5-1-1967

Guilt and the Terminal Patient-Some basic Considerations for pastoral Care

Gilbert Mueller

GUILT AND THE TERMINAL PATIENT:

SOME BASIC CONSIDERATIONS

FOR PASTORAL CARE

A Thesis Presented to the Faculty
of Concordia Seminary, St. Louis,
Department of Practical Theology
in partial fulfillment of the
requirements for the degree of
Master of Sacred Theology

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by

Gilbert Ernest Mueller

May 1967

Approved by: C. C. Draeger
Advisor

W. J. Bremer
Reader

Short Title

GUILT AND THE TERMINAL PATIENT;

Mueller; S.T.M., 1967

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CHAPTER I

GUILT ISOLATES FROM COMMUNITY

Statement of the Problem

In an age when man prides himself in his steadily increasing ability to control and manipulate his physical environment, death stands out as a phenomenon against which he finds himself helpless. One after another dreaded diseases are conquered by the ingenuity of medical science. Heart and lung machines, as well as other similar devices, have been invented which can successfully carry on the life giving functions of vital human organs. Man's life expectancy has been extended. Impressive as these advances may seem, they only delay for a time that which must eventually happen. Man must die! As man lives out his years the background music of death is constantly playing faintly in the distance. He may try to ignore it, but periodically it rises to such a tempo that he cannot help being aware of it.[1]

Man must cope with the reality of death. When he is not able to face it realistically he uses the defense mechanisms with which he is equipped. As psychotherapist, Kurt R. Eissler states, "The spirit of the present time, particularly within the American scene, is characterized by a supreme

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[1]Margaretta K. Bowers, et al., Counseling the Dying (New York: Thomas Nelson and Sons, 1964), p. 21. Margaretta Bowers, M. D. is a psychoanalyst. The other authors are Edgar N. Jackson (a Methodist pastor), James A. Knight (professor of psychiatry), and Lawrence LeShan (clinical psychologist).

effort at the denial of death. . . ."[2] The emphasis today is on the healthy and the youthful. One only has to look at life around him to see this. The majority of the advertising put out by the commercial world is directed toward youth and youthful ideas. The aged are encouraged to live apart from the rest of society in retirement villages.[3] Dying is normally done in a hospital, set apart from the healthy. As psychologist Herman Feifel points out:

> Indeed, it is now a rare phenomenon for the average individual, outside the medical and nursing professions, to see an untreated dead person. . . . (A) form of domestic technology that was familiar in most nineteenth-century households--how to deal with a corpse--has vanished.[4]

The mortician is expected to make the corpse appear as lifelike as possible and create the illusion of momentary sleep, thus aiding the denial that death has really taken place.

The denial of death is evident also in the relationship between the terminal patient and those around him. By "terminal patient" is meant the person who, humanly speaking, will in all probability die in the near future because of some biological condition in the human body (unless stated otherwise, whenever the term "patient" occurs it is to be understood as referring to the terminal patient). The professionals who deal constantly with death such as physicians, nurses, and even clergymen often refuse to face up to the fact of death. Psychiatrists are equally guilty. Eissler says,

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[2] K[urt] R. Eissler, The Psychiatrist and the Dying Patient (New York: International Universities Press, Inc., 1955), p. 293.

[3] Bowers, et al., p. 70.

[4] Herman Feifel, "The Function of Attitudes Toward Death," Death and Dying: Attitudes of Patient and Doctor (New York: Group for the Advancement of Psychiatry, 1965), p. 638.

"Since Freud has made death a central concept . . . one would have expected that psychoanalysts would devote more effort to the study of death itself. Strangely this has not happened."[5] Eissler furthermore notes, "Not only the specialty of psychiatry but also the whole field of medicine has neglected the problem of death."[6] Psychiatrist Charles W. Wahl says, "it is a . . . significant fact that the phenomenon of the fear of death . . . has almost no description in the psychiatric or psychoanalytic literature. It is conspicuous by its absence."[7] Sociologists Glaser and Strauss have made a study of the dying and those about them in social interaction in hospital situations. They report a tendency to avoid and deny a confrontation with death on the part of all members of the staff.

> The most standard mode--recognized by physicians and nurses themselves--is a tendency to avoid contact with those patients who, as yet unaware of impending death, are inclined to question staff members, with those who have not "accepted" their approaching deaths, and with those whose terminality is accompanied by great pain.[8]

The pastor is not exempt from the temptation to conform to this denial. Daniel Cappon, assistant professor in the department of psychiatry at the University of Toronto, says that clergymen hide their feelings regarding death in rituals.[9] Bowers and associates discuss numerous masks used by clergymen to shield themselves from a true confrontation with the dying

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[5]Eissler, p. 39.

[6]Ibid., p. 250.

[7]Charles W. Wahl, "The Fear of Death," The Meaning of Death, edited by Herman Feifel (New York: McGraw-Hill Book Co., Inc., 1959), p. 19.

