

*Amans:***A Buddhist Nun's Efforts to Unite the Medical and Religious Worlds in Death**

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**Introduction: Birth of *Amans***

This term *amans*, which I developed for myself, is a hybrid of the word for Buddhist nun (*ama*) and nurse (*ns*). I myself was raised in a Buddhist temple after being adopted by two nuns, who are now in their nineties and seventies respectively. When I was young, they would often go on nursing and home care visits to people in the region. The temple we lived in, Yakuzan Toshō-ji, a Soto Zen temple in Matsumoto City in Nagano Prefecture, was old and decrepit and needed rebuilding. When they rebuilt it, they made it into a temple and hospice. Thus, while doing nursing and care work, they also created a hospice to care for people in their final stages.<sup>1</sup> The other part of my inspiration comes from Mary Aikenhead (1787-1858), the Irish nun, who created the hospice archetype. She directly influenced Cecily Saunders, the English medical nurse credited with beginning the modern hospice movement. In this way, the grandmother of hospice is a nun and the mother of hospice is a female doctor. I try to put these two women together as one,<sup>2</sup> and thus far, I have not found any conflicts in doing so.

I have been blending these worlds since I was young. First, I graduated from the Department of Nursing at the University of Shinshu Junior College of Medical Technology in 1986. Then, I immediately entered the well-known Soto Zen Aichi Monastery for Nuns<sup>3</sup> where I underwent monastic training for two years. This was followed by four years of undergraduate work from 1988 to 1992 in Buddhist Studies at Komazawa University, which is the affiliated university of my Soto Zen denomination, where I also completed my Master's in Divinity in 1995. Finally, after graduating, I returned to my medical training, working as a nurse in the Palliative Care Ward and Internal Medicine Ward of Suwa Central Hospital in Chino City, Nagano from 1995 to 1999.

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<sup>1</sup> Ozaki, Takeshi (2005) "Hosupisu Kaisetsu-o Mezasu Matsumoto-no Niso"

<sup>2</sup> Ozaki, Takeshi (2005) "Hosupisu Kaisetsu-o Mezasu Matsumoto-no Niso"

<sup>3</sup> This temple is profiled in detail in: Arai, Paula. (1999) *Women Living Zen: Japanese Soto Buddhist Nuns*. New York: Oxford University Press.

In July 1999, I decided to resign from my work at the hospital due to exhaustion and burnout. I was basically unemployed at this time and needed time for self-care. We talk about the idea of “terminal period” in hospice care, but this can also have the meaning of a period of “self terminal care”. In one’s own life, there is a turning point that can be seized to do such care for ourselves. In preparing for this change, one needs to prepare both body and mind together, and it takes time to harden the resolution to shave one’s head as a nun. For women, “hair” is very important, like life itself. In this way, I spent the next year on sabbatical and returned to my monastic lifestyle as a nun.

In March 2000, I returned to my temple, Tosho-ji in Matsumoto, from where I have based my activities since. The model we have used for our present work at Tosho-ji is based on a nearby temple called, Jingu-ji, affiliated with the Myoshinji Rinzai Zen denomination, where I started volunteering in 2003. The abbot, Rev. Takushi Takahashi, wanted to revive the local community which was in decline. The area had been a resort for old people to visit the nearby Asama Hot Springs, so the elderly were frequent visitors to the area. From the main hall of Jingu-ji, we operated a mini-day service to care for the elderly and help them enjoy the hot springs. Then we renovated the hot springs’ traditional inn and opened the *Goten-no-yu* day service, which made regular visits to a nursing care facility, and the *Goten-no-yu East* helper station, which dispatched home helpers to private residences. In the end, we also started providing hospice care.<sup>4</sup> From the beginning, I performed the nursing duties but have taken a leave of absence from the work for the time being. In reviving the mini hospice at my own temple, Tosho-ji, I have used the knowhow gained from these experiences at Jingu-ji.

