing care at the end of life, or explore how members view their faith community’s practices of care or their expectations for what sorts of care their faith community should provide. After an extensive literature search I found only a handful of articles that directly address these issues (Braun and Zir 2001; Brett and Jersild 2003; Norris et al. 2004).

This gap in research is surprising considering the role religious institutions once had in support of the dying and their families and in light of the ongoing religious needs researchers have found in patients. One study found that in the 330 in-patients over 60 years old in their sample, "nearly 90% indicated they used religion to at least a moderate extent to help them cope, half … indicated that religion was the most important factor that kept them going" (Koenig 1998 quoted in Koenig 2002: 21).

Furthermore, it has been noted that religious beliefs and medical judgment can be in significant conflict about the trajectory of a patient’s care at the end of life (see Brett and Jersild 2003). This conflict suggests that guidance from religious professionals such as clergy, chaplains, or trained laity could help mediate some of these conflicts and foster active discussions about the nature of life and death that would provide ontological security for the dying and their families.

The Gallup report *Spiritual Beliefs and the Dying Process* (1997) found that only 36% of respondents said that they thought the presence of a clergy person would be
helpful to them if they were dying. The report, which called the findings a "wake up call to clergy," made several recommendations to faith communities, clergy and seminaries including the need to address peoples' fears about what happens after death, and that faith communities need to remain places on which people who have belonged to them can count when they are ill or dying.

Sherkat and Reed's (1992) study on the effects of religion on self-esteem and depression following sudden-bereavement suggest that religion is in some ways efficacious at mediating end-of-life issues. They point out that religious affiliation tends to increase an individual's social networks, a great resource in times of emotional stress, as well as provide "existential certainty... which provides a framework for understanding life's event" (Sherkat and Reed 1992: 262). In suggesting that religion operates as a resource in times of psychological stress, they open up great possibilities for delving into the practices of faith communities that bring about such effects. How do faith communities act as a resource? Do their end-of-life care practices provide, to use Byock's terms, a "sense of direction in regard to life's end?"

In their article entitled, "The Church's Role in Improving End-of-Life Care," Braun and Zir (2001: 703) conclude their study with the statement that "the church could, and should, play a significant role in helping its membership prepare for and achieve a 'good' death." Through focus group discussions on the meaning of a good death and possibilities for church involvement at the end of life, they determined five practical interventions faith communities could undertake to improve their end-of-life care. These were "help congregants prepare for death, facilitate resolution of conflict and forgiveness, clarify church theology, administer appropriate ritual, provide outreach" (Braun and Zir,
These five categories suggestively frame out possibilities for church involvement in end of life care, but there is still significant room for further study. What practical ways does a church help its members “prepare for death?” Who would members want to “facilitate resolution of conflict and forgiveness?” What is meant by “administer appropriate ritual?” Another important research question that is not addressed in this article is what do faith community members think about the current care their faith community provides?

Questions like these led staff at the Missoula Demonstration Project, now Life's End Institute, to study the role of faith communities in end-of-life care. The Institute designed a pair of companion studies to explore faith community leaders' provision of end-of-life care and faith community members' perceptions of how well their faith community provides care at the end of life. Additionally, the faith community member research was designed to explore what types of care respondents would want at the end of life and who they would want to participate in these care practices. These companion studies are two of the twelve research projects undertaken by the Institute in order to create a community profile on the state of end-of-life care in Missoula. This thesis is a secondary analysis of the Institute's faith community members research.
CHAPTER TWO
RESEARCH METHODS

GENERAL NARRATIVE

This study, designed as exploratory research about faith community members’ attitudes and desires regarding care at the end of life, was funded through a grant to the Missoula Demonstration Project (now Life’s End Institute) from the Arthur Vining Davis Foundations as part of a program entitled Enhancing the Sacred at the End of Life and During Bereavement. A mailed survey (described below) was created by Institute staff and members of an inter-faith task force which had been meeting over a period of several years to discuss their individual faith or denominational traditions at life’s end. It was piloted by twenty-five faith leaders outside of Missoula County who were recruited through the phone book. Task force members provided feedback on survey items and served as important catalysts for access into local faith communities.

The selection process included asking task force representatives to engage their congregation’s leadership in supporting the study. Then, in an effort to diversify the pool of participating faith communities across religious and ideological spectrums, task force members suggested other faith communities to be invited to participate in the research.

In the recruiting process faith community leaders were approached by the researcher. If a congregation was represented on the task force, this member accompanied the researcher. Faith community leaders were asked to support the study by facilitating their individual congregation’s participation in the research. In each case the process of gaining this support was different. In some cases the faith community leader
agreed that the church would participate after the study had been satisfactorily explained. In other cases, researchers had to return to make presentations to committees and sub-committees within the faith community after having explained the research to the leader. One congregation even required that the research project be presented to the congregation which then did a show of hands to gauge whether they would participate. Fourteen congregations agreed to participate. Six of the participating communities were represented on the task force and eight were not.

All congregations agreed to provide the researcher with their mailing list. For the seven congregations that had fewer than 200 people the survey was mailed to all members. For the seven larger congregations a computer generated random selection of 200 members were mailed a survey. Each mailed packet included a letter from the leader of the member’s faith community supporting the research, a letter from the researchers explaining the project and asking for participation, an informed consent form, the survey, and an envelope with return postage. Participants from faith communities that had less than a thirty percent return rate received follow-up phone calls to ask them to complete the survey.

**RESEARCH INSTRUMENT**

The survey (Appendix A) is based upon a twelve item instrument with a number of items comprising multiple parts. Generally this survey can be divided into three categories. The first six questions request general demographic information to ascertain the sex, age, name of the faith community of which s/he is a member, years as a member

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2 The operational definition of a faith community for the purposes of this research is the group of people whose participation in or involvement with a particular church or other gathered "community" would cause
at that particular faith community, and experience with serious illness or death for each respondent. The second group of questions asks the respondent to evaluate the current end-of-life care practices of their faith community. These questions break end-of-life care practices into four domains: ministries related to illness, ministries related to death and dying, ministries related to funerals and memorials, and ministries related to grief and bereavement. In each of these domains, several practices are listed and respondents are asked to mark those which their faith community does well. The third category of questions asks about what sorts of care a respondent would want if s/he was ill, dying or bereaved. Twenty five items are listed and respondents are asked to select all those which would be important to them if they were seriously ill, dying or bereaved.

The main limitation of this methodology is that it asks respondents to make assessments of something with which they may or may not have had experience, namely serious illness, the dying process or bereavement. In order to answer the survey questions, those who have not experienced one of these situations must project what their desires for care would be if or when they find themselves in such a situation. Those who have not had experience with serious illness, the dying process or bereavement may not in fact be in a position to accurately assess how well their faith community does at providing services and support surrounding these topics. Thus, it should be noted that this study explores a cross-section of faith community members' perceptions of faith communities' ministries of end-of-life care. Furthermore, these perceptions may or may not result from respondents having, in fact, been the beneficiary of such services.

**MODE OF ANALYSIS**

Faith community data were aggregated and then descriptive and comparative
analyses were performed. Frequencies were used to describe how often respondents
checked practices they reported their faith community performed well. In addition,
frequencies were also used to compare how often certain practices were selected as
important to respondents if they were faced with serious illness, dying or bereavement.

The data were also examined by three variables, age group, sex, and religious
affiliation between Catholic and Protestant. The first variable was chosen based on the
premise that different age groups are likely to have different levels of experience with
end-of-life issues and care. The second variable was chosen for two main reasons. First,
women bear more of the caregiving burden and thus may differ from men in their
expectations for and experience of assistance from their faith community. Second,
leadership of many faith communities has traditionally been male dominated. While it is
impossible to conjecture how and if end-of-life care practices would differ if the history
of many faith communities was different, it is interesting to explore how current practices
may or may not be viewed differently by men and women.

Finally, denominational differences between Catholics and Protestants were
evaluated for the purpose of comparing the two groups' assessment of their faith
communities' practices and what would be important to them at the end-of-life. Looking
at the data through this lens could be useful to Catholic and Protestant faith communities
in their efforts to meet the end-of-life needs of their own congregations.

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3 Respondents were grouped into five categories by age (under 40, 40-49, 50-59, 60-69, and 70 and above)
4 Three faith groups were excluded from this analysis due to confidentiality agreements these were
Buddhist, Unitarian and Latter Day Saints. As these three were each only represented by one congregation,
they could not be examined separately without breaching confidentiality.
CHAPTER THREE
RESULTS

DESCRIPTION OF RESPONDENTS

Faith community member respondents ranged in age, with the largest respondent group (26.6%) falling between 40-49 years old (Table 1). Seventy percent (70.7%) were women, 56% had attended their church for ten or more years and 77% reported regular attendance. Of the respondents roughly 67% were Protestant, 24% Catholic, 3% Unitarian, 3% Mormon, and 3% Buddhist. Due to confidentiality agreements results will not be reported by individual denomination, though data from Catholic parishes and Protestant congregations are grouped and compared. Three percent of respondents were confined to the home due to disability or illness. This mail-back survey had a 34% response rate. This low response rate may be due to the length of the questionnaire and/or the sensitive nature of the subject. Perhaps some of the non-response could be accounted for by the limitations of the methodology mentioned earlier: chiefly that potential respondents may not feel they are in a position to accurately assess their faith community’s provision of end-of-life care if they have not had need of those services. While it is impossible to know in what way these results may be biased, it should be taken into account that a high non-response rate hangs behind the discussion of these results.

