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Aspects of Funerals Affecting Public Health of Grieving Families in Japan

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ABSTRACT

The realization that bereavement grief consumes medical and welfare resources has increased public interest in preventing or reducing prolonged/persistent grief. After reviewing the merits and limitations of pharmacological and psychological approaches to grief, this research focuses on aspects of funeral rituals that exacerbated or ameliorated grief in Japan. A team of experts from the All-Japan Funeral Co-operation® categorized and discussed hundreds of anonymous open-ended responses to a nationwide survey of mourners, conducted within a year of their bereavement. The team extracted eight major categories demanding attention and improvement:

(1) Cooperating with priests and religious institutions;
(2) Detailed explanation of funeral services and costs;
(3) Coordinating with medical workers and institutions;
(4) Careful conduct of the funeral itself;
(5) Crematorium trauma and catering service;
(6) Insufficient invitation;
(7) Follow-up with the bereaved;
(8) Pre-planning of funeral rituals.

This article discusses the details of and advice for each category. In addition, the comments emphasized that funeral planners should consider and consult with the bereaved about the wishes of the deceased, and the perspectives of friends and relatives uninvited to the funeral. Overall, this study documents the importance of funeral directors' cooperation with religious and medical services, their attention to the feelings and concerns of the bereaved, and the advisability of funeral pre-planning and follow-through, for the reduction of prolonged or persistent grief.

Keywords: Loss, Grief, Bereavement, Memorial, Cremation, Presenteeism.

Introduction

Humans and even many animals grieve—feel profound sadness—at the loss of a child, parent, or close companion. This is a natural psychological reaction, typically proportional to the depth of the relationship and the importance of the departed. Over many centuries, human societies developed cultural and religious rituals to help families and friends of the departed to mourn their losses, and also to rehabilitate; to adapt, accept, and reconstruct their lives in the absence of the one they loved or depended on.

Traditionally, bereavement grief was not only a private personal reaction, but also a public social concern. Today, as modern societies witness the gradual erosion of community mourning ceremonies and social support for the bereaved, the social costs of grief become evidenced in production losses as well as medical and social work expenses—public concerns. Superficially, private funerals or direct cremations may purport an economy of time and resources. However, if this "economy" forfeits the social capital that funeral rituals provide—of rallying around and supporting the bereaved—or leaves the bereaved doubting whether they have done justice to their departed loved one, this false economy may prolong grief, resulting in greater subsequent medical and welfare costs for the society.

To be sure, the way and extent to which someone grieves for a departed loved one is also a private psychological matter. However, careful scholarly research on this question is demonstrating beyond a doubt that disenfranchised grief, or grief that persists traumatically, adversely affects our entire society and economy, in terms of declining productivity, declining health, and even declining lifespans. Let us briefly review these areas by way of background.

ECONOMIC AND MEDICAL COSTS OF GRIEF

Many people crushed by the burden of grief feel that they simply cannot work. Whether from discomfort and anxiety at the way they must interact with their colleagues, or from depression and lethargy, they absent their workplaces even after the few days they may have been permitted for mourning and funeral.

In Japan, Chen and colleagues showed that the costs of absenteeism for those Japanese people bereaved by suicide alone totaled hundreds of millions of dollars[1]. In America, unsupported grief is calculated to cost corporations US $225 billion annually in absenteeism alone, even before many employees also choose to leave their workplaces[2]. Scottish, Australian, and German studies have similarly demonstrated staggering economic losses due to grief and bereavement[3,4,5].

Far greater than the economic losses from outright absenteeism, however, are the losses from presenteeism: when the bereaved mourner physically appears at the workplace, but simply cannot focus, concentrate, or produce at normal levels[6]. It has long been understood that depression, sleeping and eating disorders have extremely detrimental effects on productivity[7]. Grief often results in depression, sleeping and eating disorders, so that grief is a major factor exacerbating presenteeism[8]. Recent estimates suggest that the costs of presenteeism average $7000 to $8000 per person per year, higher than costs of absenteeism, and higher for males than for females[9]. In countries ranging from Brazil and Japan to South Africa, presenteeism losses may account for 0.5% of the entire national GDP[10]!

Naturally, these economic losses due to absenteeism and presenteeism are concentrated in adult but not retired workers, typically in their 30's to '60s[11]. Medical problems, however, can plague mourners ranging from schoolchildren to the very elderly—especially those who lack the affiliation and social support of a workplace[12].

Not only does untreated grief reduce productivity through absenteeism and presenteeism, but it also engenders greater reliance upon medical and social services[13]. It has long been recognized that traumatic grief leaves numerous side-effects on the mental and physical health of bereaved survivors[14]. In their classic review of the literature, Stroebe, Schut, & Stroebe found that bereaved show more headaches, dizziness, indigestion, chest pain, illness, and drug use, *despite* a simultaneous tendency to avoid getting medical diagnoses[15]. This says first that many grievers' increasing medical problems cost societies through their medical insurance programs, and secondly that the real cost would be even higher, except for the fact that many bereaved who need medical help do not even have the energy or courage to ask for it—

producing greater medical issues in future years.

So in order to maintain economic productivity, and also in order to reduce the burden on public medical and social services, it becomes essential to identify the bereaved most in need of support, and to treat or support them suitably[16]. Both the ICD-11 (since 2018) and the DSM-5-TR (since March, 2022) recognize pathological grief exceeding expected norms as PGD (Prolonged Grief Disorder, or PCBD, Persistent Complex Bereavement Disorder). Diagnosis typically requires daily symptoms for over six months. Boelen's Traumatic Grief Inventory Self-Report (TGI-SR+) is considered a valuable rating tool for PCBD, enabling clinical identification of serious bereavement[17].