As both a nun and a nurse, an *amans*, there are things I know and can communicate to people, because I have walked both paths. Though my knowledge is rather limited, I know things in both Buddhism and medicine. Therefore, when I visit a temple member for a Buddhist service and he asks a medical question, I can give advice about what to say to his doctor, help him understand his medical situation, or tell him that he does not have to worry about certain matters. In this way, I think my choice to be what I am has not been a mistake so far.

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<sup>4</sup> Ozaki, Takeshi (2005) “Hosupisu Kaisetsu-o Mezasu Matsumoto-no Niso”

## **Challenges in the Japanese Palliative Care System**

### *Integrating the Work of Dying with the Work of Living*

For doctors in Japan, death has meant the defeat of medicine, and palliative care or pain control using morphine has also meant the defeat of medicine. This kind of sense was more prevalent back when I was studying hospice care, but now it has lessened. It means that doctors understand a patient's death as the result of ineffective treatment. However, when you look at death from the perspective of reality, every person is destined to die, and no amount of medicine can eliminate the reality of death. It may be fine for doctors to say death is a defeat, but I think this sensibility is proof of the tendency of medical practitioners to turn away from the reality of death.

What exactly is considered as the defeat of medicine? If a patient dies from a medical accident, this can lead a doctor to believe that it was a defeat. I personally think that an affirmative position on euthanasia is the defeat of medicine. However, I do not want people to think that providing palliative care is the defeat of medicine. When I was a trainee at a hospital twenty years ago, the doctors told us that we should not treat patients with pain until the cause of pain was determined. At this time, I could only write on a patient's chart that their pain was "under self-control" (*jisei nai*). With this perspective, medical professionals thought that death or palliative care was the defeat of medicine. As time has gone by, however, it has become understood that palliative care can, despite serious illness, provide a peaceful time for the patient and a sense of relief for the family. Then, a peaceful death eventually comes. In this perspective, death is not necessarily a defeat.

The state of palliative care in Japan is behind other countries, and it is none other than the patients and the families who suffer from this reality. When one doctor's diagnosis is different from another's, it causes confusion for nurses, families, and patients. While some doctors are interested in the method of using drugs like morphine to treat patients, others are not at all and acquire no new knowledge about it. It is scary if your life depends on which doctor is in charge of your case.

For example, let us say Doctor A is treating Patient B. A is actively treating B with palliative care and symptom control, and so B is living life with a smile. His/her "activities of daily living" (ADL) remain high, meaning he/she can go wherever and whenever they wish and can do what they want to do. Therefore, the "quality of life" (QOL) can remain high as well. On the contrary, let us say Doctor C, who has outdated

medical knowledge, is treating Patient D. D goes to Doctor C because of a long relationship with him. I think this sense of obligation to stick with the same family doctor for many years is common in Japan. Since Doctor C has outdated knowledge, he tells D to bear with the pain and does not provide morphine.

Here, Doctor A and Doctor C take completely different measures. In turn, Patient B enjoys his life whereas Patient D still suffers in pain, using the outdated method of “under self-control” (*jisei nai*). The pain causes D to be less mobile and depressed, hence ADL is low. The QOL of patient B is high, while that of patient D is low. The problem is that their condition depends on the knowledge of their doctors. Palliative care should be somehow studied not only by medical students today but also by doctors in their sixties, for example, who did not receive postgraduate education in palliative care. In this way, general practitioners will be able to provide the same quality of palliative care.

The abbot of my temple (the younger of the two nuns) is an example of this situation. When she was first experiencing symptoms of her breast cancer, she had no idea what it was and just thought she had an inflammation. However, when she got it examined, she found out that it had spread through the lymph nodes. There developed such an accumulation of water in the area that her heart was floating in water. In this situation, there was no option to receive surgery. She was already seventy-four years old, so it was either choose palliative care or receive chemotherapy and then perhaps radiotherapy. My abbot is the type of person who is always positive, and she wanted to try to keep living even though her disciple, myself, works in hospice and palliative care. She wanted to take aggressive treatment, so we found a good doctor who specializes in chemotherapy at Suwa Central Hospital. At Suwa Central Hospital, patients can receive chemotherapy, and if they have pain, they can also receive good palliative care.