[8]Barney G. Glaser and Anselm L. Strauss, Awareness of Dying (Chicago: Aldine Publishing Co., 1966), p. 5. Cf. pp. 3, 57, 59, 119.

[9]Daniel Cappon, "The Psychology of Dying," Pastoral Psychology, XII (February 1961), 35.

person.[10] The patient's family is very often also a partner in the denial of the terminal condition. At the very time when the patient needs them the most, they are least able to help because they are so bound up with their own feelings about death.[11]

This reluctance to deal with death creates numerous barriers which block the way to effective communication between the patient and those around him. The patient finds himself alone, walled off from others who appear to be allied against him in a "conspiracy of silence."[12] Physicians Weisman and Hackett of the Harvard Medical School and the Massachusetts General Hospital in Boston are convinced that his abandonment of the dying is due in most instances "to the survivor's uneasy conscience in being alive while the other one dies."[13]

While on the one hand, the patient often finds himself isolated from open, uninhibited, emotionally meaningful communication with those around him, on the other hand, he may also find himself isolated from real fellowship with God and his fellowmen by guilt from within. It is upon this problem of the isolation of the dying brought about by guilt that this study concentrates.

The purpose of this study is twofold. First, the aim is to take a closer look at the influence and power of guilt in the personality and life of the terminal patient. Secondly, the aim is to structure an evangelical

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[10] Bowers, et al., pp. 66-69.

[11] Ibid., pp. 57-60.

[12] Ibid., p. 5.

[13] Avery D. Weisman and Thomas P. Hackett, "Predilection to Death: Death and Dying as a Psychiatric Problem," Psychosomatic Medicine, XXIII (May-June 1961), 251.

pastoral approach to the terminal patient that will best serve to overcome all guilt and enable the patient to use the time remaining to him in the fullest possible fellowship with, and service to, God and fellowmen, and to victoriously meet a meaningful death.

The solution to valid guilt is seen as the Kerygma (the Gospel of Jesus Christ). It is the responsibility of the pastor (and of all Christians) to do his best to build up a trusting relationship between himself and the terminal patient that will enable the Kerygma to be fully communicated to the patient and open the way for spontaneous communication of the patient's true feelings back to the pastor.

The method of research is bibliographical and involves a study of the literature from both the fields of pastoral theology and psychology. In both areas the focus is on contemporary literature. Occasional reference shall be made to the theological heritage of the Lutheran Church--Missouri Synod in the field of pastoral theology.

Limitations of the Study

The object of this investigation is the terminal patient. The guilt of others in relation to the patient is dealt with only as it effects the restoration of the patient to full community with God and fellowmen.

Although unconscious guilt is kept in mind as an important factor in the personality, the focus of this study is on conscious and pre-conscious guilt in the terminal patient. By pre-conscious guilt reference is made to those guilt feelings which can be recalled into consciousness even though they have, for the present time, passed out of conscious awareness.

Definition of Terms

Theologians and persons schooled in the behavorial sciences often misunderstand what the other party means by the word "guilt." Theologian Lewis J. Sherrill explains the word this way:

> Guilt may refer to fact, or to responsibility, or to feeling; or to combinations of these.
>
> When the question of fact is involved, "guilt" implies that one has done something forbidden or failed to do something required. The "something" may be action, or it may be feeling. The source of the prohibition or requirement may be religious, or legal, or social, or familial, or personal; and may exist in written form, or as unwritten law.
>
> When the question of responsibility is uppermost, "guilt" indicates that one is held accountable by himself or by others for doing or feeling what was forbidden, or for failing to do or to feel what was required; and it often implies that one is accountable also for consequences that later ensue.
>
> As feeling, "guilt" refers to the emotional aspect of the experience of one who stands in judgment upon himself, and condemns himself or at least acknowledges others' condemnation of himself as deserved. The intensity of the emotion may bear little or no apparent relation to the fact with which it is associated; indeed, the frequent disproportion between fact and feeling constitutes one of the most difficult problems met in connection with guilt.[14]

Thus, guilt as a fact indicates that one has broken the law and because this is the case, it is a fact that he is guilty of the act. Guilt as responsibility has reference to a person's accountability for the consequences of his illegal activity. As feeling, guilt refers to the emotional aspect of the experience of standing in condemning judgment upon oneself. The person has a "bad conscience." Modern day psychology is concerned chiefly (almost solely) with guilt feelings. Much of the pastoral

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[14] Lewis J. Sherrill, Guilt and Redemption (Richmond, Va.: John Knox Press, 1963), p. 62.

counseling literature also has this sense of the word in mind when it is used. Unless it is stated otherwise, when the word "guilt" is used in this study it shall be understood to refer to guilt feelings.