This roughly corresponds to the religious profile of Montana, though Buddhism makes up a larger population in Missoula as seen in this study, than corresponds with Montana statistics as a whole. See http://demopedia.democraticunderground.com/index.php./Montana#Religion.
<table>
<thead>
<tr>
<th>Age</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>&lt; 40 Years</td>
<td>103</td>
<td>16.8%</td>
</tr>
<tr>
<td>40-49</td>
<td>163</td>
<td>26.6%</td>
</tr>
<tr>
<td>50-59</td>
<td>146</td>
<td>23.9%</td>
</tr>
<tr>
<td>60-69</td>
<td>91</td>
<td>14.3%</td>
</tr>
<tr>
<td>70 + Years</td>
<td>109</td>
<td>17.8%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Sex</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Male</td>
<td>182</td>
<td>29.3%</td>
</tr>
<tr>
<td>Female</td>
<td>440</td>
<td>70.7%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Religious Affiliation</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic</td>
<td>150</td>
<td>24.0%</td>
</tr>
<tr>
<td>Protestant</td>
<td>416</td>
<td>66.5%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>18</td>
<td>2.9%</td>
</tr>
<tr>
<td>Unitarian</td>
<td>21</td>
<td>3.4%</td>
</tr>
<tr>
<td>Latter Day Saints</td>
<td>20</td>
<td>3.2%</td>
</tr>
</tbody>
</table>

**PERCEPTION OF CONGREGATIONS’ DISCUSSION OF ILLNESS, DYING DEATH AND BEREAVEMENT**

When asked to rate on an eleven point scale (0=Never; 10=Regularly) how often the topics of illness, dying, death and bereavement were raised within their congregation, respondents were divided, with 37% rating the frequency of the topics between 0 and 4, 21% rating their congregation a 5, and 45% rating the frequency of these topics between 6 and 10 (Table 2). How often these topics are raised points to a certain amount of familiarity and comfort with these subjects. While the amount of discussion is not necessarily indicative of the quality of care that a church may offer, it gives a small
picture into the place that illness, dying, death and bereavement have within the community’s life.

Table 2. Rating of How Often Topics of Illness, Dying, Death and Bereavement are Raised Within Congregation

<table>
<thead>
<tr>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Never - 0</td>
<td>10</td>
</tr>
<tr>
<td>1</td>
<td>15</td>
</tr>
<tr>
<td>2</td>
<td>46</td>
</tr>
<tr>
<td>3</td>
<td>69</td>
</tr>
<tr>
<td>4</td>
<td>52</td>
</tr>
<tr>
<td>5</td>
<td>111</td>
</tr>
<tr>
<td>6</td>
<td>43</td>
</tr>
<tr>
<td>7</td>
<td>59</td>
</tr>
<tr>
<td>8</td>
<td>47</td>
</tr>
<tr>
<td>9</td>
<td>21</td>
</tr>
<tr>
<td>Regularly-10</td>
<td>68</td>
</tr>
</tbody>
</table>

END-OF-LIFE MINISTRIES: PERCEPTIONS OF WHAT IS DONE WELL

The instrument specified four general categories of end-of-life ministries -- ministry related to illness, ministry related to dying and death, ministry related to funeral and memorials, ministry related to grief and bereavement. Under each of these categories a variety of activities were listed some examples of which include, “church offers spiritual support,” “church helps with preplanning of advance directives, living wills,” “church teaches its beliefs about death and the afterlife.” Subjects were asked to place a check next to all the activities they considered their church did well.
Ministry Related to Illness

Table 3. Respondents’ Perspectives on Ministries Related to Illness that their Faith Community “Does Well”

<table>
<thead>
<tr>
<th>Ministries (in rank order)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church leaders/members visit those who are ill</td>
<td>454</td>
<td>73.8%</td>
</tr>
<tr>
<td>Church offers prayer and/or healing services</td>
<td>437</td>
<td>70.6%</td>
</tr>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>416</td>
<td>67.3%</td>
</tr>
<tr>
<td>Church offers spiritual support: listening, understanding, exploration of faith, meaning and hope</td>
<td>408</td>
<td>65.9%</td>
</tr>
<tr>
<td>Church has assigned members or groups of members who address the needs of the ill</td>
<td>332</td>
<td>54.3%</td>
</tr>
<tr>
<td>Church offers support and relief for family caregivers</td>
<td>211</td>
<td>34.3%</td>
</tr>
<tr>
<td>Church helps with household chores</td>
<td>96</td>
<td>15.6%</td>
</tr>
</tbody>
</table>

In ministries related to illness, sizeable majorities of respondents selected visiting, prayer and healing services, informal support, and spiritual support as things their church does well. A very slight majority also reported their church has assigned a group of members who address the needs of the ill. Large majorities of respondents did not indicate that the church offers support and relief for family caregivers or that the church helps with household chores.

Respondents above seventy years of age were more likely to report that their church has assigned members who address the needs of the ill. Women respondents were significantly less likely than men to choose help with household chores and support and relief for family caregivers as ministries at which their church does well. Similarly, Protestants were more likely than Catholics to report that their church has assigned
members that address the needs of the ill, does well at visiting those who are ill, and provides spiritual and informal support. (Appendix B Table 1).

**Ministry Related to Death and Dying**

Table 4. Respondents' Perspectives on Ministries Related to Death and Dying that their Faith Community "Does Well"

<table>
<thead>
<tr>
<th>Ministries (in rank order)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church provides rituals: funeral, memorial, Scripture reading</td>
<td>483</td>
<td>78.0%</td>
</tr>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>425</td>
<td>69.0%</td>
</tr>
<tr>
<td>Church offers spiritual support: listening, understanding, exploration of faith, meaning and hope</td>
<td>415</td>
<td>67.0%</td>
</tr>
<tr>
<td>Church leaders/members visit those who are dying and their family members</td>
<td>403</td>
<td>65.6%</td>
</tr>
<tr>
<td>Church teaches its belief about death and the afterlife</td>
<td>362</td>
<td>58.4%</td>
</tr>
<tr>
<td>Church offers support and relief for family caregivers</td>
<td>181</td>
<td>29.5%</td>
</tr>
<tr>
<td>Church helps with preplanning for advance directives, living wills</td>
<td>94</td>
<td>15.3%</td>
</tr>
<tr>
<td>Church helps with household chores</td>
<td>80</td>
<td>13.1%</td>
</tr>
</tbody>
</table>

In ministries related to death and dying, over two thirds of respondents reported that their church does well at providing rituals, informal, and spiritual support. Smaller majorities reported that church leaders and members visit those who are dying and their families or that their church does well at teaching its belief about death and the afterlife. Less than one third of respondents reported their church offers support for family caregivers, helps with household chores, or helps with preplanning such as advance directives and living wills.

Respondents over seventy years old were more likely to report that their church
does well at helping congregants preplan with living wills and advance directives.

However, women were less likely to choose that same item than men were. Also, women were less likely to report that their church does well at providing support and relief for family caregivers or helping with household chores. Men were less likely to indicate that their church does well at providing a ritual such as a funeral, memorial, or Scripture reading. Protestants were more likely than Catholics to report that their church does well at providing informal and spiritual support and that their leaders and members visit those who are dying. Catholics were more likely to report that their church teaches its beliefs about death and the afterlife. (Appendix B Table 2)

**Ministry Related to Funerals and Memorials**

Table 5. Respondents' Perspectives on Ministries Related to Funerals and Memorials that their Faith Community “Does Well”

<table>
<thead>
<tr>
<th>Ministries (in rank order)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church leaders provide a ritual or service: funeral, memorial, graveside service</td>
<td>439</td>
<td>71.4%</td>
</tr>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>430</td>
<td>70.1%</td>
</tr>
<tr>
<td>Church members attend/participate in the ritual or service</td>
<td>393</td>
<td>64.1%</td>
</tr>
<tr>
<td>Church leaders promote the recalling and sharing of memories about the deceased</td>
<td>316</td>
<td>51.6%</td>
</tr>
<tr>
<td>Church helps with preplanning for funerals and memorials</td>
<td>248</td>
<td>40.6%</td>
</tr>
<tr>
<td>Church teaches its belief about funeral/memorial/ burial practices</td>
<td>201</td>
<td>32.7%</td>
</tr>
<tr>
<td>Church offers support-person to go with family to the funeral home to make arrangements</td>
<td>75</td>
<td>12.3%</td>
</tr>
</tbody>
</table>

In ministries related to funerals and memorials, a large majority of respondents reported that their church leaders provide ritual services and that other church members
attend or participate in those services. A large majority also indicated that the church does well at providing informal support such as prayers, cards and food around the time of a funeral or memorial service. A slight majority said that the church leaders do well at promoting the recalling and sharing of memories about the deceased. Forty percent (40%) of respondents said their church does well at helping with preplanning of funerals and memorials while less than two-thirds of respondents said that their church does a good job of teaching its belief about funerals, memorials, and burial practices or that the church offers a support person to help the family make arrangements at the funeral home.