The chemotherapy doctor was not so talented with managing pain, so I consulted with another doctor in palliative care. He said it was fine to increase the dosage of painkillers while my abbot continued to receive chemotherapy. Although she did lose her hair, which you couldn't tell anyway because her head is shaved, it was not like she suffered pain. The chemotherapy treatment was controlled according to her age and condition to avoid pain. Unfortunately, other hospitals in the area do not have such good doctors, which would be really helpful for people like my abbot who want to take aggressive treatment as much as possible until the end. My abbot was on the verge of

death two years ago, but she has gotten better and now declares that she will live another thirty years.

In this way, I have wondered how much of difference it makes which doctor you have. As Dr. Makoto Hirakata, who established palliative care at Suwa Central Hospital, says, “In Japan, the demand outstrips the supply in terms of the number of hospital beds.”<sup>5</sup> He says that we need to examine actually how many patients require palliative care and increase the number of palliative care beds if necessary. Doctors outside of palliative care wards should be educated in order to provide the same quality of palliative care wherever it may be required. Fortunately, in 2007 the Cancer Control Act was implemented in Japan in which palliative care is incorporated together with chemotherapy. This is something a little different from the idea that palliative care equals hospice care or terminal care. In this Act, palliative care is initiated from the early phase of treatment, and palliative care training is mandated for all physicians and surgeons for cancer.

In terms of palliative care in a hospice environment, it seems that a patient is sent to the palliative ward after receiving all treatment available. I think this is not ideal. The ideal would be that a patient receives all available treatment and then decides for themselves to go to the palliative ward, communicates this to their doctor, and then the doctor talks to the palliative ward. Therefore, I see a problem in the present process.

For example, there was a woman with uterine cancer who came to our hospital after being treated at another hospital where she was told by a doctor that he had done everything he could. She felt she had been abandoned. The cancer was at the terminal stage, and the treatment caused abdominal dropsy, an abnormal accumulation of fluid in the abdomen. She was in bad shape and came to our hospital asking what she could do. First, the abdominal dropsy was treated, and she was instructed to eat whenever she could despite the lack of appetite. She also started taking drugs to ease the pain and these worked well. She was able to control the symptoms and feel somewhat better. Then she thought about what she wanted to do. She wanted to visit southern Nagano where her family used to live a long time ago. Although she could stop breathing anytime, she could still move her body and her consciousness was clear. It was now or never, so she and her family drove there. Her physician and I also tagged along. We

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<sup>5</sup> *Shinano Mainichi Newspaper*. May 5, 2009.

used a welfare taxi. Because the road on the way there was going to be rough, we gave her sleeping pills to prevent motion sickness. As it turned out, she slept through the whole trip, but her daughters filmed it so that she was able to watch it later. She was very happy that she made the trip. At the time of the trip, her condition was so severe that we had to prepare to take measures for worst case scenarios, such as her breathing stopping or death. The trip was possible, because we treated her with symptom control. In this case, she came to us, because her doctor had given up on her. However, I think it would have been better if she and her family had come to us, because they wanted to be together and wanted the time left to be meaningful. These concerns with symptom control, supporting appetite, and relieving pain so that a patient can be active in their final days are ones that Dr. Hayashi at the Kosei Vihara has also shared in his chapter.

*Problems in Creating a Comprehensive System of Care within the Hospital and Out in Society*

There are a number of different problems in the overall palliative care and hospice system in Japan. The first I see is that in hospice care clinics in Japan there is a tendency that their psycho-physiological approach is less than adequate. For example, at Suwa Central Hospital, we had a psychiatric doctor on call some days of the week. When he was there, a patient could receive his evaluation, but if he was not, a patient could only receive treatment or a prescription based on the limited knowledge of a physician. While a hospital with a psychiatric department can manage when a patient shows some psychiatric symptom, a hospital without a psychiatric department will not always be able to do that.