Guilt feelings have been classified in various ways. Of some we are fully conscious. Others are in the area of the pre-conscious. This means, as previously mentioned, that although they are not at present in an individual's conscious awareness, he can recall them into consciousness. Guilt of which a person is consciously aware can be dealt with in a healthy manner. Unconscious guilt is that which has been repressed into the area of the unconscious.[15] The individual is unable to recall the situations during which guilt originated. As long as these guilt feelings remain in the unconscious, he will not be able to truly dispose of them. He will feel guilty but he will not really know why. He will, without being consciously aware of it, displace his guilt feelings upon other thoughts, words, and deeds of his life which he supposes are wrong in the sight of God and/or man. Paul Meehl (psychologist), and his co-authors Richard Klann (Lutheran theologian), Alfred Schmieding (professor of psychology), Kenneth Breimeier (seminary dean), and Sophie Schroeder Sloman (practicing psychiatrist), use the term "displaced guilt" in their book, What, Then, Is Man?[16] to describe this unhealthy guilt situation. Other terms for unhealthy guilt mentioned by Physician Paul Tournier are "false Guilt,"

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[15] Ibid., p. 90.

[16] Paul Meehl, et al., What, Then, Is Man? (St. Louis: Concordia Publishing House, 1958), p. 223.

"infantile guilt," "functional guilt," and "neurotic guilt."[17] Although these words are at times used interchangeably, each of them conveys a slightly different aspect of unhealthy guilt. In this study the two terms to be used are "displaced guilt" (as described above) and "false guilt." False guilt is that which arises from the suggestions and taboos of society, from the fear of losing the love of others.[18] Healthy guilt (in that it is useful in bringing to light the breaking of divine law) also is described by a number of terms such as "true guilt," and "value guilt."[19] The theologian and philosopher, Martin Buber uses the concept "existential guilt."[20] In this study healthy guilt situations will be summed up in the term "valid guilt" which is the term used by Meehl and co-authors.[21] By valid guilt is meant "that which results from divine judgment."[22] To distinguish between valid guilt and unhealthy guilt, any guilt "suggested by the judgment of men is a false guilt if it does not receive inner support by a judgment of God."[23] "Ultimately it never matters what man thinks of himself, but what God thinks of him."[24] God, not man gives the law its sanction.

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[17] Paul Tournier, Guilt and Grace (New York: Harper and Row, Publishers, 1962), pp. 63-65.

[18] Ibid., p. 64.

[19] Ibid.

[20] Martin Buber, "Guilt and Guilt Feelings," Psychiatry, XX (May 1957), 17.

[21] Meehl, et al., p. 221.

[22] Tournier, p. 67.

[23] Ibid., p. 70.

[24] Meehl, et al., p. 76.

CHAPTER II

MORTAL MAN AND THE PROBLEM OF GUILT

Biblical View

Scripture makes it very clear that man is indeed guilty of the fact of sin and that he justly feels responsible for thoughts, words, and deeds whereby he falls beneath the judgment of God.

> Now we know that whatever the law says it speaks to those who are under the law, so that every mouth may be stopped, and the whole world may be held accountable to God. . . . For there is no distinction; since all have sinned and fall short of the glory of God . . . .[1]

> If we say we have no sin, we deceive ourselves, and the truth is not in us.[2]

It is impossible for man, endowed as he is with intellect and will, to take a neutral position regarding God. Man is either for God or against Him.[3]

Man is responsible to God by virtue of the fact that he is creature and God is creator.[4] He is not unmindful of his responsibility. Man knows God, "but because of his sin he knows him only as judge."[5]

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[1] Rom. 3:19,22-23.

[2] 1 John 1:8.

[3] Francis Pieper, Christian Dogmatics, translated from the German by Theodore Engelder and John T. Mueller (3 vols.; St. Louis: Concordia Publishing House, 1950-1953), I, 528. Dr. Pieper was a renowned dogmatician of the Missouri Synod during the first quarter of the twentieth century.

[4] Gen. 1:26-28; 2:7,21-23.

[5] George W. Forell, Ethics of Decision (Philadelphia: The Muhlenberg Press, 1955), p. 88. The author is Associate Professor at the School of Religion of the State University of Iowa.

> For what can be known about God is plain to them, because God has shown it to them. Ever since the creation of the world his invisible nature, namely, his eternal power and deity, has been clearly perceived in the things that have been made. So they are without excuse; for although they knew God they did not honor him as God or give thanks to him, but they became futile in their thinking and their senseless minds were darkened.[6]

The Apostle Paul later continues, "Therefore you have no excuse, O man, whoever you are. . . ."[7] Man has sinned! He has no excuse, no cloak to cover his guilt! He is responsible before his maker!