There were a number of items in this category that were significantly different by age. Respondents under forty years old were less likely to report that their church does well at providing a ritual or service, that members participate in such a service, or that their church provides informal support. Respondents, sixty and above were more likely than those below sixty to say that the church helps members preplan funerals and memorials.

Women were less likely than men to report that their church helps with preplanning funerals and memorials or that the church provided a support person to help make funeral arrangements. Women were also less likely to say that their church teaches its belief about funerals, memorials and burial practices. Catholics were more likely to pick this item than Protestants. While Protestants were more likely to say that the church provides informal support and that the church members attend and participate in funeral and memorial services. (Appendix B Table 3).
Table 6. Respondents’ Perspectives on Ministries Related to Grief and Bereavement that their Faith Community “Does Well”

<table>
<thead>
<tr>
<th>Ministries (in rank order)</th>
<th>Number</th>
<th>Percent</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>403</td>
<td>65.7%</td>
</tr>
<tr>
<td>Church offers spiritual support: listening, understanding, exploration of faith, meaning and hope</td>
<td>368</td>
<td>59.6%</td>
</tr>
<tr>
<td>Church provides opportunities to memorialize or remember loved ones</td>
<td>341</td>
<td>55.5%</td>
</tr>
<tr>
<td>Church leaders/members visit those who are bereaved</td>
<td>321</td>
<td>52.3%</td>
</tr>
<tr>
<td>Church has assigned members or group of members who address the grief and bereavement needs of the congregation</td>
<td>136</td>
<td>22.3%</td>
</tr>
<tr>
<td>Church provides bereavement support group</td>
<td>96</td>
<td>15.7%</td>
</tr>
<tr>
<td>Church provides grief education classes</td>
<td>80</td>
<td>13.1%</td>
</tr>
<tr>
<td>Church helps those experiencing grief and bereavement with household chores</td>
<td>68</td>
<td>11.1%</td>
</tr>
<tr>
<td>Church pairs the bereaved with others in the faith community</td>
<td>60</td>
<td>9.8%</td>
</tr>
</tbody>
</table>

As in the other categories, the majority of respondents reported that their church does well at providing informal support around grief and bereavement. A majority of respondents also reported that their church does well at offering spiritual support and providing opportunities to remember loved ones. A slight majority also indicated that church leaders and members visit the bereaved. Low percentages of respondents replied that their church does well at providing grief education or bereavement support, that their church has assigned members who address grief and bereavement needs in the congregation or that the church pairs the bereaved with others in the faith community or that the church helps those experiencing grief and bereavement with household chores.

Respondents over seventy years old were more likely to say that their faith
community does well at providing grief education and bereavement support groups.

Women were less likely than men to say that their church does well at helping the
bereaved with household chores. And similar to responses in the other categories,
Protestants were more likely to say that their church does well at providing informal and
spiritual support, opportunities to memorialize loved ones and that their church has
assigned members who address grief needs. (Appendix B Table 4)

**SPIRITUAL PRACTICES**

Respondents were also asked to select from a list of 25 activities which spiritual
practices would be important to them if they were seriously ill, approaching death or in
bereavement. They were directed to select all that apply. The three tables below detail
the results from these questions by age, sex and religious affiliation. Of the 25 items, 16
were selected by more than 50% of respondents.

*Importance of End-of-Life Care Practices by Age*

Age negatively correlated with many of the items: absolution/help to find
forgiveness, assistance with household chores, blessing, counsel in medical decision-
making, discussions of meaning related to death and afterlife, healing and growth through
art experiences, help with preplanning for advance directives/living wills, help with
preplanning funerals and memorials, guided imagery (visualization), holding hands/
appropriate touch, humor, life review, music, opportunity to memorialize or remember
loved ones, prayer, presence, reconciliation, sacrament of the sick (last rites), and support
for my family. Meditation was the only practice with which age was positively
correlated as respondents under forty chose the item less frequently than did those in the
other age categories.

Table 7. Importance of End-of-Life Care Practices by Age

<table>
<thead>
<tr>
<th>Practices (in rank order)</th>
<th>Percentage (n=625)</th>
<th>&gt;40</th>
<th>40-49</th>
<th>50-59</th>
<th>60-69</th>
<th>70≤</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for my family</td>
<td>84.3%</td>
<td><strong>90.3%</strong></td>
<td><strong>91.4%</strong></td>
<td><strong>88.4%</strong></td>
<td><strong>83.5%</strong></td>
<td><strong>65.1%</strong></td>
</tr>
<tr>
<td>Prayer</td>
<td>82.6%</td>
<td><strong>93.1%</strong></td>
<td><strong>85.4%</strong></td>
<td><strong>83.3%</strong></td>
<td><strong>76.9%</strong></td>
<td><strong>75.0%</strong></td>
</tr>
<tr>
<td>Help with preplanning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>1. funerals and memorials</td>
<td>71.6%</td>
<td><strong>71.6%</strong></td>
<td><strong>79.2%</strong></td>
<td><strong>75.3%</strong></td>
<td><strong>71.4%</strong></td>
<td><strong>56.9%</strong></td>
</tr>
<tr>
<td>Communion/Eucharist</td>
<td>68.3%</td>
<td><strong>67.0%</strong></td>
<td><strong>68.8%</strong></td>
<td><strong>74.3%</strong></td>
<td><strong>71.4%</strong></td>
<td><strong>62.0%</strong></td>
</tr>
<tr>
<td>Humor</td>
<td>67.9%</td>
<td><strong>70.9%</strong></td>
<td><strong>78.4%</strong></td>
<td><strong>71.0%</strong></td>
<td><strong>60.4%</strong></td>
<td><strong>53.2%</strong></td>
</tr>
<tr>
<td>Discussions of meaning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>related to death and</td>
<td>66.2%</td>
<td><strong>71.8%</strong></td>
<td><strong>75.9%</strong></td>
<td><strong>74.0%</strong></td>
<td><strong>61.5%</strong></td>
<td><strong>42.2%</strong></td>
</tr>
<tr>
<td>afterlife</td>
<td>Blessing</td>
<td>63.7%</td>
<td><strong>66.7%</strong></td>
<td><strong>67.1%</strong></td>
<td><strong>72.7%</strong></td>
<td><strong>54.9%</strong></td>
</tr>
<tr>
<td>Assistance with household</td>
<td>60.6%</td>
<td><strong>67.6%</strong></td>
<td><strong>70.6%</strong></td>
<td><strong>65.3%</strong></td>
<td><strong>53.8%</strong></td>
<td><strong>39.4%</strong></td>
</tr>
<tr>
<td>chores</td>
<td>60.5%</td>
<td><strong>60.8%</strong></td>
<td><strong>66.9%</strong></td>
<td><strong>66.4%</strong></td>
<td><strong>57.1%</strong></td>
<td><strong>47.7%</strong></td>
</tr>
<tr>
<td>Help with preplanning</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>for advance directives,</td>
<td>59.6%</td>
<td><strong>63.1%</strong></td>
<td><strong>67.9%</strong></td>
<td><strong>71.7%</strong></td>
<td><strong>50.5%</strong></td>
<td><strong>36.7%</strong></td>
</tr>
<tr>
<td>living wills</td>
<td>Absolution/ help to find forgiveness</td>
<td>59.2%</td>
<td><strong>61.0%</strong></td>
<td><strong>65.2%</strong></td>
<td><strong>62.4%</strong></td>
<td><strong>62.6%</strong></td>
</tr>
<tr>
<td>Opportunities to</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>memorialize or</td>
<td>57.0%</td>
<td><strong>57.8%</strong></td>
<td><strong>65.8%</strong></td>
<td><strong>63.4%</strong></td>
<td><strong>47.3%</strong></td>
<td><strong>44.0%</strong></td>
</tr>
<tr>
<td>remember loved ones</td>
<td>Counsel in medical decision-making</td>
<td>56.6%</td>
<td><strong>56.9%</strong></td>
<td><strong>63.1%</strong></td>
<td><strong>62.8%</strong></td>
<td><strong>58.2%</strong></td>
</tr>
<tr>
<td>Holding hands/</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>appropriate touch</td>
<td>56.3%</td>
<td><strong>55.3%</strong></td>
<td><strong>64.0%</strong></td>
<td><strong>64.1%</strong></td>
<td><strong>44.0%</strong></td>
<td><strong>46.8%</strong></td>
</tr>
<tr>
<td>Presence(quiet)</td>
<td>55.6%</td>
<td><strong>55.3%</strong></td>
<td><strong>60.4%</strong></td>
<td><strong>64.1%</strong></td>
<td><strong>46.2%</strong></td>
<td><strong>48.6%</strong></td>
</tr>
<tr>
<td>Scripture reading</td>
<td>54.6%</td>
<td><strong>54.9%</strong></td>
<td><strong>51.6%</strong></td>
<td><strong>64.8%</strong></td>
<td><strong>51.6%</strong></td>
<td><strong>49.5%</strong></td>
</tr>
<tr>
<td>Sacrament of the sick</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(last rites)</td>
<td>49.3%</td>
<td><strong>53.0%</strong></td>
<td><strong>50.3%</strong></td>
<td><strong>48.2%</strong></td>
<td><strong>51.6%</strong></td>
<td><strong>44.4%</strong></td>
</tr>
<tr>
<td>Meditation</td>
<td>47.1%</td>
<td><strong>35.9%</strong></td>
<td><strong>52.8%</strong></td>
<td><strong>52.4%</strong></td>
<td><strong>48.4%</strong></td>
<td><strong>40.4%</strong></td>
</tr>
<tr>
<td>Reconciliation or healing</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>in relationships</td>
<td>47.0%</td>
<td><strong>51.5%</strong></td>
<td><strong>57.1%</strong></td>
<td><strong>56.9%</strong></td>
<td><strong>36.3%</strong></td>
<td><strong>25.7%</strong></td>
</tr>
<tr>
<td>Life review</td>
<td>42.2%</td>
<td><strong>43.1%</strong></td>
<td><strong>47.5%</strong></td>
<td><strong>48.3%</strong></td>
<td><strong>40.7%</strong></td>
<td><strong>26.6%</strong></td>
</tr>
<tr>
<td>Laying on hands</td>
<td>41.4%</td>
<td><strong>47.0%</strong></td>
<td><strong>35.5%</strong></td>
<td><strong>50.4%</strong></td>
<td><strong>42.9%</strong></td>
<td><strong>32.4%</strong></td>
</tr>
<tr>
<td>Anointing with oil</td>
<td>38.0%</td>
<td><strong>36.0%</strong></td>
<td><strong>35.5%</strong></td>
<td><strong>46.1%</strong></td>
<td><strong>39.6%</strong></td>
<td><strong>31.5%</strong></td>
</tr>
<tr>
<td>Healing and growth</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>through art experiences</td>
<td>30.7%</td>
<td><strong>36.9%</strong></td>
<td><strong>31.4%</strong></td>
<td><strong>36.1%</strong></td>
<td><strong>30.8%</strong></td>
<td><strong>18.3%</strong></td>
</tr>
<tr>
<td>Guided imagery</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>(visualization)</td>
<td>26.7%</td>
<td><strong>27.5%</strong></td>
<td><strong>31.6%</strong></td>
<td><strong>37.5%</strong></td>
<td><strong>17.6%</strong></td>
<td><strong>12.8%</strong></td>
</tr>
<tr>
<td>Poetry</td>
<td>25.4%</td>
<td><strong>24.3%</strong></td>
<td><strong>23.7%</strong></td>
<td><strong>29.7%</strong></td>
<td><strong>23.1%</strong></td>
<td><strong>24.8%</strong></td>
</tr>
</tbody>
</table>
### Importance of End-of-Life Care Practices by Sex