A second problematic area is the way the field of psychiatric social work in Japan is determined is unclear. There are cases where the same government office is handling both rehabilitation guardianship for criminal offenders and social welfare for disabled people. They use the same terms for disabled people that they use for criminals. That is the way it has been for many years, but we should change and separate these terms into more appropriate ones according to the characteristics of each area. Moreover, the government should establish a field for terminal care, palliative care, and grief care for the bereaved in our health services.

A third problematic area is the shortage of hospice and palliative care volunteers in Japan. There are many cases where a patient is getting effective palliative treatment

and their ADL is high, but yet they are not able to go out and do the things they want to do because of a lack of volunteer support. In this way, it would be ideal to increase the number of private sector palliative care and support volunteer groups or the number of NPOs of this sort. These can be platforms for nurses to utilize their certified skills as volunteers. I believe that volunteers with knowledge and experience in palliative care and nursing could provide a tremendous relief for patients and their families as well as for hospital staff.

There are volunteers, for instance, at the Suwa Central Hospital Palliative Care Unit. They take a palliative care volunteer course and learn about each ward. Their job is similar to nursing assistants in that they talk to patients, go shopping for them, help out at seasonal events, and so forth. This kind of volunteer work was organized inside the hospital. The hospital also has three kinds of treatment services: in-patient, out-patient, and home visit. This allows the hospital to provide continuous care. For example, if the patient wants to stay home, we come to his/her house to give treatment. If he is well enough, he can come to the hospital as an out-patient. If his condition suddenly worsens, he can be immediately hospitalized.

However, I am concerned that there is not this kind of support outside hospitals in the community. Those who are well enough under palliative care and have a high ADL can go live at home. However, they cannot get the help they need from general society. For example, when they would like to go out somewhere, they may need a van, a nurse, and probably a volunteer. The lack of acknowledgement in society for palliative care is thus a fourth problematic area. There are major gaps among communities in the level of acknowledgement and effort. For example, when the Vihara Palliative Care Ward at Nagaoka Nishi Hospital which is well-known for having Buddhist chaplains was founded, there was a rumor among local people that, "Once you enter the hospital, it's all over. You go there to die." The same kind of thing was said jokingly about Suwa Central Hospital, "Their doors are made of steel". In the beginning, such stereotypical comments were made not only by patients but also among doctors. Today, the media does a better job informing the public by showing documentaries on palliative care or hospices with titles like, "Days where Life Shines". In urban areas, people are more informed, but they are not as well in rural areas. I believe there are ways religious professional can actively enlighten people in this country to live a meaningful life during palliative care and hospice care.

A patient under palliative care may live not only in the hospital but also in their community. That is why I hope more volunteer organizations will grow and support patients outside hospitals. This would bring a higher quality of life to patients and their families. In turn, these patients can educate their communities when they return home, communicating with them as usual despite their hardship. They can be proof that the saying, “the use of morphine is a sign of the end”, is not true. For this to happen, we need such supporters locally, and more ideally, neighbors who are able to provide palliative care for patients. In this way, one can learn by helping other people in the community so that when one’s family member goes through the same kind of situation in the future, one will be better prepared to know what to do, which doctor to see, and so forth.

In conclusion, I think that if psychiatric social work activities are truly fruitful, it could lead to the realization of local preventive medical care. Local priests could be active in this field and, indeed, there are many priests active today in the field of serving disabled people or rehabilitation guardianship. However, it seems that their efforts are not quite benefiting the activities of the whole community. I hope that too will change gradually. In the past, the temple was a community center that supported both the physical and mental livelihood of the common people through schools, hospitals, old age homes, and nurseries. One community function of the priest and nun was to give care to the sick and also perform memorial services. The famous Soto Zen priest, Ryokan Osho (1757-1831), was attended to by young nuns who gave him care and support in his final days of dying from cancer. Of the 80,000 Buddhist temples nationwide today, it is generally estimated that 30,000 are without abbots and are unattended. If they could be used as mini hospices, this would be a way to do efficient community care reusing social resources.<sup>6</sup>