Once the bereaved in greatest need of support have been identified, how can they best be treated? Three approaches prevail: (A) pharmacological, (B) psychological, and (C) social support/community

(A) Pharmacological Approaches to Grief

When the DSM-IV was updated to DSM-5 in 2013, one hotly-debated major change was the elimination of the "grief exclusion clause." Prior to 2014, the DSM-IV had held that grief was normal after a bereavement or loss, so that grief should not be considered a major depressive disorder (MDD). If people naturally show depression after the death of a loved one, then grief should require psychological support but not pharmaceutical therapy, so the DSM had included a "bereavement exclusion clause," excluding post-bereavement grief from pharmaceutical intervention.

From the end of 2013, when the exclusion clause was removed, grieving patients became immediately eligible for pharmacotherapy if they showed signs of MDD, regardless of its cause. Advocates of the reform pointed out that MDD can lead to suicide if inadequately addressed, and that there is no agreed-upon clinical method of distinguishing suicidal MDD (deserving medical support) from suicidal grief (deserving psychological counseling). While the pharmaceutical industry welcomed this new market, critics accused the APA of medicalizing grief, encouraging over-prescription of antidepressants, when what really needs addressing is not the surface symptoms of depression but the underlying cause, grief itself.

The removal of the "grief exclusion" from diagnosing depressive disorders did indeed increase the number of bereaved patients receiving prescriptions for anti-depressants. However effective antidepressants (particularly SSRIs and tricyclics) may be in reducing bereavement-related depression, they have limited efficacy for grief-specific symptoms[18]. While alleviating surface symptoms of depression, such psychotropics do not resolve the underlying sadness of grief itself[19]. Psychedelic treatments have also been attempted, but the evidence of their safety and effectiveness remains moot[20].

(B) Psychological Approaches to Grief

Grief is now recognized and treated as a psychiatric disorder. Pharmacological treatments may alleviate symptoms such as anxiety and depression, but cannot address underlying issues of yearning for the deceased or reconstructing one's world and worldview in their absence. A century ago, Freud wrote that people must simply learn to forget or "get over" their grief—but if it were so simple, they needn't have sought his counsel. Since Freud, methods of psychotherapy have proliferated, yet their efficacy in dealing with grief remains highly disputed[21]. Another reason for their ineffectiveness stems from the fundamental failure of psychotherapists to assess and refer their patients to the therapies most suited to the patients. An analogy should make this clearer.

Imagine you go to a hospital with a headache, and the first doctor you happen to meet were an anesthesiologist, who offers to anaesthetize you, or a surgeon, who offers to cut open your skull, or a chiropractor, who offers to massage your neck and spine. Most of these specialists would not provide the healing you seek; most operations might risk far more harm than good. In fact, when you visit a hospital, you first meet with a doctor who has no special agenda of treatment. The doctor makes two assessments: first, of your medical history and present condition, and secondly—more importantly—of the *type of treatment* most likely suited to your history and present condition, whether it be pharmaceutical, surgical, or mechanical.

However, when you go to a psychotherapist with a psychological concern (like grief), you tend to get only the treatment in which your psychotherapist specializes. If the first psychotherapist you happen

to meet were a druggist (or receives perks from big pharma, as is all too likely), he may offer you a prescription; if the first psychotherapist you happen to meet were an acupuncturist or biofeedback expert, she may offer you acupuncture or biofeedback; if the first psychotherapist you happen to meet were an expert licensed in NET, PET, CPT, CBT, or EMDR, then she will offer you NET, PET, CPT, CBT, or EMDR! This is no way to run a clinic—yet this is the way most clinics are run—which is why there are more failures (if not disasters) than successes.

What is needed in psychotherapy, as is already standard in other medical practice, is first to assess your medical history and present condition, and secondly—more importantly—the *type* of treatment most likely suited to your history, condition, and personal psychological proclivities. Rather than offering patients only the specialty of the first psychotherapist they meet, their initial assessment needs to determine to which of the myriad grief therapies they are most objectively suited. The psychotherapist should be required to refer patients to the therapist most likely to heal them—which is rarely the first gatekeeper or GP whom they encounter. Few psychotherapists have training in such comparative therapy assessment skills; many remain ignorant of or even prejudiced against "rival" methods or schools of psychotherapy. Until psychotherapy not only diagnoses grievers' medical history and present symptoms, but also assesses the most suitable methods of therapy for each incoming patient, it will retain the unenviable track record wherein each expert heals or retains less than half of their incoming patients, and unintentionally renders even greater harm to some smaller percent.

Recently, some programs carefully designed to address prolonged or complicated grief have shown significant signs of success, such as the RCTs of CBT group treatments by Katherine Shear and colleagues at Columbia University[22,23]. Unfortunately, these programs are neither known nor available to the vast majority of bereaved who might benefit from them.

C) Social Support/Community Approaches to Grief

If pharmacological and psychological approaches have such limited success, what remains are social or communal approaches to grief[24]. For millennia of human experience prior to pharmacology and psychology, communities collectively helped their members to deal with grief, typically by publicly acknowledging their losses, assembling friends and relations to provide them with spiritual as well as physical support in their time of deepest need[25]. Recent research suggests that the lines between traditional communities and funeral support services are blurring; that funeral service providers can play an increasingly important role as traditional communities slowly fade[26]. Even today, funeral services, wakes, and memorial rituals assist bereaved families to carry on despite their losses.

In Japan, for example, after the wake, funeral, and cremation ceremonies, further rituals to respect the bereaved and honor the departed (somewhat like a Jewish shiva minyan) were conducted on the 7th, 21st, 49th, and 100th days after the death, and thereafter by the family at the home altar or the family gravesite on the equinoxes and solstices. It was believed that if these rituals were not properly conducted, spirits from the next world would haunt or plague the family. Today, hardly anyone believes that other-worldly spirits attack inadequately filial survivors—yet even today, the litany of health problems observed above suggests that lack of social support connects to less salutary outcomes.