Table 8. Importance of End-of-Life Care Practices by Sex

<table>
<thead>
<tr>
<th>Practices (in rank order)</th>
<th>Percentage (n=625)</th>
<th>Sex</th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for my family</td>
<td>84.3%</td>
<td></td>
<td>81.3%</td>
<td>85.7%</td>
</tr>
<tr>
<td>Prayer</td>
<td>82.6%</td>
<td></td>
<td>78.9%</td>
<td>84.3%</td>
</tr>
<tr>
<td>Help with preplanning funerals and memorials</td>
<td>71.6%</td>
<td>69.4%</td>
<td>72.6%</td>
<td></td>
</tr>
<tr>
<td>Communion/Eucharist</td>
<td>68.3%</td>
<td>68.7%</td>
<td>68.5%</td>
<td></td>
</tr>
<tr>
<td>Humor</td>
<td>67.9%</td>
<td></td>
<td>58.8%</td>
<td>71.7%</td>
</tr>
<tr>
<td>Discussions of meaning related to death and afterlife</td>
<td>66.2%</td>
<td>61.9%</td>
<td>68.0%</td>
<td></td>
</tr>
<tr>
<td>Blessing</td>
<td>63.7%</td>
<td>59.4%</td>
<td>65.6%</td>
<td></td>
</tr>
<tr>
<td>Assistance with household chores</td>
<td>60.6%</td>
<td>55.0%</td>
<td>62.8%</td>
<td></td>
</tr>
<tr>
<td>Music</td>
<td>60.5%</td>
<td></td>
<td>50.5%</td>
<td>64.8%</td>
</tr>
<tr>
<td>Help with preplanning for advance directives, living wills</td>
<td>59.6%</td>
<td>61.2%</td>
<td>55.5%</td>
<td></td>
</tr>
<tr>
<td>Absolution/ help to find forgiveness</td>
<td>59.2%</td>
<td>58.8%</td>
<td>59.4%</td>
<td></td>
</tr>
<tr>
<td>Opportunities to memorialize or remember loved ones</td>
<td>57.0%</td>
<td>50.6%</td>
<td>59.6%</td>
<td></td>
</tr>
<tr>
<td>Counsel in medical decision-making</td>
<td>56.6%</td>
<td>49.4%</td>
<td>59.5%</td>
<td></td>
</tr>
<tr>
<td>Holding hands/ appropriate touch</td>
<td>56.3%</td>
<td>42.3%</td>
<td>62.1%</td>
<td></td>
</tr>
<tr>
<td>Presence (quiet)</td>
<td>55.6%</td>
<td>45.9%</td>
<td>59.7%</td>
<td></td>
</tr>
<tr>
<td>Scripture reading</td>
<td>54.6%</td>
<td>57.2%</td>
<td>53.6%</td>
<td></td>
</tr>
<tr>
<td>Sacrament of the sick (last rites)</td>
<td>49.3%</td>
<td>48.0%</td>
<td>49.9%</td>
<td></td>
</tr>
<tr>
<td>Meditation</td>
<td>47.1%</td>
<td>43.4%</td>
<td>48.5%</td>
<td></td>
</tr>
<tr>
<td>Reconciliation or healing in relationships</td>
<td>47.0%</td>
<td>44.0%</td>
<td>48.3%</td>
<td></td>
</tr>
<tr>
<td>Life review</td>
<td>42.2%</td>
<td>38.1%</td>
<td>43.9%</td>
<td></td>
</tr>
<tr>
<td>Laying on hands</td>
<td>41.4%</td>
<td>40.1%</td>
<td>42.0%</td>
<td></td>
</tr>
<tr>
<td>Anointing with oil</td>
<td>38.0%</td>
<td>45.8%</td>
<td>34.7%</td>
<td></td>
</tr>
<tr>
<td>Healing and growth through art experiences</td>
<td>30.7%</td>
<td>24.4%</td>
<td>33.2%</td>
<td></td>
</tr>
<tr>
<td>Guided imagery (visualization)</td>
<td>26.7%</td>
<td>17.8%</td>
<td>30.3%</td>
<td></td>
</tr>
<tr>
<td>Poetry</td>
<td>25.4%</td>
<td>17.3%</td>
<td>28.7%</td>
<td></td>
</tr>
</tbody>
</table>

Bold type indicates significant correlation (p < .05); Chi square used to determine significance.
Of the 25 items from which respondents could select those that would be important to them if they were seriously ill, approaching death, or in bereavement, women were significantly more likely than men to choose the following practices: assistance with household chores, counsel in medical decision making, healing and growth through art experiences, guided imagery, holding hands/appropriate touch, humor, music, opportunity to memorialize or remember loved ones and poetry. Men were significantly more likely than women to choose anointing with oil as an important practice.