It should be noted, however, that God's law alone is authoritative for man. Pieper points out,

> Every man is subject to God's Law. Laws enacted by men are a norm binding our consciences only when God sanctions them and thus makes them His precepts. . . .
>
> The so-called "laws of the Church" cannot bind our consciences Christ has not given His Church any legislative power. . . .[8]

God has established and upholds civil government[9] and parental authority.[10] Even the laws of such authorities are not to be obeyed without question. They are sanctioned by God only when they agree with the divine law.[11] It will be important to remember this when comparing the Freudian concept of guilt with the Biblical one.

Man was created in the "image of God."[12] As theologian and exegete

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[6]Rom. 1:19-21.

[7]Rom. 2:1.

[8]Pieper, p. 530.

[9]Rom. 13:1-7.

[10]Col. 3:20.

[11]Acts 5:29.

[12]Gen. 1:27.

Martin Scharlemann puts it,

> the word "image" points to a relationship of dependence and of distinction. Man was not made to be a god. Nor was he created to be on his own. He is to reflect God in some way and to remain in dialog with Him.[13]

Man was not content with this arrangement. He rebelled.[14] He was determined to be free to be creator rather than creature.[15] Thus sin, which is a breaking of God's divine law,[16] came into the world. Although it was the devil who first seduced man,[17] man is also the cause of sin. "Seduction by the devil does not do away with the fact that man perpetrates the sin; it does not relieve him of the responsibility for it."[18] God held Adam and Eve personally responsible for their deed.

Since the fall into sin all mankind is in the condition called "original sin." The Lutheran Confessions speak of it in this way:

> That original sin in human nature is not only a total lack of good in spiritual, divine things, but that at the same time it replaces the lost image of God in man with a deep, wicked, abominable, bottomless, inscrutable, and inexpressible corruption of his entire nature in all its powers, especially of the highest and foremost powers of the soul in mind, heart, and will. As a result, since the Fall man inherits an inborn wicked stamp, an interior uncleanness of the heart and evil desires and inclinations. By nature every one of us inherits from Adam a heart, sensation, and mind-set which, in its highest

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[13] Martin H. Scharlemann, Healing and Redemption (St. Louis: Concordia Publishing House, 1965), p. 75.

[14] Gen. 3:1-24.

[15] Scharlemann, p. 44.

[16] 1 John 3:4.

[17] John 8:44.

[18] Pieper, p. 534.

> powers and the light of reason, is by nature diametrically opposed to God and his highest commands and is actually enmity against God, especially in divine and spiritual matters. True, in natural and external things which are subject to reason man still possesses a measure of reason, power, and ability, although greatly weakened since the inherited malady has so poisoned and tainted them that they amount to nothing in the sight of God.[19]

Thus, this rebellion against God has become a part of man's nature in every detail. He who was pronounced good together with all the rest of creation became one whose whole being is intent on evil. Man, who was created to live in blissful community with God, has chosen to separate himself from his creator and oppose him. Instead of living in communion with God in a state of dependency, and at the same time, honor, man has chosen isolation. This isolation from God serves to perpetuate itself in every generation. By himself man is unable to break out of this "vicious circle."

By means of his rebellion man has always hoped to find freedom. To fallen man, obedience to God has seemed too restricting, too confining. Rebellion has appeared as an open door to free expression in every sense. This gateway to freedom has proven to be a false hope. Freedom from the service of God is not freedom but rather slavery.[20]

Forell maintains that the basic sin, at the bottom of all man's rebellion is pride and self-centeredness.

> This basic sin of being centered in ourselves rather than in God is at the bottom of all other sins. Every actual sin is an expression of original sin. Every particular sin is an expression of our revolt

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[19]"Formula of Concord, Solid Declaration, Article I," The Book of Concord, translated and edited by Theodore G. Tappert (Philadelphia: Fortress Press, 1959), p. 510.

[20]Forell, p. 73.

> against God. . . . Thus my entire life is the proud effort to defy God and to make my own personality the center of everything.[21]

Pride cannot tolerate anything above it. Pride demands the highest place. God is by His very nature in first place. Because of these facts human pride is always arrayed against God. As Forell also notes, irreligious people are often separated from God by greed, unchastity or other similar animal vices, but it is pride which separates religious people from God. Our Lord was able to accomplish much more with the prostitutes and the crooked tax collectors than he was with the proud, highly religious Pharisees.[22]

Pride not only divides man from God but it also isolates man from his fellowmen. C. S. Lewis has said that other vices sometimes bring people together. Alcoholics and adulterous people may find a certain satisfying fellowship as they continue to live contrary to their consciences. Pride permits no fellowship. Everyone else must be beneath it.[23]

This rebellion against the restraints of society and the shackles of community found expression in the individualization process of the Renaissance. It can be seen in the developments in the western world following the French Revolution.[24] Western man was gradually cut off from the community around him and separated from a sense of continuity with what had gone before. As clinical psychologist, O. Hobart Mowrer expresses it,

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[21] Ibid., p. 74.

[22] Forell, p. 76.

