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Ministry to the Terminal Patient its Problems and a Pastoral Approach

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MINISTRY TO THE TERMINAL PATIENT ITS PROBLEMS AND A PASTORAL APPROACH

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TABLE OF CONTENTS

MINISTRY TO THE TERMINAL PATIENT ITS PROBLEMS AND A PASTORAL APPROACH

The Purpose Of The Study

The purpose of this study is to relate the pastor's ministry to the terminal patient. The pastor has a valid and rightful place in ministering to the terminal patient. The pastor is bound by his calling to help the terminal patient to face his death.

> In short, it is the pastor's responsibility, in light of his vocational calling, to meet his people as they face death with an incarnate trust and confidence, which does not gloss over the pangs of death with superficial reassurances, but rather meets the fact of death squarely.[1]

The validity of the pastor's ministry is called into existence, because he has a responsibility to his people where they can depend upon him.

> As a pastor, his people depend upon him for strength, in the facing of death, they confess their sins to him, relate their emotional problems to him and in many instances, especially in the context of the terminal setting, use him as an object upon whom they can transfer their own feelings of inadequacy, doubt, guilt, hostility, and resentment.[2]

The purpose of this study then is to see the importance of the problems involved as the pastor and the terminal patient face the challenge of death.

Importance of Problem

The problem of facing death has importance by the fact

that all men have to die and it is the meaning or meaninglessness of death that presents the most fundamental challenge in ministering to the terminal patient.

> In this context, then it may be said that the close proximity of death brings out in every man an internal wrestling with the "real" issues of existence, regardless of the degree to which he has previously repressed them or denied their presence or necessity.[3]

The dilemma of death presents to the pastor and terminal patient a quest for meaning. The pastor and terminal patient are together in the quest for meaning of death. The meaning of death then involves the search for man's existence.

> Thus, whether he likes it or not, each man, if he is to live a productive life free from unnecessary anxiety and self-pity must come to grips with the fact that he will die one day.[4]

Thus when the pastor and the patient each face the fact of their own existence in relationship to their death then it will give meaning to their lives.

"Confronted by death, man is compelled by death to provide in some form a response to the question: Who am I?"[5] If the pastor and the patient do not confront the basic fact of death, then they will confront the basic issues of their existence and its meaning towards death. The quest for meaning then is "an effort to face the basic existential problems of human existence so that there is enough meaning for life to make it possible to accept death."[6] Otherwise,

man is confronted by meaninglessness.

Meaninglessness is when man cannot find any meaning for his life other than himself. If a person's existence depends only on what one does and receives then it presents real problems for a meaningful death.

> Therefore, if man can find no meaning in life beyond that which he himself puts into it and derives from it in terms of transitory relationships, then the thought of death becomes an interminable burden, for it promises to destroy everything that ever mattered.[7]

Whether man can find meaning in his death is found in how he faces life in the shadow of death. Thus the pastor has to face the dilemma of death and its quest for meaning with the patient and how this does or does not involve God.

> In short, the dilemma often remains with God, for if God does ~~not~~ exist, then man is troubled by the problem of guilt, which he sees as a possible threat to his inheritance of eternal life, and then again if God does not exist man becomes anxious for he is threatened by the problem of meaninglessness.[8]

What the pastor is confronted within the quest for meaning is that if man has not thought through his death in relationship to God, he has problems not only with his dying, but with God in his life. This bad relationship with God then affects man's death for it can bring guilt on how he has lived his life or if he has serious doubts about God within himself, then he is confronted by the dilemma of meaninglessness. Only when the pastor and the patient

confront death with God will it give meaning to their lives, "that is, where life is a preparation for death, and death a preparation for life, and God, in his mercy, is seen to be the focal of both."[9]

Limitations of Study

The limitations taken in this study concern the practical problems of man's facing death and a pastoral approach to them in order to minister to the terminal patient. This study will not attempt to give an exegetical study of the biblical passages pertaining to death and dying nor will it attempt systematically to present a study of the biblical meaning of death and dying, nor will it attempt to give a historical study of death and dying in the history of the church.