### **The Role of Buddhism in Dying and “Postvention”**

#### *Problems in Buddhism’s Handling of Death*

What are the religious beliefs of Japanese people? When hospitals ask patients about their case history, they include questions about their religious beliefs. Patients often answer that they are Buddhist, but some of them do not know the name of their family

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<sup>6</sup> Ozaki, Takeshi (2005) “Hosupisu Kaisetsu-o Mezasu Matsumoto-no Niso”

temple or its affiliated denomination. In this way, there is a gap between what we priests consider as belief and what the patients and family consider as belief. In hospitals, we have been asking patients what is their belief, just in case, without concrete means to use that information. In many cases, this information is not used in their care, but it seems that patient families are not particularly bothered by this. It would probably be different if a patient could answer, "I am Buddhist and xx-ji is my temple. If something happens to me, I want my priest to come." However, this is a rare situation in reality. This may not be considered as a problem, but from another perspective how Buddhism and temples can reach out and communicate with temple members is something to be concerned about.

I think it is more important to become a priest whom his temple members want to have by their sick-bed, rather than one who thinks it is important to visit a member's sick-bed, propagate the teachings, and educate them about death. In Japan, I think that Buddhist priests are not really welcomed in hospices or palliative care wards. People usually think, "I don't want a priest here at my bed". As Rev. Tomatsu points out in his chapter, we need to have a solid relationship with them in order to change that. Compared to a doctor, a priest can have a longer time to build trust with a patient and his family over the years. However, I think it is wasteful and sad that this trust has not been utilized well in terminal care situations. I think a priest can express something to a patient that is beyond what a doctor can say. This is something we need to think about.

In the Japanese "Vihara" concept, a major premise is the priest visiting terminal care patients. However, it is painful for a patient to be preached to about Buddhist teaching in the extreme situation of terminal illness. I can imagine this feeling as if I was a patient. Why is the preaching done then and not earlier? I think we should put more effort into speaking to members about what to do and how to accept a terminal illness if it ever happens when they are still well and healthy. Then maybe they will want to call us priests to be there at their sick bed. As a nurse, I do not want a priest to be there when a patient does not want them there, because it tires them and their family.

We have to make it clear that patients are the main people who should take the leading role, while doctors should play a supporting role. A patient's terminal care should be designed under their own wishes, lifestyle, and way of ending it as the first priority. Their funeral should take place accordingly. However, religious professionals conducting funerals seem to perform them as routine work, despite it being a ritual for a

family who provided much of their time in the terminal care and went through much together in the last phase. I see quite an emotional gap here. I believe that the funeral should be conducted with the deceased and his family as the first priority, in the same way that hospital care should be conducted with the patient and his family as first priority.

The first time I served as an assistant priest at a funeral after resigning from my hospital work, the other priest engaged in casual conversation about where he had been recently, what kind of good food he had, and the nice condition of the golf course he had played. I understand that he was just chitchatting, but he never mentioned anything about the bereaved family or the deceased; for example, “He died after fighting the sickness and the family took care of him for a long time”. We can do a funeral without knowing about the person and the family, but I feel this is a sad situation. Back then, I questioned if this kind of routine work with no heart in it was acceptable. As I do more funerals, I started to think that this is how it is. However, for example, the main mourners are usually very tired if the person died after a long fight with a disease. In this way, how you speak to them will be different if you know about that situation. I think also that the family will be very depressed if the deceased has committed suicide. Let us say a priest is busy and in a hurry while he is chanting and striking a wooden block (*mokugyo*). The family may sense this and think, “Why is he doing it in such a superficial manner?” In this way, I'm afraid that the memorial service does not become a service, and people get further away from Buddhism.

When I was working in palliative care, there was a time I wanted to report to the priest of the patient's temple that the patient died after his whole family took very good care of him together until the end and that he died happily with his will fulfilled. We had designed the patient's palliative care with his and the family's wish as priority. When finally he passed away, I wanted to ask the priest to speak to the family with kindness. That is the kind of report I wanted to do as a person who took part in his care. In reality, however, I never actually got to do a report like that at all and still I am not able to do it today. I think a priest ought to have a mindset like this. As I mentioned earlier, people are getting further away from Buddhism. We need to change our mindset, how we approach and speak to the bereaved, in order to stop this tendency.