[23] C [live] S [taples] Lewis, Christian Behaviour (New York: The Macmillan Company, 1944), pp. 46-47. At the time he wrote this book, the author was a fellow of Magdalen College, Oxford.

[24] Scharlemann, p. 22.

> most persons who are today living in the Free World are so "free," so rootless, so uncommitted, that they have lost their identity, do not know who they are or are supposed to be, and do not even know how to go about finding out.[25]

This emphasis on the individual has not been without its achievements in terms of democracy and the countless benefits of western culture (few of us would care to go back to the life of the Middle Ages), yet it has exacted its price. Scharlemann, looking at life today says,

> today people observe that they cannot really live meaningfully in this way. They are not so certain any more that putting man at the center of the universe and concentrating on the individual and his needs, to the exclusion of matters relating to his solidarity with the world around him, quite matches the dimensions of redemption promised by early proponents. People feel trapped.[26]

Man, who promised himself so much if only he could have his freedom, finds himself the victim of a cruel paradox. As man probes out into space it would almost seem that this feat added to all his other scientific genius makes him master of the universe. Yet this "master of the universe" is unable to come to grips with himself.[27]

Man was not created to be as he is today. Why isn't man the creature God intended? Forell puts it this way, "The trouble with man is that he made the wrong decision and that he is still making it."[28] Man, made in the image of God, cannot be really man when he tries to ignore, disown, and revolt against Him of Whom he is the image. Separated from the Original from whence he gets his meaning, man is meaningless.[29]

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[25] O. Hobart Mowrer, The New Group Therapy (Princeton, N. J.: D. Van Nostrand Co., 1964), p. 22.

[26] Scharlemann, p. 23.

[27] Mowrer, p. 1.

[28] Forell, p. 70.

[29] Ibid., p. 68.

Not only was man created in God's image to be in community with God but to live in community with others. The Genesis account tells us that it is not good for man to be alone.[30] It is only in fellowship with others that a human being can be a whole person. Only in a return to community with God and with his fellowman can a person find himself. Only there will he find the meaning of life. In such belonging there is healing.[31]

Scripture not only speaks of man's lost and guilty condition, but its main purpose is to show man the solution to his predicament.[32] It is in this solution that we can best learn the answer to the question regarding man and his meaning. Christ's judge, Pontius Pilate, unwittingly gave the answer when he said, "Here is the man!"[33] Christ is <u>the</u> man! He is the man for many reasons. He is the man because He was perfect in his relation to God and man as no other man has been.[34] He is the man because He is God in the flesh, true God and true man in every respect.[35] He is the man because He is our substitute, taking both the responsibility for living a perfect life and the curse of our sin upon Himself.[36] Professionals in

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[30] Gen. 2:18.

[31] Scharlemann, p. 78.

[32] 2 Tim. 3:15.

[33] John 19:5.

[34] 1 Peter 2:22.

[35] Luke 22:69-70; Col. 2:9.

[36] Gal. 3:13; Is. 53:5.

the behavioral science fields often speak of the dignity of man.[37] Christianity has been criticized for emphasizing man's sin to the detriment of any value or worth in man. Those who do so have failed to take the man into account. God valued fallen man so highly that He gave His only son into death for man. No higher value could be placed on man than that! What man lost via his rebellion, his proud isolation from God and fellowman, has been restored through the man, Jesus Christ![38]

Man was created for service. He was not made to be served, but to serve God and his fellowmen. He is not the center of the universe around which everything revolves, but God is. Our blessed Lord told His disciples:

> whoever would be great among you must be your servant, and whoever would be first among you must be your slave; even as the Son of man came not to be served but to serve, and to give his life as a ransom for many.[39]

In the account of the last judgment, Christ makes it very plain that service rendered for the benefit of fellowmen is service rendered to God.[40] Being forgiven and restored to community with God, Christians live out this fellowship with their fellowmen. When man is whole he lives in such fellowship.[41]

The Christian church is pictured by the Apostle Saint Paul in his letter to the Ephesians as one big, happy family and as a holy temple.

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[37] Cf. Florence Hollis, Casework: A Psychosocial Therapy (New York: Random House, 1964), p. 12.

[38] Rom. 5:6-21.

[39] Matt. 20:26-28.

[40] Matt. 25:31-46.

[41] Scharlemann, p. 61.

> So then you are no longer strangers and sojourners, but you are fellow citizens with the saints and members of the household of God, built upon the foundation of the apostles and prophets, Christ Jesus himself being the chief cornerstone, in whom the whole structure is joined together and grows into a holy temple in the Lord; in whom you also are built into it for a dwelling place of God in the Spirit.[42]

Here, to use Scharlemann's terms, are found community, solidarity, and continuity.[43] Christians live together as members of one family. They support one another and hold one another up in time of need. They are not meaningless individuals existing without purpose or goal in the sea of time, but fellow citizens with those who have gone before in centuries past as well as with those who are now living. Their purpose is service to the Lord.