The concerns of exegesis, systematics, and history do have a bearing on the pastoral approach to the terminal patient, but this study will not attempt to give any analysis of them.

Goal of Study

The goal of this study will attempt to give a pastoral approach to the terminal patient involving the cultural attitude, the processes of dying, and the family and how each

of these affect a pastoral ministry to the terminal patient.

First, this study will show the cultural attitude towards death and dying. Robert Fulton and Gilbert Geiss summarize the cultural attitude of death.

> In western societies, however, attitudes toward death tend to reflect emerging secular emphasis which transpose it into an event of awesome dimensions which must perforce be disguised.[10]

Secondly, this study attempts to give an understanding of the processes of dying. The understanding of this dying process involves the attitude of the patient towards his death and how this attitude changes through the stages of death. Dr. Elizabeth Kubler-Ross describes five stages:

1. Denial and isolation
2. Anger
3. Bargaining
4. Depression
5. Acceptance

These stages involve what E. Mansel Pattison describes as:

1. Fear of the unknown
2. Fear of loneliness
3. The fear of loss of family and friends
4. The fear of loss of body
5. The fear of self control
6. The fear of pain
7. The fear of loss of idenity
8. The fear of degression
9. Fear and hope

Thirdly, this study attempts to show how the family is involved in the terminal patient's acceptance of death. Dr. Elizabeth Kubler-Ross puts it this way:

> Our goal should always be to help the patient and his family face the crisis together in order

> to achieve acceptance of this final reality simultaneously.[11]

Finally, a pastoral approach will be presented taking into account the factors of cultural attitude, processes of dying, and the family.

Overview of Cultural Problem and Problem of Awareness

The Cultural Problem

The cultural problem concerning death is how the American society faces the reality of death and what consequences this has on the treatment towards the terminal patient and his attitude towards death. E. Mansel Pattison describes four different attitudes as: (1) the death-desiring attitude, (2) the death-defying attitude, (3) the death-accepting attitude, and (4) the death-denying attitude. The death denying attitude is the one that really presents the problem for the American society. "Since death is repressed, we are perhaps poorly prepared to deal with it."[12]

It is generally accepted that our American society has a death-denying attitude. This denial leads to an avoidance not only of the subject of death, but also in terms of isolating a person who is about to die from any personal contact.

> Moreover, as in our handling of many contagious diseases, those who are caught in the throes of death are isolated from their fellow human beings,

> while those who have succumbed to it are hidden quickly from view.[13]

What this means is that we place a patient into a hospital where often the concern for the patient is rather impersonal, and affects the patients self-worth. "Like birth in a hospital, death in a hospital is robbed of all dignity."[14]

Thus the patient is affected by his cultural attitude towards death not only by other people, but also by himself.

> In this context, judging from the cultural attitude, it is fair to say that the fear of death does not stem so much from the fact of extinction as it does from the way or process in which one sees himself dying.[15]

The cultural problem has effects not only on the patient, but also in his religious attitudes towards death. Richard A. Kolish states, "First, I will assume that Americans—at least by comparison with past generations do not have a firm belief in an afterlife."[16] What is implied is that the cultural problem influences a person's attitude towards his religious view of death. A person will replace his religious view with something that will hide the fact that he will die.

> To try to pull these ideas together, the religious worship of God has, to some extent, been replaced by the worship of material goods and services, with secondary gods such as education, taste, knowledge, scientific advances, and human relationships.[17]

This other worship is really the influence of culture upon the person. Current research claims, "the devoutly religious person seems more influenced by his culture than

by his religion."[18]

What this cultural influence means is that the terminal patient, if he is a Christian, cannot be depended upon to have a firm belief in God nor have thought through the fact of his death.

> Regular church attendance, righteous behavior, generous contribution to parish funds and active participation in parish life do not guarantee the presence of intrinsic Christian faith or the ability to cope with death.[19]

What this means is that the pastor has to deal with the cultural problem confronting him in his ministry to the terminal patient.

The Problem of Awareness

The problem of awareness is whether one should or should not confront a patient with his death. The problem lies within our cultural attitude.