Methods

Beginning in 2018, Kyoto University convened a Japan-wide team of experts to address the lack of research on this topic. With the invaluable assistance of the All-Japan Funeral Co-operation®, we distributed questionnaires to approximately 5500 families bereaved within the prior year. Over the following three years, we received anonymous responses from some 1400 bereaved mourners, reporting their emotional and physical health, medical and welfare use, conduct of and satisfaction with funeral rituals, and effects of the bereavement on their economics and daily lives. Statistical analyses showed significant correlations between grief and reliance on medical, pharmaceutical, or social services. Although satisfaction with funerals and memorial rituals ***per se*** was not sufficient to lessen grief, we found an unexpected and strongly significant statistical correlation between ***dis***satisfaction with funerals and subsequent use of medical, pharmaceutical, or social services after bereavement[27].

Because statistical correlation alone would leave the possibility that perpetually negativistic people were coincidentally negative about both their funeral experience and their medical experience, we asked about *changes* in medical, pharmacological, and psychological dependence before and after their losses. This showed that their heavy medical dependency was not a previous pattern, but began *after* the death and funeral. While all respondents faced recent bereavement, those with unsatisfying funerals constituted a disproportionately large portion of those who needed medical or pharmacological support to carry on thereafter. In other words, bereaved families' satisfaction or dissatisfaction with funerals—and the support that funerals provided—was a major factor in their bereavement trajectory; those who had more satisfying funerals were more likely to grieve with better health and physical activity than those who had dissatisfying funerals[28].

The Next Step: Analysis of Open-Ended Responses

This led to the next logical question, rarely discussed in academic journals: What can be done ***to avoid or prevent*** the kind of funeral dissatisfaction that worsens long-term grief and consequent medical and welfare expenses?

To answer this research question, we needed to analyse the hundreds of anonymous comments from mourners who elaborated their concerns in addition to responding to our quantitative statistical survey. We printed each comment on a separate sheet of paper, of which we made three copies each, for a total of about 1000 pages. When two or more significantly different ideas were expressed by the same respondent, these were divided into two sheets, so that each could be distinctly categorized. Then we invited a team of funeral experts from the the All-Japan Funeral Co-operation® to read and classify these responses.

We were concerned that our content analysis remain inductive, deriving categories from the words of our respondents, rather than fitting the data to pre-established deductive categories[29]. Some of the categories that we ultimately derived do overlap with discussion already provided by the insightful research at the University of York[30], but to remain inductive, we deliberately refrained from sharing the York work with our panel of experts, so as not to influence or predetermine their conclusions. To avoid superimposing our own interpretations on the data, we sought categories (as opposed to themes) following Graneheim's important distinction[31]. We conducted our qualitative content analysis following Mayring's widely-used approaches and cautions[32]. In the process of reading and re-reading the write-in responses, our experts came to agree on eight major categories where improvement appeared desirable:

1 Cooperating with priests and religious institutions
2 Detailed explanation of funeral services and costs
3 Coordinating with medical workers and institutions
4 Careful conduct of the funeral itself
5 Crematorium trauma and catering service
6 Insufficient invitation
7 Follow-up with the bereaved
8 Retrospect: Pre-planning of funeral rituals

After abstracting the categories and placing all comments within their respective categories, we asked the panel to discuss the implications of each mountain of comments for community support and funeral practice. We present the results in detail below, including relevant discussion within each category.

Results:

1 COOPERATING WITH PRIESTS AND RELIGIOUS INSTITUTIONS

Like many European countries, Japan is rapidly secularizing. As Mircea Eliade proposed, this very secularization may lead people to desire the stability found in familiar rituals or traditional music and ceremony, especially in times of crisis[33]. Japanese research has clinically demonstrated that even for ostensibly "non-religious" Japanese, listening to priests chanting Buddhist sutras indeed significantly reduces bereavement stress[34]. So there is reason to suggest that funeral directors should rely on the cooperation of the Buddhist priesthood to help and heal the recently bereaved, especially through the funeral and memorial rituals traditionally conducted by Buddhist priests.

However, among the respondents to our national survey, Buddhist priests were a leading category of dissatisfaction. The greatest sources of this dissatisfaction were (A) priests' lack of human care and communication in memorial services, and (B) exorbitantly high costs for posthumous names.

1A Lack of care and communication

98% of Japanese funerals follow Buddhist ritual formats, in which priests are invited to chant sutras for the soul's repose or ascendance to a heavenly Pure Land, where a Buddha or Bodhisattva will welcome the deceased. In the absence of regular Sunday services, funerals and memorial rituals become eminently important opportunities for Buddhist priests to communicate the Dharma (Buddhist teachings), assuaging the grief of the bereaved through Buddhist parables, histories, or assurances of ultimate transcendence.

Well into the 20th century, Catholic priests conducted requiems in a version of Latin language incomprehensible to many listeners; even today, Buddhist requiems and sutra-chanting are conducted in a Japanese version of classical Chinese, incomprehensible to most Japanese and Chinese scholars alike. Some priests use these "teachable moments" to interpret and explicate the meaning of the sutras being chanted: what they teach us about life, death, and how to carry on in the absence of lost loved ones. Survey respondents waxed very positive about the consoling or empowering effects of gently-delivered compassionate sermons or eulogies. Conversely, priests who simply arrived with hardly a greeting to the congregated mourners, chanted their sutras as if tape-recorded, bowed and requested fees for services, left their mourners with less consolation than anxiety or exacerbation of their grief.

In traditional Japan, funerals were conducted by Buddhist priests, either at the home of the bereaved, or at their local temple. Today, most funerals are conducted at professional funeral homes, yet the performance of Buddhist priests remains central to most Japanese funerals. Thus it behooves funeral homes and directors to assure that the attendant priests respectfully address the participant families by name, responding to their psycho-spiritual needs for compassionate condolence. If priests have not yet acquired the requisite interpersonal skills, funeral homes might coach them, not only on the names and backgrounds of the celebrants, but also on the sorts of sermons that have proven most memorable or praiseworthy. If funeral homes include the priests' fees in their bills (as many celebrants expect or desire), this obviates the need for passing money to the priest in the hour of the service itself.