**Importance of End-of-Life Care Practices by Religious Affiliation**

Of these same items Catholics were significantly more likely to select the following items as important: absolution/help to find forgiveness, anointing with oil, blessing, Communion/Eucharist, guided imagery (visualization), laying on hands, music, poetry, sacrament of the sick (last rites). There were no items in this list that Protestants were significantly more likely to choose than Catholics.
Table 9. Importance of End-of-Life Care Practices by Religious Affiliation

Bold type indicates significant correlation (p < .05); Chi square used to determine significance

<table>
<thead>
<tr>
<th>Practices (in rank order)</th>
<th>Percentage</th>
<th>Religious Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for my family</td>
<td>84.3%</td>
<td>84.0% 83.7%</td>
</tr>
<tr>
<td>Prayer</td>
<td>82.6%</td>
<td>86.7% 80.8%</td>
</tr>
<tr>
<td>Help with preplanning funerals and memorials</td>
<td>71.6%</td>
<td>70.0% 70.4%</td>
</tr>
<tr>
<td>Communion/Eucharist</td>
<td>68.3%</td>
<td>87.3% 65.6%</td>
</tr>
<tr>
<td>Humor</td>
<td>67.9%</td>
<td>69.3% 64.9%</td>
</tr>
<tr>
<td>Discussions of meaning related to death and afterlife</td>
<td>66.2%</td>
<td>63.3% 65.9%</td>
</tr>
<tr>
<td>Blessing</td>
<td>63.7%</td>
<td>78.0% 57.2%</td>
</tr>
<tr>
<td>Assistance with household chores</td>
<td>60.6%</td>
<td>60.7% 57.7%</td>
</tr>
<tr>
<td>Music</td>
<td>60.5%</td>
<td>68.0% 55.3%</td>
</tr>
<tr>
<td>Help with preplanning for advance directives, living wills</td>
<td>59.6%</td>
<td>55.3% 58.7%</td>
</tr>
<tr>
<td>Absolution/ help to find forgiveness</td>
<td>59.2%</td>
<td>82.0% 53.6%</td>
</tr>
<tr>
<td>Opportunities to memorialize or remember loved ones</td>
<td>57.0%</td>
<td>57.3% 55.8%</td>
</tr>
<tr>
<td>Counsel in medical decision-making</td>
<td>56.6%</td>
<td>60.0% 53.6%</td>
</tr>
<tr>
<td>Holding hands/ appropriate touch</td>
<td>56.3%</td>
<td>55.3% 54.6%</td>
</tr>
<tr>
<td>Presence(quiet)</td>
<td>55.6%</td>
<td>56.0% 54.6%</td>
</tr>
<tr>
<td>Scripture reading</td>
<td>54.6%</td>
<td>56.7% 54.3%</td>
</tr>
<tr>
<td>Sacrament of the sick (last rites)</td>
<td>49.3%</td>
<td>88.7% 38.0%</td>
</tr>
<tr>
<td>Meditation</td>
<td>47.1%</td>
<td>48.0% 43.8%</td>
</tr>
<tr>
<td>Reconciliation or healing in relationships</td>
<td>47.0%</td>
<td>50.0% 44.5%</td>
</tr>
<tr>
<td>Life review</td>
<td>42.2%</td>
<td>45.3% 39.4%</td>
</tr>
<tr>
<td>Laying on hands</td>
<td>41.4%</td>
<td>54.0% 34.4%</td>
</tr>
<tr>
<td>Anointing with oil</td>
<td>38.0%</td>
<td>74.0% 24.3%</td>
</tr>
<tr>
<td>Healing and growth through art experiences</td>
<td>30.7%</td>
<td>27.3% 28.6%</td>
</tr>
<tr>
<td>Guided imagery (visualization)</td>
<td>26.7%</td>
<td>30.7% 21.4%</td>
</tr>
<tr>
<td>Poetry</td>
<td>25.4%</td>
<td>29.3% 21.4%</td>
</tr>
</tbody>
</table>

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CHAPTER FOUR
DISCUSSION

Faith communities have a unique role in society, in part because they comprise people of all ages. As faith communities have members in all stages of life, they must be able to provide ministries to people in illness, those who are dying, and those in bereavement. However, members’ expectations for these ministries are varied and complex, combining elements of spiritual care, practical help and guidance, and formal ritual. While faith communities do provide a framework of meaning for crucial experiences in life, they are also social networks (Sherkat and Reed 1991). Thus, members’ expectations of their faith communities’ provision of care at the end of life reflect the layered role that faith communities have in parishioners’ lives.

The data revealed several themes which are discussed below. Faith communities’ provision of care at the end of life is explored first through types of care: formal ritual, spiritual and informal support, caregiving, grief and bereavement, practical guidance, and humor. In each of these categories differences that emerge through each of the three variables, age, sex, and religious affiliation are discussed. This paper is a secondary analysis of research collected through an instrument that was designed to provide baseline information about faith community members’ experiences of the sorts of end-of-life care provided through their faith community. As this paper is a secondary analysis, it should be noted that these three variables were chosen after data collection had been completed. The intent of this paper is to contribute to a more comprehensive framing of care of the dying and bereaved in contemporary U.S. society. Thus, sex, age and religious affiliation are different lenses through which to explore faith community
members' experiences of and desires for end-of-life care provided by their faith communities.

**FORMAL RITUAL**

According to study participants, faith communities tend to provide ritualistic types of support well. Across all four domains ritualized services were consistently selected as activities done well – healing services, opportunities to memorialize loved ones, graveside services, Scripture reading were selected consistently by both men and women. Perhaps, this is no surprise as one important and easily identifiable characteristic of faith communities are rituals. Faith communities serve multiple purposes in society, including social cohesion, a sense of purpose and meaning and social control (Durkheim [1915] 1965). These ends are accomplished though multiple means, of which ritual is the most formal and official. Rituals serve to mediate relationships: between faith and life, between hope and despair, between individuals and the unknown, between individuals and their communities. However, while rituals are integral to the sense of meaning faith communities provide, they are also highly structured, discreet services. Though they provide an avenue for acknowledging loss, they also maintain strict management over the expression of that loss. In other words, they provide a formalized opportunity to display emotions such as loss, grief, doubt, hope for healing, honoring of another’s life, and support for someone grieving, but due to their nature as formal and time-limited, they create a sphere of “appropriateness” in which such expression is “safely” contained. On the whole, respondents did not select rituals as the most important types of support they would want if they were ill, dying or bereaved. Of the twenty-five items listed.
“Communion/Eucharist” was the most commonly selected ritual, with 68% of respondents selecting it.

A recent article reporting on results from a study of faith community leaders, also in Missoula, found that these leaders were more likely to report comfort with “discrete ministerial services, and immediate, short-term types of support” (Norris et al. 2002: 36). However due to the often lengthy trajectory of illness and decline towards death, and the sometimes long grieving periods for families, the ministries required “may be less well defined and require more intensive level of training than do rituals and funerals or memorial services.” The findings of that study, namely that faith community leaders report being most comfortable with support through rituals is corroborated by the high percentage of respondents in this study who selected rituals as ministries that their faith community does well. Similarly, the suggestion that other types of support are needed, is also supported by the data of this study, as more respondents chose such things as support for my family, prayer, humor, and discussions of meaning related to death and the afterlife as important to them.

Catholics were more likely than Protestants to select rituals as important, though they were no more likely to report that their churches do well at providing rituals.

SPIRITUAL AND INFORMAL SUPPORT

Respondents reported that faith communities provide spiritual and informal support well. Spiritual support - defined as listening, understanding, exploration of faith, meaning and hope - was selected by a majority of men and women in the three domains of ministry in which it was listed as a choice. Informal support – defined as prayers,
cards, and food – was also selected consistently by a majority of both men and women across all four domains of ministry. These two categories involve different members of a faith community – the official trained leadership of a faith community and its general lay community. While it is possible that faith community leaders are providing food and cards, it is likely that this type of support engages many from the faith community. Similarly, while exploration of faith, meaning, and hope can certainly happen between members of a faith community, it is probable that much of the spiritual support as defined above involves faith community leaders.

While the data revealed no significant differences between men and women in terms of how well faith communities provide ministries in the areas of spiritual and informal support, Protestants consistently selected these more than Catholics did. In Protestant churches leadership may be more diffuse than in Catholic churches, involving many lay members in both church governance and ministries. As a result, there may be fewer expectations on the role of a few key leaders and higher expectations for participation from other congregants in fulfilling the activities of the church.

CAREGIVING

One theme that emerges from this data is a gendered perception of faith communities’ roles in supporting family caregivers. Across all three domains of ministry in which “church helps with household chores” was a choice, women were less likely than men to select it as something their faith community does well. Additionally, in the two domains in which it was listed, “church offers support and relief for family caregivers” was selected less frequently by women than by men. However, when asked
what would be important to a respondent if they had a terminal illness, were dying or in
grief and bereavement, both men and women selected “support for my family,” as the
most important item. In this same question, women were significantly more likely than
men to select assistance with household chores as something that would be important. It
is telling that family support is the number one issue for both men and women, and yet,
women are less likely than men to see support for family caregivers and household help
as something that their faith community does well. It should be noted, that support can
take many forms, and “support for my family” might mean spiritual, emotional and
physical support for family members, while help with household chores is more defined
in scope, as is support and relief for family caregivers.