> Americans are characteristically unwilling to talk openly about the process of dying itself, and they are prone to avoid telling a dying person that he is dying.[20]

> From one point of view the problem of awareness is a technical one. Should the patient be told that he is dying and what is to be done if he knows, does not know, or only suspects?[21]

The general consensus towards the technical aspect is that the doctors who do not know how to deal with dying do not want the dying patient to be told.

It may well be that without realizing the emotional

> meaning of it, the denial of truth to the patient is more for the protection of the physican in his encounter with death than it is a protection to the patient."[22]

The problem of awareness is much more than a technical one. "But the problem is also a moral one, involving professional ethics, social issues, and personal values."[23] The problem of whether to tell or not to tell a patient that he is dying really reflects the lack of openess to discuss dying and death and how to approach the dying person with the fact that he is dying. "Medical training offers little help to the doctor in the treatment of the process of death except familiarization with the use of drugs to alleviate pain and to blunt awareness of suffering."[24]

What is needed then is an openess towards the dying patient on the part of professionals. "There is a place and a value in denying death, but not at a price which demands that we also deny the humanity of the person who requires our presence."[25] The rights of the patient should be the prime consideration. "As such, each person simply because he is an individual has an inherent right to pass his last months or day or hours in the way which he himself sees fit, for it is his life to live as well as his death to die."[26] Therefore, the rights of a dying person is that he has the right to know about his death if he is going to die with dignity and face

the problems which confront him in his attitudes toward death.

Death As A Part Of Dying

Dealing with Death

The professional persons who deal with the terminal patient need to incorporate in their lives a concept about death and dying that will enable them to help and understand the dying person. Dr. Elizabeth Kubler-Ross expresses her concern for the terminal patient this way,

> It might be helpful if more people would talk about death and dying as an intrinsic part of life just as they do not hesitate to mention when someone is expecting a new baby.[27]

What she is saying is that people should deal with death and dying as a part of life. As a part of life the persons who work with the terminal patient must face the fact of their own death.

> In the long run it is the persistent nurturing role of the therapist who has dealt with his or her own death complex sufficiently that helps the patient overcome the anxiety and fear of of his impending death.[28]

The prime reasoning being that when you have dealt with your own death, then you are much more aware and capable of handling the problems caused by our culture. Thus your dealings with the patient will allow you to reflect on your own reactions to the patient and be aware of the

problems involved.

> This shows the need to examine more closely our own reactions when working with patients as they will always be reflected in the patients behavior and can contribute a great deal to his well-being or detriment.[29]

Communicating Death

The terminal patient is the one who will let the therapist, doctor, or minister know whether he feels like talking when approached with the subject of death. The earlier one approaches the patient the better it will be. "A healthier, stronger individual can deal with it better and is less frightened by oncoming death when it is still "miles away" than when it is right in front of the door,. . ."[30] The interviews with the patient should be honest, so that the patient can communicate his feelings without fear or anxiety.

> Only the patient can reveal to us the degree of his insight into his condition, and what we say to him about his condition must wait upon and be controlled by what he reveals.[31]

It is only when one really listens to the patient that confidence will grow, because you will be trying to meet the patient's needs and how much he wants to face death at any given moment.

> To determine to what one should lend an ear, and to what one should give tongue, the patient's psychiatric status, his prevalent feeling of tone, his ego status, and the state and

> quality of ego defenses, his motivation in dying, and his foreboding should be revealed.[32]

It is the general consensus that the patient will wish to share his feelings.

> As long as the patient knows that we will take the extra time when he feels like talking, when we are able to perceive his cues, we will witness that the majority of patients wish to share their concerns with another human being and react with relief and hope to such dialogues.[33]

Dying can be lonely without other human contact and response. The noting of this loneliness of death is the key towards understanding the human need of the patient and communicating with him.

An Understanding of the Patient's Needs

An understanding of the patient's needs has a vital role to play in giving a warm human response to his situation. As the patient lets you into his confidence some goals should be kept in mind as you help him face his situation. "In treating the dying patient, the goal is to resolve the negative feeling towards himself and his past."[34] These negative feelings are often guilt feelings that the patient needs to resolve. He needs to resolve them within himself, if he is going to come to terms with the dying process.