1B Posthumous names

When a Japanese dies, they are typically bestowed a posthumous Buddhist name, in addition to their family/earthly name, reflecting the character or activities of the deceased when they were alive. Some families will pay more for especially auspicious or high-ranking posthumous names; others may believe that the elegance or authority of the name expresses their respect or status, may be appreciated by the now disembodied departed, or may even somehow bless the soul of the departed in transition to their next life.

While not to the extent of the sale of indulgences in Europe's middle ages, some Japanese Buddhist priests have used this bestowal of posthumous names to gain additional income for their temples, by demanding high fees for more auspicious names. Increasingly secular bereaved families fail to see any value in or necessity for such expenses, especially when charged without careful consultation. Although funeral homes cannot take total responsibility for priests' conduct, since unscrupulous practices and hidden or exorbitant fees create dissatisfaction with the entire funeral process, it behooves funeral homes to create close working relationships with trustworthy temples. When the funeral home counsels the bereaved in advance about the fees that temple priests may expect, assuring that those fees are seen as reasonable and responsible, the satisfaction of the bereaved is significantly heightened, partially protecting them from anger and anxiety in months of subsequent grief.

2 DETAILED EXPLANATION OF FUNERAL SERVICES AND COSTS

A second major predictor of funeral dissatisfaction was the sense that the funeral was too costly, charging more than it was worth. However, there was no simple statistical correlation between high cost and high dissatisfaction, nor low cost and low dissatisfaction. In other words, "costly" refers not to any objective figure, but to the gap between the bereaved's ideal of a service, for which they would willingly pay, and the service for which they were charged. Only a very few respondents simply said their funerals were too costly; typically they complained that they were given no explanation of billing breakdown, charged for a blanket package without consultation about options and details, or

later informed of unexplained or hidden charges added to the total bill. In the worst cases, a few funeral directors themselves appeared to be selling as large or elaborate funerals as possible, disregarding the emotional as well as economic state of their clients.

Funeral directors have a unique position as "first responders" to intense grief. Although they have just met, recently bereaved families will often entrust their funeral directors with many private or personal details about their relations to the deceased, with a vulnerability rare in other first encounters. If the funeral director suddenly moves the conversation from feelings and respect for the departed to matters of billing and credit cards, it is not surprising that the trusting family feel betrayed; they have been speaking as if to a confidante, but then are reduced to mere customers in a business transaction.

Such comments strongly suggest that funeral homes need to listen first and foremost to the mourners' hopes and desires, giving as many choices and options to the bereaved as possible. If the bereaved themselves have chosen each element of the funeral, and later are given a careful itemization of each cost involved, they appear to understand and accept the billing, or otherwise can renegotiate in good grace to reduce the elements they feel least essential or important to their ideal of a funeral. Funeral directors' advanced discussion about Buddhist names and charges can also ameliorate the "sticker shock" associated with temple billing.

3 COORDINATING WITH MEDICAL WORKERS AND INSTITUTIONS

In pre-modern Japan, virtually every doctor was also a Buddhist priest, for only those who had the time and ability to master the (Chinese) Buddhist texts could also read the (Chinese) medical texts. This had the advantage that doctors caring for aging and dying patients were also on scene for their passing on, and then in their role as priests could care psycho-spiritually for the bereaved. Today, of course, medicine is totally divorced from religion (some would aver that it has become a religion, its priests the white-frocked doctors). Yet it remains the case that families of dying patients pin unreasonable hopes on the skills of their presiding physicians. When death ultimately overcomes the best efforts of medical science, the disappointment of the bereaved is exceeded only by their shock.

To be sure, the attitudes of the hospital and physicians are not a responsibility of the funeral home alone. Nevertheless, the impression left by the medical profession casts a long shadow over the funeral and mourning period. So for funeral homes to communicate and coordinate with hospitals or physicians whose families they serve would benefit not only the funeral homes but also the entire community supporting the bereaved. Analysis of questionnaire respondents indicated three primary areas of (3A) shock, (3B) anger, or (3C) disappointment with the medical profession which emerged in their evaluation of the funeral process as unrealistic hopes, indifference, and disrespect for the departed.

3A Shock

Our previous statistical analysis noted a curious conclusion: unsurprisingly, prolonged heavy grief corresponded to shock and inability to accept the loss of the loved one, but surprisingly, almost none of the deaths that caused shock were medically sudden, like suicide, traffic accidents, or sudden seizures; the greatest "unexpected shock" came from cancer death.[20] In Japan, the time from cancer diagnosis to death typically takes months if not years. Then why should families be shocked that their loved ones died from cancer? Further inspection revealed that the physicians had typically been so optimistic—or at least so reluctant to admit their inability to overcome the cancer—that they continued their upbeat "we can beat this" message even until the last days, leaving the hopeful family incredulous when the cancer proved fatal. This shock cast a pall over the ensuing funeral and mourning period. While not directly the territory of funeral directors themselves, all of us in public health should be educating physicians not to give overly optimistic portrayals of cancer to patients' families, lest the families themselves become medical patients due to their shock and ensuing grief.

3B Anger

A second all too common phenomenon was anger at the "indifference" of some Japanese medical professionals towards the deceased. To the attendant family, the lifeless body remains their loved one, still deserving of affection and respect. But the helpless (not to say "vanquished")

physician all too often wants only to remove himself from the scene, to devote his energies to patients more likely to respond, and perhaps also to conceal his own grief at his latest casualty[35]. When the appearance of caring attention towards a dying patient changes suddenly to one of distance and concern only with their physical removal to the morgue, this gives an impression of cold indifference to the family unaccustomed to daily death in the hospital.