These data suggest that men are less likely to choose the practical support of daily
help than women are, and analogously, men consider their faith community to be doing
well at these types of support more than women do. As women make up the majority of
caregivers in this country (The Robert Wood Johnson Foundation, 2001) and historically
have taken the responsibility in household chores, this finding may be explained by the
fact that men may not accurately perceive the possibility that chores could become a
burden in times of physical and emotional stress. In addition, women who take on more
of the responsibility for caregiving and chores are in a better position than men to judge
how much support they receive from their faith community. Another explanation may be
that faith communities are better at helping men with chores and caregiving relief.
Typically more women are caregivers than men and have a higher life expectancy. Thus,
men taking on the role of caregiving or being widowed may generate more support from
their faith community as their position is unexpected and therefore more visible.
An important dimension of caregiver support and relief and help with chores is that these both require a degree of organization. Informal support such as cards, prayers and food do not take much coordination and are things that individual members can easily undertake. In addition, these are things that usually happen in response to an acute need, at a time of family crisis such as a surgery, an accident, a death, a funeral. Relief and support for family caregivers and help with household chores imply a more sustained and coordinated effort. Family caregiving is usually a long term effort, stretching over a number of years. It can be punctuated with acute crises, but caregiving often stretches at length between these. It is these “in between times” (Norris et al. 2004: 37) that can easily slip out of the notice of a faith community more accustomed to respond to acute needs. As the baby-boom generation ages, it is estimated that 40% of that population will die only after lengthy illnesses accompanied by increasing dementia and disability (Presidents Council on Bioethics, 2004). The increasing length of the dying process, complicated by multiple frailties underscores the need for ministries that provide practical relief and support for family caregivers throughout the duration of the caregiving process. Extra attention during a crisis is not a substitute for committed support over the long term caregiving trajectory.

GRIEF AND BEREAVEMENT

Grief and bereavement like caregiving are experiences that can extend over lengthy periods of time. They have no fixed end and can be intermittent. Furthermore, while having some common responses such as social withdrawal, lack of appetite, and sleeplessness, they can illicit widely varying methods of coping. The lengthy periods of
bereavement, the intensely personal nature of it, and the social embarrassment that often surrounds expressions of grief may be some of the reasons that taken as a whole ministries related to grief and bereavement were selected less frequently than ministries in the other domains.

Like caregiving support, substantial care of the bereaved takes some preplanning and organization. Bereavement support groups, assigned members of the congregation who address the needs of the bereaved, and grief education classes are all activities that demand coordination and a commitment of resources. While a sizeable majority of respondents (64%) did select informal support in the form of prayers, cards, and food as something at which their church did well, support needs still exist for the bereaved after the casseroles stop coming.

**PRACTICAL GUIDANCE**

Times of emotional crises are difficult for decision making. The use of advance directives and living wills and funeral and memorial pre-planning can help relieve some of the emotional distress that accompanies illness and death. Furthermore, advance directives, though primarily medical and legal documents, are enmeshed with questions of ethics and values. This suggests there may be a role for faith communities in helping their members think about and prepare these documents. Only 15% of respondents selected “church helps with preplanning for advance directives, living wills,” as something their church does well, though 59% reported that it was something that would be important to them. Similarly, 56% selected counsel in medical decision making as important, with women choosing this significantly more than men. Forty percent of
respondents selected “church helps with preplanning for funerals and memorials,” as something the church does well, while 71% indicated that it would be important to them.

Preplanning is clearly important to people, but sizeable discrepancies exist between the desire for assistance with preplanning and the help faith communities offer. This sort of assistance demands a certain amount of training. Though advance directives can be as simple as naming a healthcare power of attorney, they typically include technical instructions about desired medical treatment. Preplanning of memorials and funerals also presumes some knowledge of the options available both within a faith community and in the funeral industry. Besides having trained individuals available for facilitating these types of preparation, one must also plan to preplan. Like caregiver relief, preplanning requires deliberate efforts and by its nature must take place before an acute crisis.

HUMOR

Of the list of twenty five practices that would be important to respondents if they were ill, dying or in bereavement, humor emerged as the fourth most important, following only support for my family, prayer, and help with preplanning funerals and memorials. Humor is used in many ways in society, including diffusion of stressful situations and diversion. It is also associated with health and well-being (Boyle and Joss-Reid 2004; Celso, Ebener and Burkhead, 2003). In situations of extreme severity such as serious illness, dying, death and bereavement, it is conceivable that humor is employed as a way of changing the focus of the situation. Humor broadens the horizon by reminding that there is life beside the present loss, effectively setting the present stress in the context
of the rest of life. Humor also can be used as a mode of remembrance and honor. Memorial services often contain the recounting of humorous events from the deceased’s life, allowing the hearers to remember and enjoy the singularity of the deceased.

AGE

Looking through the lens of age, a number of interesting differences emerge. Individuals 70 years of age and above were more likely to report that their faith community does well at having assigned members who address the needs of the ill, preplanning for advance directive and living wills, preplanning funerals and memorials, providing bereavement support groups and grief education. As it is more likely that people in these age groups would have had the need for these services, it follows that they are more likely to select them as things their faith community does well.

Respondents below forty years of age were less likely to report that their faith community leaders provide a funeral, memorial or grave-side service, that church members attend or participate in the ritual or service, or that their church provides informal support to individuals around funerals and memorials.

Of the twenty-five item list of practices that respondents could choose as important to them if they were seriously ill, dying, or in bereavement, eighteen of the practices were negatively correlated with age. In general, respondents sixty and above were less likely to select these items than respondents below sixty. There were no significant differences by age of any of the traditional ritual practices in this list such as Communion/Eucharist, laying on hands, sacrament of the sick, anointing with oil, and Scripture reading. While these differences may be accounted for in part by changes in
needs such as support for family that may occur between younger and older respondents, these findings are consistent with the observations some have made about the differences between baby-boomers and the preceding generation (Noble, Schewe and Kuhr 2004; Donelan et al. 2002). Baby-boomers tend to have higher expectations for services and are open to less-traditional experiences.

**SEX**

Looking through the lens of differences by sex, caregiver relief and support and help with household chores emerge as one important difference that emerges from the data. As discussed earlier, the role of faith communities in caregiving is seen differently by men and women. Men are more likely than women to report that their faith community does well in supporting family caregivers. Men are also more likely to report that the church does well at helping with chores for those who are ill, dying, or bereaved. Women, on the other hand, are more likely to report that help with chores would be important to them if they were ill, dying, or in bereavement.

Women were also significantly more likely than men to choose creative practices such as music, guided imagery, poetry, and healing and growth through art experiences and relational practices such as opportunities to memorialize loved ones, quiet presence, and holding hands/appropriate touch. These differences may suggest opportunities for faith communities to direct the practices they offer at life’s end to incorporate those that are outside the scope of traditional practices but may appeal more to their women constituents.
RELIGIOUS AFFILIATION

Comparison of responses of Catholic and Protestant faith community members, reveal a few important differences. As mentioned earlier, Catholic respondents reported that their faith community does well at teaching beliefs about death and the afterlife and funerals and memorials than did their Protestant counterparts. Protestants, on the other hand, were more likely to report that their faith community does well at providing spiritual and informal support. They were also more likely to report that their faith community does well in care practices that involved visitation from church leaders or members.

In the list of end-of-life care practices from which respondents were asked to select those that would be important to them if they were ill, dying, or bereaved, there were no items that Protestants were more likely than Catholics to choose. There were several items which Catholics were more likely to choose, all of which fall into one of two categories: traditional church practices such as Last Rites, Communion/Eucharist, and laying on of hands and creative practices such as music, guided imagery, and poetry.
CHAPTER FIVE
CONCLUSIONS & RECOMMENDATIONS

The findings of this study suggest possibilities for further research. Parsons’ 1963 suggestion, that comprehensive assessment of death and dying in America should include study of the clergymen’s role, still stands as an important area of sociological inquiry. This research has explored what faith community members think about the care that their faith community provides in serious illness, through dying and bereavement and what practices would be important to them during these stages of life. Qualitative research of faith community members who have recently experienced the loss of a loved one could significantly contribute to a more complex picture of the role faith communities play in end-of-life care. One limitation of this study is that members who for the most part are not currently confronted with end-of-life issues are required to project into the future in order to speculate about what would be important to them if they were seriously ill, dying, or in bereavement. What they think they want may be different than what they would choose when they in fact are in such a situation. A study of those who recently experienced a loss would not be subject to this limitation.

As more women become clergy in some denominations of Protestant churches, it would be valuable to research the end-of-life care practices of female-lead congregations and compare those with male-lead congregations. Are there differences in these practices? If so, do they correspond to the practices in this study that women were more likely to indicate would be important to them at the end of life?