> For although we cannot deal with the ultimate death, we can focus upon the various part-aspects of the dying process, and we can assist the

> dying person to resolve the crisis in a fashion that enhances his self-esteem, dignity, and integrity."[35]

The various part processes might include his loss of self-control or the pain involved in his death, or the great loss of everything, but mainly we help him die with dignity. "The therapist insists that the patient must constantly search his own being for the sources and directions, the channels and paths of his self."[36] The patient then seeks to find the answer or way of looking at the question, "Who am I?"

The Terminal Patient

Attitudes towards Dying

Each terminal patient's attitude towards his death is unique. This uniqueness must be kept in mind when dealing with the terminal patient, because each person is an individual and his own personality has a bearing upon how he will face his death.

> In this respect it is necessary to realize that a person, even in the face of death, tends to remain true to his basic personality structure; that is, the approach of death in no way transforms or remolds his inherent personality constitution as a man, a constitution that may have remained hidden to those throughout his lifetime."[37]

Thus each man's experience of death differs in relationship to his meaning of life.

Each terminal patient when facing his death faces a personal crisis. The patient may know the fact of his death, but be unable to accept that fact. The patient might even have a great fear of his death due to the fact that many of the things in his life might be unfulfilled. James C. Diggory and Doreen Z. Rothman say,

> Our hypothesis, that a person fears death because it eliminates his opportunity to pursue goals important to his self-esteem, is supported by the following: fear that one can no longer care for dependents varies systematically with roles defined by marital status, sex and age; the purposive items of having experiences and completing one's own projects are consistently near the high end of of the fear scale, except for people who may be assumed to believe that death is not the end of experience.[38]

The fear of death might be contributed to other factors such as impairment of the body, physical pain and suffering, leaving loved ones behind, entering the unknown or the fact that he no longer belongs to the living which are influenced by the above hypothesis. "We have learned that for the patient death itself is not the problem, but dying is feared because of the accompanying sense of hopelessness, helplessness, and isolation."[39] What the world looks like to the patient is something increasingly remote and unreal, because it gets along without him. Thus the patient not only faces the reality of death, but also his attitude towards death and the conflicting fears and guilt that are

associated with it. This is important to remember, because these attitudes towards death play a major role as a terminal patient goes through the stages of death.

Hope In the Face of Death

One single theme will come through the processes of dying and that theme is hope.

> It gives the terminally ill a sense of a special mission in life which helps them maintain their spirits, will enable them to endure more tests when everything becomes such a strain—in a sense it is a rationalization for their sufferings at times; for others it remains a form of temporary but needed denial."[40]

Thus hope in the patient is always the door left open just a crack to see whether there might be a miracle. Hope helps the patient in keeping down the greatness of his fears and helps lead him through the dying process.

Stages of Dying

The dying process can be described in the stages of dying. This study will present Dr. Kubler-Ross's five stages. The first stage is denial and isolation. Denial is considered one of the most active attitudes in the patient. A patient's denial may be to preserve his social image, or a relationship, or the patient's sense of self destiny.

Denial functions as a buffer after unexpected

> shocking news, allows the patient to collect himself and, with time, mobilize other, less radical defenses.[41]

Thus denial plays an important function. Yet a patient may never move from the stage of denying his death as far as his attitude goes. Isolation, as a part of the first stage, is a natural feeling of why did it have to happen to me? This makes him feel alone, because he feels he is the only person who is dying.

The second stage is anger. Thus the natural feeling of why did it happen to me turns outward to why isn't someone else? This anger will be expressed in every direction of the person's environment. "In contrast to the stage of denial, this stage of anger is very difficult to cope with from the point of view of family and staff."[42] This stage is frustration at the fact that one is dying and the feelings that are associated with it.

The third stage is bargaining. This stage is helpful to the patient for brief periods of time. It is a child's way of bargaining with his parents, "I'll be good, if you let me . . .," hoping to offer good behavior for something they want, but the promise of good behavior is never kept. Bargaining for the patient might be guilt fears that he wants to resolve by excessive punishment or it might just be a wish that he wants fulfilled. Guilt has to be resolved.