Other studies have already suggested the great therapeutic value of physicians sharing a few moments of reverent silence with the families, and addressing the patient as if the patient were still hearing them: not "they gave it their best, now they're in higher hands" but "you did your best, go and live well" (we use the Japanese phrase "go and live" to mean passing on to the next world)[36]. Doctors' (and funeral directors') treating the departed as if they were still present helps to gradually palliate and ameliorate the family's grief[37]. If funeral homes can work to create a common culture of respect for the departed among the PCUs with which they work, this too can improve bereaved families' grief trajectories.

3C Disappointment

Other write-in responses revealed even more painful remorse about medical disrespect. Long after the passing, one hospital mailed the bereaved family a DVD showing the details of the patient's test results; the respondent felt this an inappropriate imposition, utterly insensitive to the feelings of the bereaved family. (273) As another example, "we were told that there wasn't enough time between her passing and the funeral home deadline, so even though it was less than a 30-minute drive from the hospital, we were told not to go home to get her final resting clothes. We ended up having to send her off in cheap pajamas sold in the hospital, and the daughters broke down in tears." (620)

Surely funeral homes also face deadlines and time constraints, but for the sake of public health as well as of humane compassion, it were desirable that the home and hospital could negotiate procedures enabling proper respect for the deceased, even if occasionally on short notice or short fuse. From a hospital's perspective, the corpse's garments may seem insignificant, but to the family who will live with the indelible memory of their mother disrespected, such an incident leaves significant trauma prolonging otherwise manageable grief.

4 CAREFUL CONDUCT OF THE FUNERAL ITSELF

Each funeral is a once-in-a-lifetime event that can never be redone or amended. So attending to fine details becomes just as important as creating a warm feeling of welcome for all. For years thereafter, the bereaved will remember, ruminate, and worry about the effects of ostensibly minor or superficial mistakes.

Some mistakes are of personal details, like the funeral staff mispronouncing the name of an attendant or on a telegram of condolence. Some details known only to the family are communicated to but not followed through nor carried out by the funeral parlor, such as the bereaved's favorite clothing or flowers or incense. Omitting other rituals, like the breaking of the deceased's ricebowl, or the proper placement of the Buddhist ritual implements, leave the bereaved wondering whether their loved one can in fact find their way to the next world.

Researchers have long stressed the importance of audience participation in planning and conducting funerals[38,39]. Our respondents expressed great satisfaction with being allowed to write messages, view the body and put things in the coffin, speak about the departed's life, and share photos of the deceased. Conversely, others expressed dissatisfaction at having inadequate time to touch or view the body, inadequate time to greet and interact with their invitees, inadequate or unprofessional audio-visual documentation of the funeral for those who could not attend.

Japan exhibits tremendous regional as well as sectarian variations in its funeral rituals. Respondents expressed gratitude for their funeral staff rehearsing in advance the particular words and ritual actions expected in their particular region or religious sect. Conversely, others vented grave dissatisfaction at funeral homes that mistook the details of their own religious rituals, or inadequately communicated the expectations of the local community towards ritual behaviors. Only a minority of funerals are conducted by Christian, Shinto, or other non-Buddhist religious faiths. Not all funeral homes can be expected to know all the formalities of all the minority religions they may

encounter, so it particularly behooves them to carefully consult with their clients and their clergy about their hopes and expectations in their ritual wording and actions. No funeral may be perfect, but the fewer mistakes, the less potential aggravation of the grief of the bereaved.

5 CREMATORIUM TRAUMA AND CATERING SERVICE

After the Buddhist funeral ceremony, close family usually accompany the hearse to a crematorium. For the hours while the deceased is being cremated, the family typically share a catered meal together, after which they watch the ashes emerge from the incinerator, using special chopsticks to pick out some remaining shards of bone to place in the urn that they will inter in a temple or columbarium. Although the body be no longer intact, the bereaved still express anger or frustraton against crematory operators who treat their loved one's ashes too casually.

The process of cremation, however hygienic, can also be traumatizing for bereaved family members. Some felt they were given too little opportunity to say their final goodbyes before the incineration, or that the crematorium staff treated them brusquely. One crematorium asked the family to press the switch to ignite the incineration, which psychologically traumatized the bereaved. Disposal of the deceased's body is not a pleasant activity, so this is all the more reason that funeral homes should coordinate with their affiliated crematoria to provide adequate time, maintain a reverent atmosphere, and reduce the trauma of cremation as much as possible for the family.

Respondents also showed significant dissatisfaction towards the shared meal and meal catering. Some felt that the menu were too limited, that they should have had dishes remembering or honoring the taste of the departed. Others felt that the staff were rushing them through the meal, when this was one of the rare occasions on which so many of the family would gather to dine together. A few felt that the quality of the catering was unacceptable in view of the price they had paid, especially if they were later criticized for the quality of the dinner.

On the one hand, these seem like small items; on the other, dining together in a shared meal proves one of the most memorable parts of the funeral ceremony. In fact, following dissatisfaction with priests and funeral directors, issues with the meal showed a statistically high score of dissatisfaction in our survey.

6 INSUFFICIENT INVITATION

Funerals are a rare chance to re-unite family and community around the memories of a common loved one or acquaintance. The greatest element of self-criticism and self-regret from the respondents was that they had failed to inform and invite all the friends and relations whom they should have considered. Only a few cases rejoiced that unexpectedly many people attended; several dozen regretted that friends and relations later felt snubbed, alienated, or distanced because they were not informed nor invited. Unsurprisingly, this was particularly true of those who chose to hold small direct family funerals.