*Preparing for a “Society of Many Deaths”*

When we discuss issues of death, it is necessary to pay attention to the local customs and way of life. These things are more likely to influence a person's preparation for death. Therefore, when we step forward with educating people concerning terminal care and preparation for death, I think we should not only work on individual preparation (such as making living wills), but we should also prepare a system where local society can accept and support a person's living will. This means environmental maintenance of terminal care at the local level.

As I have talked about, when a deceased's living will is not properly fulfilled, this often means a lack of consensus among family members or interference by the local community. For example, they may say, “Why does he want to do it that way? In this community, we do it this way...” It is unlikely for someone to plan a funeral according to his own will. That is even more so in rural areas, where people say, “We have these customs, and you must do it this way.” The elder of the community usually shows up and conducts the funeral planning. Thus, it is often the case that the deceased's will concerning his own funeral is not fulfilled. When we think about a living will, it is necessary that each person in the community gradually changes their consciousness for the sake of fulfilling the deceased's living will.

“Living Will : Preparation for Departure” is a series of booklets published by the Life Design Center located in Matsumoto City. There are three booklets entitled: “Birth, Aging, Sickness, and Death: Invitation to Preparation whilst Still Alive”, “Preparation for Departure”, and “Design Notes for Departure”. “Preparation for Departure” involves how to write a living will, what to do about inheritance, and so forth. It is like a study aid, written by various specialists in corresponding fields. I wrote the section about anamnesis (case history) in which I suggested creating one's own “medical chart”. Such a chart would state what kind of medical treatment you received and your daily habits, in case of an emergency where you are unable to communicate this kind of information. There is a section where you write down what kind of terminal care you wish to receive and so forth. It is based on the living will form created by the Japan Society for Dying with Dignity (*Songenshi Kyo-kai*). This chart also has sections where you write whether you would like to receive chemotherapy or whether you (and also your family) would like to know from a doctor when you have cancer.

This booklet also has a section on funerals. First, it asks if you want a funeral or

not. It may become a problem if one chooses not to have a funeral, so it would be good if one writes whether they want a funeral and their family temple's priest to conduct a funeral for guiding their consciousness after death. Today in Japan, I think there are people who do not wish to have a funeral. In that case, there is a section to write how one regards their connection with their temple. One can write about their ideas of what to do instead of a funeral. One can also designate which priest they want for their funeral. If one designates someone other than their temple's priest, that again can become a problem. There are also places to write about which photo to use for the funeral, what kind of flowers to use, where to hold the funeral, and who will be informed about the funeral and in what manner. If one has met and spoken with a funeral home about it, that can be indicated in the form as well.

When I was helping out Jingu-ji, there were some cases where funerals were performed based on living will forms like this. Except important Buddhist ritual matters like administering the precepts (*jukai*) and guiding the deceased's consciousness (*indo*), the funeral home, the families, and us had talks to integrate as much of the deceased's wishes as possible. Only in this case can we say the living will was fulfilled and the funeral was for the person foremost. It is necessary for this kind of thing to be informed in advance, so I have been doing lectures to promote writing a living will like this.

Dr. Makoto Hirakata, who established the Palliative Care Ward at Suwa Central Hospital, wrote an article called "Constructive Preparation for a 'Society of Many Deaths'" in which he said Japan is facing becoming a society of many elders and eventually a "society of many deaths." Without preparation for a "society of many deaths," he thinks the country will be filled with a sense of helplessness. Appropriate preparation for "a society of many deaths" thus needs to be started from now. To quote him directly:

To deal with a "society of many deaths," I suggest that we accept death positively and talk actively about death. There are people who find out that their remaining life is actually short and decide to travel with their family or hold a farewell party while still somewhat well. Some also tell younger family about the family's tradition and history, while others might teach junior workers valuable knowhow and other forms of intangible wealth. To talk about death has been considered taboo not only in medical contexts and

the media, but also in education and other everyday settings. In order to form a healthy “society of many deaths”, I think we should get rid of the notion that it is bad to talk about death, actively talk about real death, and speak especially about good death.<sup>7</sup>