> We then pursued them [guilt feelings] until the patient

> was relieved of irrational fears or the wish for punishment because of excessive guilt, which was only enforced by further bargaining and more unkept promises when the "deadline" was past.[43]

Guilt plays an important role in the patient during the dying process.

> Clinical experience shows, however, that it is the feeling of guilt more than any other one thing that separates a dying person from those around him as well as from cosmic support.[44]

Thus bargaining takes place with God as well as man. "Most bargains are made with God and are usually kept a secret or mentioned between the lines in a chaplain's private office."[45] Since most bargains are made with God, the role of ministry plays a very important and functional part at this stage of dying.

The fourth stage is depression, one is reactive depression, the other is preparatory depression. The first is very different than the second. The first type is the immediate reaction to the fact that one is dying. "The second type of depression is one which does not occur as a result of a past loss but is taking into account impending losses."[46] Therefore they have to be dealt with differently. The first one is a reaction to death and the past history or life that the patient has lived in the face of his death, but the second type is much more important. "The patient is in the process of losing everything and everybody he loves."[47] The preparatory stage is not one

which every patient reaches, but it is one where patients who have really worked through their feelings might reach. "Only patients who have been able to work through their anguish are able to achieve this stage.[48] This depression does not need encouragements and reassurances for the patient is preparing to die—to give up everything.

The final stage is acceptance. "Acceptance should not be mistaken for a happy stage. It is almost void of feelings."[49] This is where nonverbal communication plays a very important role towards helping the patient. It is a very difficult time for the family. "This is also the time during which the family needs usually more help, understanding, and support than the patient himself."[50] Thus the last stage ends in death. The point one has to remember is that all terminal patients do not go through all the stages of dying, but that it depends upon the terminal patient's own personality structure whether he will reach an acceptance of death.

The Family And The Terminal Patient

Conflicts

The family plays a very important role in the terminal patient's dying with dignity. The family can create many conflicts within the patient that can keep him from dying with dignity. One of the most difficult things for the

family is accepting the patient's death or the fact that he is going to die.

> As a result of this contemporary indoctrination against the possibility of the death of a loved one, the family upon learning of the terminal diagnosis of one of it members, generally reacts by denying . . ."[51]

The terminal patient, especially if he is middle-aged, can cause a break in the family unit which causes much conflict. The family has fears about the terminal patient's death, because it increases their fears and doubts about how they are going to manage. They might feel guilty, because they see the patient deserting them. This dying member of the family might cause conflict to the family in that they will identify with the patient's death.

The patient not only affects the family, but the family problems might affect the patient so that he can not work through the dying processes. "These are complicated family situations, in which a sick member of the family is rendered more incapable of functioning because of the relatives conflicts."[52] These conflicts will make it hard for the family to really relate to the patient. "The panic of the relatives may keep them conflicted between their desire to relate to the patient and to escape from him."[53]

Assistance

One of the first problems to be approached by the

family is to bring their line of thinking into the reality of the situation. The family needs assistance with accepting the dying process of the patient. They also need help in their own conflicts of guilt, desertion, fears about the future, and identity with death. They need to be aware of their own conflicts and how these might influence the patient.

The dying patient can be of great help to his family. The dying patient can relate his feelings more effectively than the pastor, doctor, or therapist. "One of the ways is naturally to share his thoughts and feelings with the members of the family in order to help them share."[54] The pastor can help in this process in cooperation with the doctor and therapist to get the patient and the family to talk with one another. What this will accomplish is to bring an acceptance of death not only to the patient, but also to the family.

Problems For The Pastor In Terminal Setting

The Pastor's Role

The pastor has some problems that he has to deal with inside of himself before he can effectively minister to the terminal patient. First, the conflict of role of the pastor in the treatment of the terminal patient can be a hindrance for the pastor.