If the bereaved family waits until the end of the year to communicate the passing of their loved one to the dozens of people on their holiday card mailing list, then the recipients of the cards get a double message: firstly, that their acquaintance passed some months earlier; and secondly, that they themselves are not considered important or close enough to be invited to the funeral or to come to the home to offer incense, as they would normally do if informed soon after the passing. In other words, whether everyone on the holiday card list is invited or not, they should all be informed promptly, lest the bereaved risk losing their social support thereafter. If the family feels too busy or pressured to inform everyone themselves, the funeral home might offer to send notices to everyone on the holiday card list in their stead.

Even if dozens of people on the holiday card list are invited, for reasons of distance and timing, not all will show for the wake or funeral. Yet after the funeral, a certain percentage of the more sensitive or perceptive attendants will take it upon themselves to phone, visit, or invite the bereaved to join them for meals, walks, or shared activities. If the funeral is attended only by a few of the closest family, the likelihood is that only one or two such invitations will follow. If the funeral welcomes dozens of old friends and relations, the chances are that several will continue to call, visit, or invite out the bereaved. This natural community support is surely far more effective in helping the bereaved recover from their loss than is an unknown medical

social worker who only later finds the immune-depressed bereaved are insomniac and alcoholic. Many of our write-in comments expressed thanks to the funeral home for enabling many guests to come, and/or to the acquaintances themselves who visited and supported them during and after the ceremonies.

7 FOLLOW-UP WITH THE BEREAVED

After the funeral itself, Japanese bureaucracy requires countless complicated legal procedures of the chief bereaved person, from filing papers at multiple municipal offices, to changing official financial and real estate registries. Most bereaved people have not previously conducted such transactions, which can feel bewildering if not overwhelming after the shock of the loss. Funeral homes can assist their clients through the miasma of red tape after the ritual ceremonies, a much-appreciated if too-seldom offered service. Some offer package services; others provide pamphlets or websites to guide their clients after the funeral.

Other funeral homes send monthly cards, flowers, food, or housecalls after a departure; these were extremely valued by their recipients. In other cases, funeral homes coordinated with local priests to make monthly housecalls. Interestingly, because such followup was not listed on the billing accounts, it tended to reduce any lingering doubts that the funeral home were merely running a business enterprise to make a profit.

These follow-up contacts also provide chances for funeral homes to confirm the health and standing of their recent clients. One respondent said that they felt "saved" by the periodic attention of the funeral home staff; another that he should have suicided had it not been for the ongoing support of the funeral home. Such responses too demonstrate the invaluable role of funeral homes in protecting the public health of their communities.

8 RETROSPECT: PRE-PLANNING OF FUNERAL RITUALS

Most of the problems noted above, from religious preparations and costs to details of rituals, music, and invitation lists, can be obviated by advance discussion and perhaps pre-paid funeral contracts. The 10-15% of respondents who in fact had thoroughly discussed and designed funeral activities with their loved ones before they passed were universally relieved and thankful that they had done so. Some specifically said that having pre-paid or set aside the needed funds for the funeral took a tremendous burden off their minds as well as pocketbooks.

Conversely, dozens of open-ended responses expressed that they wished they had discussed funeral issues with their loved ones at leisure in advance. Some said that the hours and days immediately after the passing were so hectic that they could not carefully consider their options, which they later regretted. Others felt themselves completely benumbed or mentally paralysed, unable to think objectively or rationally about the funeral that they and their loved ones really wanted.

In short, not only for the benefit of the funeral home, but more importantly for the family's higher psycho-social satisfaction deriving from lower stress and pre-planned logistics, it makes eminent sense for communities to discuss and advocate pre-planned funerals, which in turn will likely reduce their bereaved members' extra use of medical, pharmaceutical, and social services.

Discussion:

Three perspectives: the deceased, the bereaved, the uninvited

One of the unexpected discoveries of our nationwide survey was not limited to the aspects of service categorized above, but rather the perspectives from which desirable services were considered. Our questionnaire asked merely "your comments, memories, or opinions," unconsciously focussing on the respondent. Unlike many Anglo-European languages and cultures, however, Japanese language and culture makes it improper to consider oneself first, ahead of related others. Only children and selfish puerile adults would prioritize their own interests above those of their friends, family, or community. Therefore, the comments of our Japanese respondents were not focussed so much on personal feelings or wishes as on those of others around them: specifically, the deceased, and those who would remember them.

More than a dozen of our responses specifically mentioned the perspective of the departed; "he/she must have been delighted by the attendance/ ceremony/ memorial (etc.)." Some

wrote "the deceased must have been so upset/ disappointed/ troubled by our failure to do such and such," while others wrote: "when I pass, I hope I too may look down and see my friends assemble at such a funeral/memorial" or, "it was such a great chance to talk directly to Father for the last time."

Yet a larger set of respondents mentioned not their personal satisfaction, but the satisfaction or dissatisfaction expressed by their friends, relations, or third parties, invited and uninvited. Of course their mutual satisfaction is inextricably interconnected, but the point is that their estimation of the quality and acceptability of the funeral comes not directly from the respondents themselves, but rather from the evaluation of their peers. Many reported that far beyond the effort, trouble, and cost of the funeral was the lasting feeling of satisfaction derived from the thanks or praises of the attendants, from previously unknown perspectives on the life and activities of the departed, or from visitors' comments that "she looks so natural/peaceful,"— such comments made all their funeral expenses and efforts worthwhile.

This adds an important perspective for funeral directors in Japan—and perhaps in Europe as well. Even prior to asking bereaved clients what they themselves would like to do in and for the funeral, it may be fruitful to ask them, "What would the deceased most relish or enjoy?" and also, "What would your friends and relations most appreciate and remember?" Through these multiple lenses, funeral directors may derive a fuller, more holistic vision of what each family really wants for their loved ones, departed as well as living.

Limitations

Because the All-Japan survey of bereaved was conducted in an Asian Buddhist context, some of the central elements identified here may not be directly applicable to European needs or situations. Yet it is hoped that our clarification of categories and examples can provide some insights if not guidance into the ways that better funeral coordination can aid in organizing community support and reducing psychological angst for bereaved families.