I also think that we tend to be negative when we think about death. Instead, we all should accept death and talk about death positively. To talk about death, I think, means that we should have time to talk about living wills. In my Soto Zen denomination, in addition to farewell parties, we persuade people to receive a Buddhist dharma name (*seizen kaimyo*) or to take initiation into the Buddhist precepts (*jukai*) before they die so that they can feel secure about the after life.<sup>8</sup> In 2006, from the parishioner’s office of my temple, I set up a voluntary civic group called the Heartbeat Care Group, where we study about total care through the four Buddhist sufferings of birth, aging, sickness, and death. We invite doctors and nurses from hospices as well as social workers to visit as guest speakers.

*Postvention: Grief Care as Preventive Medical Care*

A more concrete step that religious professionals, specifically Buddhist priests, can participate in is the work of grief care as preventive medical care. A group of temple members can be described as a group of the bereaved. Therefore, there are sympathetic feelings to be shared among temple members. Temples are also needed as a place to gather, and grief care is provided when they go to their affiliated temples to participate in a memorial service. What I mean by grief care here is not what a priest provides, but rather it is a kind of peer counseling where people who share grief get together and talk. In this way, translating grief care into religious activities can be considered an unfinished issue.

Hideki Onishi, Professor of Psycho-oncology at Saitama Medical University’s International Medical Center, talks about postvention as:

In Japan, an annual memorial service (*nenkai hoyo*) and how it is held

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<sup>7</sup> *Shinano Mainichi Newspaper*. May 5, 2009.

<sup>8</sup> It has become a peculiar Japanese custom for lay Buddhists to take the precepts and receive a dharma name after death and not before.

periodically has been designed well. I think it has been a mistake of today's Japanese people to dismiss this annual service. The bereaved have a so-called "anniversary reaction". For example, if a person dies on Friday, the family will react in some way every Friday. When my temple member's first or third year memorial is approaching, I tell the family to rest and avoid any schedules that month. I mark the thirteen month as a reference when I see the family, because they have an "anniversary reaction" in the twelfth month and sometimes get sick. So they might want to slow down at work too. People in the old days probably knew well about this, and I think this is very interesting from the perspective of psychiatry.<sup>9</sup>

Here Prof. Onishi echoes the viewpoints of the other Japanese writers in this volume concerning the essential role of Buddhist memorial services, such as the ones held every week for seven weeks after a death and the annual memorial service (*nenkai hoyo*). From the perspective of an "anniversary reaction" to a loved one's death, a memorial service can function as an element of grief care, thus I think it is necessary for us to work hard in the care of the family. At his medical center, Prof. Onishi has helped to create a grief care program as an out patient service, but has commented that:

There are many people who don't know where to go when they are bereaved. Here at the Medical Center, we have a sign saying, "Out-patient Services for Bereaved Families". However, it is hard for them to go to a psychiatrist, so it would be nice if Buddhist priests or religious professionals could team up with medical care personnel to show families that priests are there for them when they come for counseling. If they talk with such priests and are still depressed or if there is something unhealthy about them, then we doctors can treat them. That kind of situation would be ideal.<sup>10</sup>

I would like to now quote at length from the book *Deaths of Man* (1974) by Edwin S. Shneidman. Shneidman, who recently died, was a pioneer in the study of death, suicide,

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<sup>9</sup> Iijima, Keido. (2008) "Amanzu Diarogu 4: 'Izoku Gairai' no aru Byoin". *Sousei* (The Magazine of the National Soto-shu Youth Association) No. 142, July, 28.

<sup>10</sup> Iijima. "Amanzu Diarogu 4" p. 29.

and suicide prevention as well as the founder of the American Association of Suicidology. In this excerpt, he talks about the bereaved and after-treatment:

A person's death is not only an ending; it is also a beginning – for the survivors. Indeed, in the case of suicide, the largest public health problem is neither the prevention of suicide (about 25,000 suicides are reported each year in the United States but the actual number is much higher, probably twice the reported rate) nor the management of suicide attempts (about eight times the number of reported committed suicides), but the alleviation of the effects of stress in the survivor-victims of suicidal deaths, whose lives are forever changed and who, over a period of years, number in the millions.