Freudian View

Those who follow Freudian psychology use the concept of "anxiety" repeatedly. Protestant institutional chaplain, Ernest E. Bruder explains the difference between anxiety and fear.

> Broadly speaking, fear is the response to an external stimulus, while anxiety arises in response to an internal stimulus--internalized fear. Anxiety is triggered very often by external stimuli, and we may often be both fearful and anxious. In anxiety, however, there is aroused an internal response not only to the immediate threat in the environment, but to previous 'fears' that have remained unresolved and that persist in the area outside of immediate awareness. There is no clear and adequate explanation of all this as yet, but both fear and anxiety arise from conditions which are or have been a threat to the life or integrity of the organism.[44]

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[42] Eph. 2:19-22.

[43] Scharlemann, pp. 26-68.

[44] Ernest E. Bruder, Ministering to Deeply Troubled People (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963), p. 72.

Anxiety is the result of threatened self-esteem.[45] It is so painful to the human being that a person will not willingly submit to an anxiety experience a second time if he can possibly avoid it.[46]

Sigmund Freud, the founder of psychoanalysis, was much concerned with the problem of guilt (although he limited his concern almost entirely to guilt feelings). He said that the sense of guilt was the most important problem in the evolution of culture and "the price of progress in civilization is paid in forfeiting happiness through the heightening of the sense of guilt."[47] The sense of guilt is, therefore, an evil which needs to be eradicated!

Guilt is basically the dread of losing love. Psychoanalyst Theodor Reik says,

> Whence does the sense of guilt come? Its first stage can be best designated as dread of losing love. A bad deed is one that, when discovered, would be followed by the loss of love (and of protection) for the child. At this state the sense of guilt is still "social anxiety." It will remain that in its core: that means anxiety that the father or mother and later the community will disapprove of and punish the misdoer.[48]

Guilt is seen as arising from the taboos of society and as inhibiting man from being his true self. "We have just seen too many examples of guilt-feelings aroused by the suggestion of educators and society to deny the mechanism described by Freud and his school. It is the guilt produced by

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[45] Ibid., p. 30.

[46] Ibid., p. 72.

[47] Sigmund Freud, Civilization and Its Discontents, The International Psycho-Analytical Library, edited by Ernest Jones (London: The Hogarth Press, Ltd., 1957), XVII, 123.

[48] Theodor Reik, Myth and Guilt (New York: George Braziller, Inc., 1957), p. 21.

fear of taboos."[49] These taboos become fixed in the superego (conscience) and cause the ego (which serves as the intermediary between the superego and the id) to repress the basic animal desires of the id (which might be called our lower nature). Thus the id is inhibited and cannot satisfy its appetites. The result of this internal battle is compromise. This does not make for a satisfactory solution. The impulses of the id continue to strive for satisfaction while the superego keeps refusing the possibility of such expression. David E. Roberts, (who was Professor of the Philosophy of Religion at Union Theological Seminary, New York, at the time of his death) has a good discussion of the Freudian view of personality in his book, Psychotherapy and a Christian View of Man.[50] Speaking of the rejected impulses he says,

> rejected impulses do not cease operation merely by being excluded from consciousness; but so long as the conscientious part of the self has the upper hand, these repressed impulses are compelled to engage in a sort of running warfare. They may manifest themselves in disguised forms which can be explained away, so that the real significance of the manifestation is missed.[51]

The outcome of this internal struggle is a feeling of guilt.

For the Freudian the superego is often the source of much unnecessary torture.[52] When a person has an overly severe superego he is likely to function in a neurotic manner, that is, his actions will not be consistent with reality because of the unsatisfied impulses within himself that are striving to reach fulfillment. Speaking of the Freudian school of thought Mowrer says,

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[49]Paul Tournier, Guilt and Grace (New York: Harper and Row, 1962), p. 64.

[50]David E. Roberts, Psychotherapy and a Christian View of Man (New York: Charles Scribner's Sons, 1950), pp. 23-25.

[51]Ibid., p. 23.

[52]Reik, p. 21.

> Here the "neuroses," both mild and severe, were seen as springing from the fact that the mind, under the sway of unfortunate or misdirected social experience, has, in effect, turned against the body and is no longer ministering to its needs.[53]

The neurotic resorts to unhealthy means to keep the forces within him in a state of equilibrium.

When the ego counters the anxiety producing threats with unhealthy methods the defense mechanisms are put into use. These mechanisms serve to deny, falsify, or distort reality and impede the development of personality.[54] They do prevent the cause of the anxiety from troubling the conscious mind and if they are successful they may even prevent any awareness of anxiety. Continued distortion of reality by such means will finally lead to personality difficulties.