This research does not imply that large costly funerals are universally superior to small inexpensive ones, but rather that funeral directors (and clergy) need to help the bereaved find in their heart of hearts exactly what sort of gathering and commemoration they deem most suitable—both for themselves, and for the bereaved and other mourners.

Conclusions

Bereavement grief is a public as well as private burden, but most pharmacological and psychological approaches to grief remain severely limited. The time-honoured avenue for helping the bereaved consists in mobilizing their social support community, typically through funeral and memorial rituals. Previous research has already discovered that dissatisfaction with funerals is strongly correlated to levels of grief requiring medical, pharmacological, and social service intervention. The present research strengthens the hypothesis that community support through funerals is highly salutary. Conversely, misunderstandings or lack of support during bereavement can aggravate grief, angst, frustration, and self-criticism long after the passing and funeral itself, threatening greater public costs for subsequent medical and social services. Our work documents the importance of funeral directors' cooperation with religious and medical services, their attention to the feelings and concerns of the bereaved, and the advisability of funeral pre-planning and follow-through. It also suggests that funerals may more effectively protect the health of the bereaved if the desires of the deceased and of other friends and relations are included in the funeral planning process.

Conflict of Interest Statement:

The authors received no reimbursement for this work and report no conflict of interest. The funders had no role in the design of the study, in the collection, analyses, or interpretation of data, in the writing of the manuscript, nor in the decision to publish the results.

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Ethics Review Board Statement:

The survey was approved by the Kyoto University Psychology Ethics Committee, #30-P-14. The study did not involve the treatment of animals or humans.

Informed Consent Statement:

Informed consent was obtained from all subjects involved in the study. All data was anonymized and double-blinded by a third-party data management firm so that no participant could be personally identified.

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References:

1. Chen, J., Choi, Y.J., Mori, K. *et al.* Those who are left behind: An estimate of the number of family members of suicide victims in Japan. *Soc Indic Res.* 2009; **94**: 535-544. https://doi.org/10.1007/s11205-009-9448-3

2. https://strategicchro360.com/how-much-is-grief-costing-your-company/ accessed Dec. 15, 2025

3. Stephen, A.I., Macduff, C., Petrie, D.J. *et al.* (2015) The economic cost of bereavement in Scotland, *Death Studies*. 2015; 39 (3): 151-157. doi: 10.1080/07481187.2014.920435

4. Kinchin, I., & Doran, C. M. The economic cost of suicide and non-fatal suicide behavior in the Australian workforce and the potential impact of a workplace suicide prevention strategy. *Int. J. Environ. Res. Public Health*. 2017; 14: 347. doi:10.3390/ijerph14040347

5. van den Berg, G.J., Lundborg, P., & Vikstrom, J. *The Economics of Grief.* IZA Discussion Paper 7010, November 2012, Bonn, Germany. https://papers.ssrn.com/sol3/papers.cfm?abstract_id=2183543

6. van der Klink M. A., Heijboer L., Hofhuis J. G. *et al.* Survey into bereavement of family members of patients who died in the intensive care unit. *Intensive and Critical Care Nursing*. 2010; 26(4): 215-225. doi: 10.1016/j.iccn.2010.05.004

7. Holden, L., Scuffham, P., Hilton, M., *et al.* Health-related productivity losses increase when the health condition is co-morbid with psychological distress: Findings from a large cross-sectional sample of working Australians. *BMC Public Health*. 2011; 11: 417. https://doi.org/10.1186/1471-2458-11-417.

8. Fox, M., Cacciatore, J., & Lacasse, J. Child death in the United States: Productivity and the economic burden of parental grief. *Death Studies*. 2014; 38: 597-602. https://doi.org/10.1080/07481187.2013.820230.

9. Gilbert-Ouimet, M., Sultan-Taïeb, H., Aubé, K., *et al.* (2024). Costs of presenteeism and absenteeism associated with psychological distress among male and female older workers. *Journal of Occupational and Environmental Medicine*, 2024; 66: e467-e475. https://doi.org/10.1097/jom.0000000000003182.

10. Evans-Lacko, S., Evans-Lacko, S., & Knapp, M. Global patterns of workplace productivity for people with depression: Absenteeism and presenteeism costs across eight diverse countries. *Social Psychiatry and Psychiatric Epidemiology*. 2016; 51. https://doi.org/10.1007/s00127-016-1278-4.

11. Wilson, D., Rodríguez-Prat, A., & Low, G. (2020). The potential impact of bereavement grief on workers, work, careers, and the workplace. *Social Work in Health Care*. 2020; 59: 335-350. https://doi.org/10.1080/00981389.2020.1769247.

12. Zisook, S., Iglewicz, A., Avanzino, J., *et al.* Bereavement: Course, consequences, and care. *Curr Psychiatry Rep*. 2014;16(10): 482. doi: 10.1007/s11920-014-0482-8.

13. Becker, C. B., Taniyama, Y., Kondo-Arita, M. *et al.* Unexplored costs of bereavement grief in Japan: Patterns of increased use of medical, pharmaceutical, and financial services. *Omega: Journal of Death and Dying*, 2021; *83*(1): 142-156. https://doi-org.kyoto-u.idm.oclc.org/10.1177/0030222821992193

14. Prigerson, H. G., Bierhals, A. J., Kasl, S.V, *et al.* Traumatic grief as a risk factor for mental and physical morbidity. *Am. Jl Psychiatry*. 1997; 154: 616-623. DOI: 10.1176/ajp.154.5.616

15. Stroebe, M., Schut, H., & Stroebe, W. Health outcomes of bereavement. *Lancet*. 2007; 370:1960-1973. doi:10.1016/S0140-6736(07)61816-9

16. Genevro, J. & Miller, T., Emotional and economic costs of bereavement in health care settings. *Psychologica Belgica.* 2010; *50*: 69-88. doi: 10.5334/pb-50-1-2-69

17. Lenferink, L.I.M., Eisma, M.C., Smid, G.E. *et al.* Valid measurement of DSM-5 persistent complex bereavement disorder and DSM-5-TR and ICD-11 prolonged grief disorder: The Traumatic Grief Inventory-Self Report Plus (TGI-SR+), *Comprehensive Psychiatry*. 2022; 112: 152281. https://doi.org/10.1016/j.comppsych.2021.152281.