This is the process I have called “postvention”: those appropriate and helpful acts that come *after* the dire event itself (1968, 1971). The reader will recognize prevention, intervention, and postvention as roughly synonymous with the traditional health concepts of primary, secondary, and tertiary prevention, or with concepts like immunization, treatment, and rehabilitation. Lindemann (1944) has referred to “preventive intervention in a four-year-old child whose father committed suicide”; it would be simpler to speak of postvention.<sup>11</sup>

In short, he suggests that grief care is postvention, which eventually becomes preventive care. He further explains that:

Postvention, then, consists of those activities that serve to reduce the aftereffects of a traumatic event in the lives of the survivors. Its purpose is to help survivors live longer, more productively, and less stressfully than they are likely to do otherwise.<sup>12</sup>

In Japan, I think bereaved families are often left with grief. If memorial services

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<sup>11</sup> Shneidman, Edwin S. (1974) *Deaths of Man*. Baltimore, MD: Penguin Books Inc., 33.

<sup>12</sup> Shneidman, Edwin S. (1974) *Deaths of Man*. 33-34.

function properly as medical care, then that should not be the case. However, even if they do serve their function, I think that their grief does not totally dissolve. To quote Shneidman again:

The recent investigations of widows by Dr. C. M. Parkes (1972) are most illuminating. The principal finding of his studies is that independent of her age, a woman who has lost a husband recently is more likely to die (from alcoholism, malnutrition, or a variety of disorders related to neglect of self, disregard of a prescribed medical regimen or commonsense precautions, or even a seemingly unconscious boredom with life) or to be physically ill or emotionally disturbed than nonwidowed women. The findings seem to imply that grief is itself a dire process, almost akin to a disease, and that there are subtle factors at work that can take a heavy toll unless they are treated and controlled.<sup>13</sup> (34)

In this way, losing a family member or someone very close can negatively affect the health and the lives of the bereaved. However, I think postvention can prevent that. Here Shneidman is talking about research on widows, but today in Japan men are perhaps weaker when they lose their wives, often losing their appetite and daily rhythm. There are cases that a widower's death follows his wife's recent death. Either way, losing someone close is very stressful, and some kind of intervention is necessary.

It would be good if every out-patient facility has outpatient services for bereaved families like at Saitama Medical University's International Medical Center, but that is not the reality in Japan today. I hope this kind of service becomes available in more communities. As Prof. Onishi said, I hope many local Buddhist priests will team up with psychiatrists from the perspective of preventive medicine in order to provide grief care. I think it would be a good model project to team up with Prof. Onishi to research and collect data on the psychological state of the bereaved and what kind of support they require. I wish the Soto Zen denomination would do it. However, regardless of the denomination, I think this kind of project could take the shape of something according to Japanese culture. This is preventive medicine, so it will be good for mental and

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<sup>13</sup> Shneidman, Edwin S. (1974) *Deaths of Man*. 34.

physical health. I think we need to establish grief care locally, where local Buddhist priests would voice their opinions.

I would like to now conclude with a final quote from Edwin Shneidman:

Three brief final points: Postvention can be viewed as prevention for the next decade or for the next generation; postvention can be practiced by nurses, lawyers, social workers, physicians, psychologists, and good neighbors and friends – thanatologists all; and a comprehensive mental health program in any enlightened community will include all three elements of care: prevention, intervention, and postvention.<sup>14</sup>

Shneidman wrote this in 1974 predicting the need for postvention in the following decade. However, in Japan today, postvention is not yet taken seriously, so this is still our issue to make postvention a part of prevention. I think that also means studying palliative care and preventive care as postvention within society.

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<sup>14</sup> Shneidman, Edwin S. (1974) *Deaths of Man*. 41.