> Too often the pastor retreats from a genuine encounter with the patient through verbal escapes and ritualized expressions that do not meet the dimension of his psyche.[55]

The pastor needs to look at his own feelings about death and dying and must encounter this fact before he can give meaningful expression to the patient. The pastor who does not do this can hide behind his role as a pastor. Carl G. Carlozzi describes it as "the ecclesiastical defense syndrome." This syndrome is described generally as a set-apartness through ritualized actions, special language, and special attire. The pastor needs to think through his role as a pastor and find what purpose it really serves to the patient.

The Pastor as a Man

The greatest conflict for the pastor is himself. The pastor needs to look at himself and what he does and how he feels in order to accomplish an encounter with the patient. "In the ministerial encounter no part of oneself is immune from being affected."[56] What approach the pastor takes towards a relationship with the patient will reflect how he himself feels. The pastor who looks at himself and his attitude towards a ministry to death and dying will be helped in his listening to and understanding of the patient. "But he can only do it if he is secure in the faith that

grounds his being."[57]

A Pastoral Approach To The Terminal Patient

Essential Aspects

A pastoral approach to the terminal patient incorporates the essential aspects of what factors influence the patient as he faces death. The following will assume that the pastor will have some knowledge of them in order that he may encounter the patient. N. H. Cassem describes four essential aspects of the ministerial/pastoral encounter as: interpersonal, counselor, spiritual-religious (minister), and theologizer. This ministerial/pastoral encounter covers all aspects of the pastor's responsibilities and it requires preparation within the pastor's own being to be able to cope with the terminal patient. The greatest preparation towards a pastoral approach is to have a firm theology of death and dying. Secondly, the pastor needs to have thought through his own death. This will enable the pastor to reach out to his people in their dying. "The pastor who puts his people first and is not afraid of them or their feelings is the pastor who can accept himself."[58] Thus his preparation will help him to accept himself.

The encounter with the patient must be one where the patient is allowed to express himself to his pastor.

The concentration will express itself in a loving,

> listening attention, the desire and the effort to understand, concerned not for what we shall say to the dying person but for what the dying person is saying to us.[59]

This creates the interpersonal aspect that will be needed to build the patient's confidence in his pastor. This will allow the patient to express himself with his anxieties, fears, and guilt to the pastor knowing that he will be understood. This is where counseling will take place and reassurance will be given even if we do not know the answers.

> It is often a reassurance to the patient to know that there are some questions that do not have quick and easy answers, and that we all stand before death aware of our inadequacy.[60]

Pastoral Acceptance of Death

The pastor's own acceptance of death is one of the most fundamental approaches to the terminal patient. The acceptance of death will mean that the patient is not alone in his dying and that death is a part of life that all men have to face.

> When the pastor is able to communicate his acceptance of death as an event in life having meaning to God, the helplessness, isolation, and guilt are seen as a shared experience of all living men.[61]

This acceptance of death conveys acceptance by God to the patient that forgiveness is offered to him in his dying. Forgiveness by God is the highest form of acceptance that

can be conveyed by the pastor to the patient.

> That is, if the individual has incorporated within himself a truly Christian outlook on death and has not used religious faith as a mere psychological crutch and cover-up for the real issues of life, then the sting of death can be transcended.[62]

The pastor can help the patient towards incorporating his faith into his life, but only if the patient is willing. The pastor has God to give and the assurance of Jesus Christ.

> The whole idea of the resurrection and Easter is to come to terms with the event of death as if it were not final defeat but the prelude to a final victory for meaning.[63]

It is this meaning that the pastor brings to his personal encounter with the patient and it is this meaning that comes to terms with death.