18. Bui, E., Nadal-Vicens, M., & M. Simon, N. Pharmacological approaches to the treatment of complicated grief: Rationale and a brief review of the literature. *Dialogues in Clinical Neuroscience*. 2012; *14*(2): 149–157. https://doi.org/10.31887/DCNS.2012.14.2/ebui

19. Shear, M.K., Reynolds C.F., Simon N.M., *et al.* Optimizing treatment of complicated grief: A randomized clinical trial. *JAMA Psychiatry.* 2016; 73(7): 685-694. doi:10.1001/jamapsychiatry.2016.0892

20. Beesley, V.L., Kennedy. T.J., Maccallum, F., *et al.* Psilocybin-Assisted supportive psychotherapy in the treatment of prolonged Grief (PARTING) trial:

Protocol for an open-label pilot trial for cancer-related bereavement. *BMJ Open* 2025; 15: e095 992. doi:10.1136/bmjopen-2024-095992

21. Jordan, J.R., & Neimeyer, R.A. Does grief counseling work? *Death Studies*. 2003; 27(9): 765-86. doi:10.1080/713842360.

22. Shear, M.K., Wang, Y., Skritskaya, N., *et al.* Treatment of complicated grief in elderly persons: A randomized clinical trial. *JAMA Psychiatry.* 2014; 71(11):1287-1295. doi:10.1001/jamapsychiatry.2014.1242

23. Breen, L.J., Greene, D., Rees, C. S. *et al.* A co-designed systematic review and meta-analysis of the efficacy of grief interventions for anxiety and depression in young people, *Journal of Affective Disorders*. 2023; 335: 289-297. https://doi.org/10.1016/j.jad.2023.05.032.

24. Comans, T., Visser, V., & Scuffham, P. Cost effectiveness of a community-based crisis intervention program for people bereaved by suicide. *Crisis,* 2013; 34: 390-397. Doi: 10.1027/0227-5910/a000210

25. Hyland, L., & Morse, J. M. Orchestrating comfort: The role of funeral directors. *Death Studies. 1995; 19*(5): 453–474. https://doi.org/10.1080/07481189508253393

26. Lowe, J., Rumbold, B., & Aoun, S. M. Memorialization practices are changing: An industry perspective on improving service outcomes for the bereaved. *Omega: Journal of Death and Dying*. 2019; *84*(1): 69-90. doi: 10.1177/0030222819873769.

27. Becker, C.B., Taniyama, Y., Sasaki, N., *et al.* Mourners' dissatisfaction with funerals may influence their subsequent medical/welfare expenses: A nationwide survey in Japan. *Int. J. Environ. Res. Public Health*. 2022; 19(1): 486. https://doi.org/10.3390/ijerph19010486

28. Becker, C.B., Taniyama, Y., Kondo-Arita, M., *et al.* Costly causes of funeral dissatisfaction and satisfaction: responses to an All-Japan survey. *Psychology International*. 2024; 6(3): 722-733. https://doi.org/10.3390/psycholint6030045

29. Elo, S., & Kyngas, H. The qualitative content analysis process. *J Adv Nurs*. 2008; 62(1): 107-15. doi: 10.1111/j.1365-2648.2007.04569.x

30. Rugg, J. & Jones, S. *Funeral Experts by Experience: What matters to them.* (2019). Available at: https://eprints.whiterose.ac.uk/id/eprint/162914/

31. Graneheim, U.H., Lindgren, B-M., & Lundman, B. Methodological challenges in qualitative content analysis, *Nurse Education Today*. 2017; 56: 29-34. https://doi.org/10.1016/j.nedt.2017.06.002.

32. Mayring, Philipp. *Qualitative Content Analysis. Theoretical Foundation, Basic Procedures and Software Solution*. Monograph. Klagenfurt, Austria, 2014. https://www.ssoar.info/ssoar/handle/document/39517

33. Saliba, George. *'Homo Religiosus' in Mircea Eliade*. 2023; Leiden, The Netherlands: Brill. https://doi.org/10.1163/9789004669369

34. Taniyama, Y., Becker, C., Takahashi, H., *et al.* "Listening to Sutra-chanting reduces bereavement stress in Japan." *Journal of Health Care Chaplaincy.* 2021; 27 (2): 105-17. doi:10.1080/08854726.2019.1653637.

35. Redinbaugh, E., Sullivan, A., Lock, S., *et al.* Doctors' emotional reactions to recent death of a patient: Cross-sectional study of hospital doctors. *British Medical Journal.* 2003; 327: 1-6. doi: 10.1136/bmj.327.7408.185

36. Schwarz, C.S., Münch, N., Müller-Salo, J., *et al.* The dignity of the human corpse in forensic medicine. *Int J Legal Med*. 2021; 135 (5): 2073-2079. 10.1007/s00414-021-02534-x

37. Mathijssen, B. The human corpse as aesthetic-therapeutic. *Mortality*. 2023; *28*(1): 37-53. https://doi.org/10.1080/13576275.2021.1876009

38. Doka, K. J. Expectation of death, participation in funeral arrangements, and grief adjustment. *Omega: Journal of Death and Dying*. 1984; *15*(2): 119-129.

39. Gamino, L. A., Easterling, L. W., Stirman, L. S., *et al.* Grief adjustment as influenced by funeral participation and occurrence of adverse funeral events. *Omega: Journal of Death and Dying*. 2000; *41*(2): 79-92.