This study only minimally explores types of caregiving support and grief support provided by faith communities. As these are processes that can continue over a period of years, the complexity of them and the possibilities for support are not dealt with in-depth
through this research. However, the need for caregiving support will continue to grow as baby-boomers age and medical advances continue to lengthen life though often with serious debilitating diseases. An in-depth inquiry into faith communities’ provision of caregiver support would be beneficial to understanding the social structure of caregiving.

The aging of baby-boomers, both in terms of sheer population and in terms of baby-boomer expectations for services, may cause many faith communities to revisit their role in supporting family caregivers, end-of-life care, and bereavement support. While the processes of care of the dying have been going through large social structural and cultural changes over the past century, the aging of the baby boomers is likely to add another set of significant challenges and changes to these systems. In general, the coming decade will be an interesting time to study end-of-life care and cultural sense-making of dying, death, and grief.

**Practical Implications**

Faith community leaders that wish to address end-of-life care within the context of their faith community, could use the findings of this research to guide their thinking about what services they provide and where gaps in service may exist. For example, consistently throughout the four domains of end-of-life ministries, respondents indicated that their faith communities seem to do better at providing short-term types of informal support such as food, prayers, cards, and short-term types of formal support such as memorial services and funerals. Consistently, respondents indicated that long-term support, such as grief support groups and family caregiver relief, were not done well by their faith communities. Similarly, a majority of respondents did not think that their faith community did well at helping preplan advance directives, funerals and memorials, or
providing someone to go with a family to make funeral arrangements.

Taken as a whole, this data suggests that faith communities might consider more pro-active planning of their role in end-of-life care so that they are better able to meet the needs and expectations of care that members hold. While the data indicates that faith communities do well at responding with support in crises, there seems to be room to grow into systematic care that has evolved to fit the needs of contemporary dying: e.g. support for family caregivers, preplanning and counsel about medical decisions with ethical import, and help with negotiating the funeral industry.

This research also contains interesting implications for faith communities as they look toward changing with their congregations. Many items in the list of end-of-life care practices from which respondents could select those that would be important to them if they were seriously ill, dying or in bereavement were negatively correlated with age. It is possible that younger congregants may have expectations for more and wider services from their faith communities than traditionally offered. Clergy and lay leaders may want to assess their particular congregations for the types of practices that would best fit their members.

Sociological Implications

Dying, death, and loss are life experiences which, while common to humans in general, are structured by the particularities of the historical-cultural moment. These universal events are embedded in historical processes, cultural trends, social structures and personal meaning. All of these frame the field of end-of-life care and structure how one will experience the end of life.

Faith communities, though by no means a homogenous group, are one set of
players on this field. Faith communities are many things: social networks, places of meaning-making, multi-generational spaces. As such, they play a role in structuring social and cultural life in general, and can play an especially significant role in structuring the social and cultural life of those who associate themselves with a faith community in particular. Thus, they along with other social institutions such as institutions of medicine, law, and workplaces, to name a few, have a hand in structuring the end-of-life and grief experiences of their members.

This study is only one step towards understanding the role that faith communities play in the end-of-life experiences of faith community members. A study with faith community leaders’ perceptions of the care they provide and the meaning they attach to these practices could help explore how the “cultural scripts,” as defined by Seale (1998), are appropriated by people as they seek to understand their experience in care settings. That is to say, we need to see how the people who work in these settings think about their work, what they do on an everyday basis, and how they, as ‘system representatives’ seek to mould the subjectivities of the people for whom they care. (p. 117).

Faith community “system representatives” may “mould the subjectivities of the people for whom they care” as regards end-of-life experiences. How they do so and what meaning they attach to their care would help further map out the terrain of end-of-life care in contemporary U.S. society.
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Faith Community Member Survey

This confidential survey was created for faith community members within Missoula County. We believe churches are foundational to spiritual growth. Our goal is to learn from your experience and help enhance spiritual care for those who are sick, at the end of life and in bereavement. In this survey we ask about your church's success in providing spiritual care and we also explore your perspective on areas in which you would like to see your church improve. Ultimately we hope to use this information to engage the entire community of Missoula in supporting and enhancing the spiritual care process. Please sit down and relax as you spend the next 15 minutes completing this survey. Thank you.

DEMOGRAPHICS. These first questions are about you.

1. Your date of birth ___/___/___ 2. Your sex 1__female 2__male

3. Please write the name of your church.

4. How long have you attended this church? (check one)
   1__0-11 months
   2__1-3 years
   3__4-10 years
   4__10+ years

5. How often do you attend this church? (check one)
   1__never
   2__rarely
   3__occasionally
   4__regularly

6. Are you confined to your home due to disability or illness?
   1__Yes  2__No

7. Have you had experiences with: (check all that apply)
   1__serious illness (including being a caregiver for someone who is ill)
   2__dying/death
   3__funerals/memorials
   4__bereavement (loss & grief)
   5__none of the above

8. How often are the topics of illness, dying, death and bereavement raised within your congregation? (circle the appropriate number)
   0 never 1 2 3 4 5 6 7 8 9 10 regularly
9. Which of the following end-of-life ministries does your church do WELL? (check all that apply)

A. Ministry related to illness:
1. church leaders/members visit those who are ill
2. church has assigned members or group of members who address the needs of the ill
3. church offers spiritual support: listening, understanding, exploration of faith, meaning, and hope
4. church offers support and relief for family caregivers
5. church helps with household chores
6. church provides informal support to individual and family: prayers, cards, food
7. church offers prayer and/or healing services
8. other: ____________________
9. not applicable

B. Ministry related to dying and death:
1. church helps with preplanning for advance directives, living wills
2. church teaches its beliefs about death and the afterlife
3. church offers spiritual support: listening, understanding, exploration of faith, meaning and hope
4. church provides informal support to individual and family: prayers, cards, food
5. church offers support and relief for family caregivers
6. church helps with household chores
7. church leaders/members visit those who are dying and their family members
8. church provides rituals: funeral, memorial, Scripture reading
9. other: ____________________
10. not applicable
Which of the following end-of-life ministries does your church do WELL? (check all that apply)

C. Ministry related to funerals/memorials:

1. church helps with preplanning for funerals and memorials
2. church teaches its beliefs about funeral/memorial/burial practices
3. church leaders promote the recalling and sharing of memories about the deceased
4. church leaders provide a ritual or service: funeral, memorial, grave-side service
5. church members attend/participate in the ritual or service
6. church provides informal support: prayers, cards, food
7. church offers support-person to go with family to the funeral home to make arrangements
8. other:________________________
9. not applicable

D. Ministry related to grief and bereavement:

1. church provides grief education classes
2. church provides bereavement support group
3. church leaders/members visit those who are bereaved
4. church provides informal support: prayers, cards, food
5. church helps those experiencing grief and bereavement with household chores
6. church pairs the bereaved with others in the faith community
7. church provides opportunities to memorialize or remember loved ones
8. church offers spiritual support: listening, understanding, exploration of faith, meaning and hope
9. church has assigned members or group of members who address the grief and bereavement needs of the congregation
10. other:________________________
11. not applicable
10. Your church has decided to enhance or strengthen its spiritual care at the end of life. Which one of the following ministries would you like your church to begin? (check one)

1____ ministry related to illness (including ministry to family caregivers)
2____ ministry related to dying and death
3____ ministry related to funerals and memorials
4____ ministry related to grief and bereavement
5____ none of the above

11. A. Please check the letter of those spiritual care practices and activities which would be important to you if you were seriously ill, approaching death, or in bereavement. (check all that apply)

B. Then circle the person(s) whom you would like to provide these practices. (circle all that apply)

A____ absolution/help to find forgiveness
B____ anointing with oil
C____ assistance with household chores
D____ blessing
E____ Communion/Eucharist
F____ counsel in medical decision-making
G____ discussions of meaning related to death and afterlife
H____ healing and growth through art experiences
|   | help with preplanning for advance directives, living wills | help with preplanning for funerals and memorials | guided imagery (visualizations) | hands/appropriate touch | humor | laying on hands | life review | meditation | music | opportunity to memorialize or remember loved ones | poetry | prayer | presence (quiet) | reconciliation or healing in relationships |
|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|---|
| I | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| J | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| K | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| L | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| M | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| N | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| O | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| P | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| Q | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| R | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| S | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| T | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| U | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
| V | pastor | trained lay leader | member(s) of faith community | someone to whom you feel close | by yourself |
1. Please rate how WELL your church provides ministry in the following areas. (circle the appropriate number)

a). ministry related to illness (including ministry to family caregivers)?
check box if this does not apply □ comments:

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c). ministry related to funerals and/or memorial services?
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d). ministry related to grief and bereavement?
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Thank you for completing this survey!
Appendix B Table 1: Respondents' Perspectives on Ministries Related to Illness that their Faith Community “Does Well” by Age, Sex and Religious Affiliation