Physician Edith Weigert observes that "a bad conscience is a man's . . . worst enemy. It is not a sign of inner badness; it is the result of a cruel superego, the tragic consequence of failure of tender co-operation and the repression of trust."[55] Since guilt is viewed as the dread of losing love, the early relationships of a child with his environment, especially with his parents, are viewed as vitally important in the development of a healthy personality. Carroll A. Wise, professor of pastoral psychology and counseling, says,

> Even the five- or six-year old child may be struggling with feelings which are completely beyond his power to formulate in words--feelings

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[53] O. Hobart Mowrer, The Crisis in Psychiatry and Religion (Princeton, N. J.: D. Van Nostrand Company, Inc., 1961), p. 15.

[54] Calvin S. Hall, A Primer of Freudian Psychology (New York: The New American Library, 1963), p. 85. For a fuller treatment of defense mechanisms, see pp. 85-97. The author was a professor of psychology at Syracuse University at the time of writing.

[55] Edith Weigert, "The Psychoanalytic View of Human Personality," The Nature of Man, edited by Simon Doniger (New York: Harper and Brothers, Publishers, 1962), p. 11.

> of guilt, for example. Nor does he have to be told that he is forgiven or accepted. If the adults who are most significant to him really forgive and accept him, he will know it, and will not have to be told. In turn he will learn to be forgiving, even though he may not be able to verbalize it.[56]

Viewed from the Freudian approach, a sense of oneness, of trust, of community is highly important to a whole, healthy personality. Guilt viewed as loss of love is essentially a process resulting in isolation. The guilty person is anxious lest he be found standing alone with all those whom Mowrer calls the "significant others"[57] arrayed against him. This would mean that he would be cut off from community. Deep within him, man fears being alone.

Where guilt has arisen, the Freudian solution has been to remove the sense of responsibility for that guilt. Mowrer comments,

> The genius of Freud's "discoveries" has been characterized in many ways, but for our purposes what is important is the fact that they purported to rescue man from the . . . ravages of unresolved guilt, not by restoring him to full ethical responsibility, but by "relieving" him of <u>all</u> responsibility. In short, the notion was that one should not feel guilty about anything.[58]

The real source of trouble for the Freudian is in the superego which has been made too severe by society.

Biblical and Freudian Views Compared

Both the Biblical and Freudian view of guilt see it as resulting in the isolation of the guilty person. Scripture describes guilt as the fruit of self-centered pride leading to rebellion against God. Freudian psychology looks upon guilt as the dread of losing love. This threat

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[56]Carroll A. Wise, <u>The Meaning of Pastoral Care</u> (New York: Harper and Row, Publishers, 1966), p. 109.

[57]Mowrer, <u>Group</u>, p. 93.

[58]<u>Ibid</u>., p. 6.

becomes focused in the superego and is used against the impulses of the id. In both cases the result is isolation. Psychology has helped to deepen man's insight into the depths of self-isolation. The guilty person not only builds up facades to hide his misdeeds from others, he does the same within himself by means of defense mechanisms. As Sherrill points out that

> The human organism seems capable of enduring anything in the universe except a clear, complete, fully conscious view of one's self as he actually is.
>
> . . . . . .
>
> The deepest sense of guilt is shielded from one's own view, and is screened off from the gaze of others by protecting devices and by the discharge of other more socially acceptable feelings.[59]

Both views stress the importance of trust in community with others and of the need for love which completely accepts the person as he is.[60]

There are also great differences in the two views of guilt. As already mentioned, Scripture recognizes and deals with guilt as fact, as responsibility, and as feeling. Psychology is primarily concerned only with the sense of guilt. It has no remedy or help for valid guilt, as a fact which cannot be explained away. Buber comments,

> The psychotherapist . . . can no longer imagine that he is able to do justice to his task as doctor of guilt-ridden men merely through the removal of guilt feelings. Here a limit is set to the tendency to derive guilt from the taboos of primeval society. The psychologist who sees what is here to be seen must be struck by the idea that guilt does not exist because a taboo exists to which one fails to give obedience, but rather that taboo and the placing of taboo have been made possible only through the fact that the leaders of early communities knew and made use of a primal fact of man as man--the fact that man can become guilty and know it.

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[59] Lewis J. Sherrill, Guilt and Redemption (Richmond, Va.: John Knox Press, 1963), p. 90.

[60] 1 John 4:18; John 15:12,17.

> Existential guilt--that is, guilt that a person has taken on himself as a person and in a personal situation--cannot be comprehended through such categories of analytical science as "repression" and "becoming--conscious."[61]

Psychology has also failed to comprehend or face up to the depth of guilt as the result of rebellion against God, Himself! Since a sense of valid guilt alerts man to his condition before God, guilt feelings are not evil, but good. Guilt feelings are similar in function to that of a fever in the body. They are symptoms and signs that an unhealthy condition exists and something needs to be done about it!