Use of Sacraments and Prayer

The use of sacraments and prayer can convey to the terminal patient in a meaningful way his relationship to God in Christ. It is the privilege of the pastor to serve the terminal patient with the sacraments. It is generally considered that they convey more than just words. "Probably many things done in the name of religion have more meaning at the subconscious level than we are aware of."[64]

The sacraments convey that we are not alone when we die but that we are a part of the community in Jesus Christ. Luther states,

> He can be certain, as the sacraments point out, that a great many eyes are upon him: first, the eyes of God and Christ himself, for the Christian believes his words and clings to his sacraments; then also, the eyes of the dear angels, of the saints, and of all Christians."[65]

The Sacrament of Holy Communion expresses the community of Christ with the patient and the fact that Christ is personally with him. It is in the sacraments then that assurance of God with the patient can be expressed. "Sacraments may have important emotional meaning in overcoming the feeling of seperation."[66]

The expression of prayer is the other meaningful way of communication to the patient for the pastor. "The act of praying is the conscious effort to bring the encounter of the self and the beyond-self into active expression."[67] Prayer can be a meaningful way to share with the patient the feelings that he might have inside. Luther says of prayer, ". . . remind him [God] of his command and promise and not to doubt that our prayer will be fulfilled."[68] It conveys the needed hope that the patient might need, if he knows God cares for him. The pastor reaches out in prayer to God, so that the reassurances of God may be conveyed to the patient.

Anticipatory Grief Therapy

The pastor has a responsibility to the family, if he

is going to help the patient. The pastoral approach must deal with the family, since they play a significant role in relationship to the patient. "They play a significant role during the time of illness and their reactions will contribute a lot to the patient's response to his illness."[69] The pastor helps the family by working with them through their feelings of guilt, the impending loss, and their doubts before the patient dies. This is commonly termed "anticipatory grief therapy" and it has a very valid role in a pastoral approach to the terminal patient.

This anticipatory grief therapy will give the family members insight in enabling the patient to die with a sense of dignity and help them face the fact of death.

> In essence, the goal of anticipatory grief therapy is to create a genuine spirit of openness wherein both the patient and family can vent their internal feelings of doubt, hostility, and apprehension, and thereby enter onto the road of becoming a "whole person" even in the face of death."[70]

This will enable continued human contact by the family to the patient, so that the degrees of the patient's seperation can be faced in understanding.

The Role of the Parish

The parish has a very important role in a pastoral approach to the terminally ill. "To this end, it is hoped the pastor may along with his people come to realize that 'while

in the midst of life we are in death' . . ."[71] The pastor can help the parish work through the fact of death and help its members face this crisis, so that they might be spared the grief of working through the fact of death from the ground up. "Since death is a crisis, the ultimate crisis, the parish should make better teaching use of it."[72]

Thus the pastor can show his people that life and death are related and help them work through this fact with the Word of God.

> The crucifixion of Jesus, baptism into His death and resurrection, regular participation in the action of the eucharist, the learning how in daily relationships to 'die' to selfishness and to 'rise again' into outgoing love, the whole Christian understanding of discipleship as a dying to live, all these little deaths we voluntarily die to self are rehearsals for that greater death when we must hand ourselves over finally to the God to whom we have been learning to hand over all our lives."[73]

The promise of God is here in the church. The promise that death is defeated in Jesus Christ. The pastor helps his people realize that fact, so that they will be able to work with it in their lives and their facing of death made easier. A pastoral approach leads to the building of faith and how this faith not only approaches life, but how faith approaches death as a part of life.

FOOTNOTES

[1]Carl G. Carlozzi, Death and Contemporary Man (Grand Rapids, Michigan: William B. Eerdmans Publishing Company, 1968), p. 61.

[2]Ibid., 53.

[3]Ibid., 23.

[4]Ibid., 18.

[5]Robert Lester Fulton, Death and Identity (New York: John Wiley and Sons, Inc., 1965), p. 359.

[6]Margaretta K. Bowers and Others, Counseling the Dying (New York: Thomas Nelson & Sons, 1964), p. 13.

[7]Carlozzi, Contemporary Man, p. 20.

[8]Ibid., 18-19.

[9]Ibid., 79.

[10]Fulton, Identity, p. 67-75.

[11]Elizabeth Kubler-Ross, On Death and Dying (London: The Macmillian Company, Collier-Macmillan Ltd., 1969), p. 153.

[12]E. Mansell Pattison, "Afraid To Die," Pastoral Psychology, XXIII (June 1972), 43.

[13]Fulton, Identity, p. 360.

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[40]Kubler-Ross, Dying, p. 123.

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