<table>
<thead>
<tr>
<th>Ministries (in rank order)</th>
<th>Percentage (n=625)</th>
<th>Age</th>
<th>Sex</th>
<th>Religious Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church leaders/members visit those who are ill</td>
<td>73.8%</td>
<td>71.3% 72.8% 74.3% 72.5% 78.7%</td>
<td>73.0% 74.2%</td>
<td>57.3% 81.0%</td>
</tr>
<tr>
<td>Church offers prayer and/or healing services</td>
<td>70.6%</td>
<td>67.6% 72.5% 71.5% 64.8% 73.4%</td>
<td>71.8% 70.1%</td>
<td>75.3% 68.5%</td>
</tr>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>67.3%</td>
<td>69.3% 65.0% 67.6% 73.6% 62.0%</td>
<td>66.1% 67.8%</td>
<td>46.7% 74.3%</td>
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<tr>
<td>Church offers spiritual support: listening, understanding, exploration of faith, meaning and hope</td>
<td>65.9%</td>
<td>69.6% 69.8% 62.8% 61.5% 67.0%</td>
<td>62.8% 67.2%</td>
<td>54.7% 69.2%</td>
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<tr>
<td>Church has assigned members or groups of members who address the needs of the ill</td>
<td>54.3%</td>
<td>52.5% 48.7% 53.5% 56.0% 63.0%</td>
<td>53.4% 54.8%</td>
<td>38.7% 58.9%</td>
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<tr>
<td>Church offers support and relief for family caregivers</td>
<td>34.3%</td>
<td>40.6% 29.7% 28.5% 40.7% 38.0%</td>
<td>43.6% 30.4%</td>
<td>26.7% 34.4%</td>
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<td>Church helps with household chores</td>
<td>15.6%</td>
<td>16.8% 14.6% 13.2% 17.6% 17.6%</td>
<td>20.2% 13.6%</td>
<td>10.0% 15.1%</td>
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</table>
Appendix B Table 2: Respondents’ Perspectives on Ministries Related to Death and Dying that their Faith Community “Does Well” by Age, Sex and Religious Affiliation

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<tr>
<th>Ministries (in rank order)</th>
<th>Percentage (n=625)</th>
<th>Age</th>
<th>Sex</th>
<th>Religious Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&gt;40</td>
<td>40-49</td>
<td>50-59</td>
</tr>
<tr>
<td>Church provides rituals: funeral, memorial, Scripture reading</td>
<td>78.0%</td>
<td>69.6%</td>
<td>83.0%</td>
<td>77.9%</td>
</tr>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>69.0%</td>
<td>70.3%</td>
<td>69.2%</td>
<td>69.4%</td>
</tr>
<tr>
<td>Church offers spiritual support: listening, understanding, exploration of faith, meaning and hope</td>
<td>67.0%</td>
<td>68.6%</td>
<td>71.7%</td>
<td>65.5%</td>
</tr>
<tr>
<td>Church leaders/members visit those who are dying and their family members</td>
<td>65.6%</td>
<td>61.4%</td>
<td>65.0%</td>
<td>65.3%</td>
</tr>
<tr>
<td>Church teaches its belief about death and the afterlife</td>
<td>58.4%</td>
<td>59.8%</td>
<td>60.9%</td>
<td>55.6%</td>
</tr>
<tr>
<td>Church offers support and relief for family caregivers</td>
<td>29.5%</td>
<td>38.6%</td>
<td>22.4%</td>
<td>27.1%</td>
</tr>
<tr>
<td>Church helps with preplanning for advance directives, living wills</td>
<td>15.3%</td>
<td>11.8%</td>
<td>10.8%</td>
<td>16.9%</td>
</tr>
<tr>
<td>Church helps with household chores</td>
<td>13.1%</td>
<td>16.8%</td>
<td>11.5%</td>
<td>10.5%</td>
</tr>
</tbody>
</table>

Bold type indicates significant correlation (p < .05); Chi square used to determine significance.
Appendix B Table 3: Respondents’ Perspectives on Ministries Related to Funerals and Memorials that their Faith Community “Does Well” by Age, Sex and Religious Affiliation

<table>
<thead>
<tr>
<th>Ministries (in rank order)</th>
<th>Percentage (n=625)</th>
<th>Age</th>
<th>Sex</th>
<th>Religious Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td>Church leaders provide a ritual or service: funeral, memorial, grave-side service</td>
<td>71.4%</td>
<td>&gt;40</td>
<td>71.7%</td>
<td>71.3% 71.4%</td>
</tr>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>70.1%</td>
<td>40-49</td>
<td>74.5%</td>
<td>72.9% 75.8% 73.1%</td>
</tr>
<tr>
<td>Church members attend/participate in the ritual or service</td>
<td>64.1%</td>
<td>50-59</td>
<td>72.9%</td>
<td>75.8% 73.1%</td>
</tr>
<tr>
<td>Church leaders promote the recalling and sharing of memories about the deceased</td>
<td>51.6%</td>
<td>60-69</td>
<td>72.3%</td>
<td>75.8% 73.1%</td>
</tr>
<tr>
<td>Church helps with preplanning for funerals and memorials</td>
<td>40.6%</td>
<td>70±</td>
<td>72.9%</td>
<td>75.8% 73.1%</td>
</tr>
<tr>
<td>Church teaches its belief about funeral/ memorial/ burial practices</td>
<td>32.7%</td>
<td></td>
<td>72.3%</td>
<td>75.8% 73.1%</td>
</tr>
<tr>
<td>Church offers support-person to go with family to the funeral home to make arrangements</td>
<td>12.3%</td>
<td></td>
<td>72.3%</td>
<td>75.8% 73.1%</td>
</tr>
</tbody>
</table>

Bold type indicates significant correlation (p < .05); Chi square used to determine significance.
Appendix B Table 4: Respondents’ Perspectives on Ministries Related to Grief and Bereavement that their Faith Community “Does Well” by Age, Sex and Religious Affiliation

Bold type indicates significant correlation (p < .05); Chi square used to determine significance

<table>
<thead>
<tr>
<th>Ministries (in rank order)</th>
<th>Percentage (n=625)</th>
<th>Age</th>
<th></th>
<th></th>
<th></th>
<th></th>
<th>Religious Affiliation</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>&gt;40</td>
<td>40-49</td>
<td>50-59</td>
<td>60-69</td>
<td>70s</td>
<td>male</td>
</tr>
<tr>
<td>Church provides informal support to individual and family: prayers, cards, food</td>
<td>65.7%</td>
<td>68.3%</td>
<td>66.2%</td>
<td>66.4%</td>
<td>67.0%</td>
<td>59.3%</td>
<td>66.3%</td>
</tr>
<tr>
<td>Church offers spiritual support: listening, understanding, exploration of faith, meaning and hope</td>
<td>59.6%</td>
<td>63.7%</td>
<td>63.8%</td>
<td>59.0%</td>
<td>53.3%</td>
<td>56.5%</td>
<td>64.1%</td>
</tr>
<tr>
<td>Church provides opportunities to memorialize or remember loved ones</td>
<td>55.5%</td>
<td>52.0%</td>
<td>53.5%</td>
<td>60.1%</td>
<td>58.2%</td>
<td>53.7%</td>
<td>54.7%</td>
</tr>
<tr>
<td>Church leaders/members visit those who are bereaved</td>
<td>52.3%</td>
<td>50.5%</td>
<td>48.7%</td>
<td>54.5%</td>
<td>50.5%</td>
<td>57.4%</td>
<td>56.2%</td>
</tr>
<tr>
<td>Church has assigned members or group of members who address the grief and bereavement needs of the congregation</td>
<td>22.3%</td>
<td>26.7%</td>
<td>16.0%</td>
<td>19.7%</td>
<td>24.2%</td>
<td>26.9%</td>
<td>23.6%</td>
</tr>
<tr>
<td>Church provides bereavement support group</td>
<td>15.7%</td>
<td>14.9%</td>
<td>9.6%</td>
<td>15.5%</td>
<td>17.6%</td>
<td>24.1%</td>
<td>17.4%</td>
</tr>
<tr>
<td>Church provides grief education classes</td>
<td>13.1%</td>
<td>9.9%</td>
<td>8.3%</td>
<td>12.7%</td>
<td>15.4%</td>
<td>23.1%</td>
<td>15.2%</td>
</tr>
<tr>
<td>Church helps those experiencing grief and bereavement with household chores</td>
<td>11.1%</td>
<td>13.9%</td>
<td>7.1%</td>
<td>9.9%</td>
<td>12.1%</td>
<td>14.8%</td>
<td>19.7%</td>
</tr>
<tr>
<td>Church pairs the bereaved with others in the faith community</td>
<td>9.8%</td>
<td>14.9%</td>
<td>5.1%</td>
<td>8.5%</td>
<td>9.9%</td>
<td>12.0%</td>
<td>12.4%</td>
</tr>
</tbody>
</table>