Mowrer's Theory of Guilt

In contrast to the Freudian approach the Lutheran theologian will find the theory of O. H. Mowrer, research professor of psychology at the University of Illinois, enlightening.[62] Mowrer holds to a "guilt theory" of anxiety as opposed to what he terms the "impulse theory" of the Freudians.[63] The real trouble is not caused by repressed drives which are refused expression, but rather by a repressed super-ego. When guilt feelings are continually repressed instead of being dealt with in a healthy manner, the super-ego finally resorts to some rather violent means to make itself heard. Looking back on his years of experience as a psychologist, Mowrer says,

> Under the sway of Freudian psychoanalysis, we psychologists and psychiatrists tried for several decades to believe that the painful

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[61] Martin Buber, "Guilt and Guilt Feelings," Psychiatry, XX (May 1957), 116-117.

[62] Mowrer, Crisis, passim.

[63] Ibid., p. 26.

> discrepancy which is found in every case of so-called neurosis or functional psychosis between an individual's moral standards and his actual conduct or performance occurs, not because his performance has been inferior or "bad," but because his standards are unrealistically high. In short, according to (this) . . . view, people fall "ill" because they are trying to be too good. . . .
>
> The alternative view which is now in process of emerging is as follows. As long as neurosis was attributed to a too severe, too demanding conscience, it was perhaps logical enough to say that the individual himself was "not responsible" for his personality problems. Obviously we get our consciences from our parents and other representatives of adult society; and if we end up with too much conscience, it is clearly their fault, rather than ours. But we are now, for a variety of reasons, beginning to suspect that the real problem is not that our standards are too high but that we fail or refuse to live up to them. If this is the situation, then the responsibility or "blame" comes back squarely upon ourselves.[64]

Concerning mental illness, Mowrer, in another place comments,

> My own clinical experience leads me to believe that neurotic difficulties commonly, if not invariably, have their roots in unresolved personal guilt, rather than in the unfortunate or traumatic things which happen to us.[65]

Thus, Mowrer would see valid guilt over broken relations with community (the result of sin) as being behind virtually all mental illness except for that which has a biological origin.

Mowrer takes the Biblical injunction, "confess your sins to one another,"[66] seriously. He believes that such confession is a vital part of any complete removal of guilt and of restoration to integrity in community with others. The assurance of forgiveness from God is not a substitute for authentic relationships with one's fellowmen. Mowrer believes that the church errs when it stresses the vertical relations between man and God while neglecting the horizontal relation between man and his fellowman

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[64] Mowrer, Group, p. 60. The word in parenthesis is my own.

[65] Ibid., p. 94.

[66] James 5:16.

against whom he has also sinned.[67]

In support of his position Mowrer quotes the German theologian, Dietrich Bonhoeffer. Regarding confession Bonhoeffer writes,

> He who is alone with his sin is utterly alone. It may be that Christians, notwithstanding corporate worship, common prayer, and all their fellowship in service, may still be left to their loneliness. The final break-through to fellowship does not occur, because, though they have fellowship with one another as believers and as devout people, they do not have fellowship as the undevout, as sinners. The pious fellowship permits no one to be a sinner. So everybody must conceal his sin from himself and from the fellowship. We dare not be sinners. Many Christians are unthinkably horrified when a real sinner is suddenly discovered among the righteous. So we remain alone with our sin, living in lies and hypocrisy. The fact is that we <u>are</u> sinners![68]

Later in the chapter Bonhoeffer makes the following observations,

> In confession the break-through to community takes place. Sin demands to have a man by himself. It withdraws him from the community. The more isolated a person is, the more destructive will be the power of sin over him, and the more deeply he becomes involved in it, the more disastrous is his isolation. Sin wants to remain unknown. It shuns the light. In the darkness of the unexpressed it poisons the whole being of a person. This can happen even in the midst of a pious community. In confession the light of the Gospel breaks into the darkness and seclusion of the heart. The sin must be brought into the light. The unexpressed must be openly spoken and acknowledged. All that is secret and hidden is made manifest. It is a hard struggle until the sin is openly admitted. But God breaks gates of brass and bars of iron (Ps. 107:16).[69]

When the Christian confesses his sin in the presence of a Christian brother, he surrenders, giving up all his evil. He finds forgiveness in the fellowship of Jesus Christ and his Christian brother. Now the fellowship bears the sin, that is, Christ has taken away the burden and punishment,

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[67] Mowrer, <u>Group</u>, p. 72.

[68] Dietrich Bonhoeffer, <u>Life Together</u>, translated from the German by John W. Doberstein (New York: Harper and Brothers, Publishers, 1954), p. 110.

[69] <u>Ibid</u>., p. 112.

and the fellow believer also pronounces absolution, offers comfort and upholds the brother in his efforts to rise above his sin.[70]

Many people may fail to see any need for a "break-through to community." They have appeared to be successful in keeping their sins from other people. They feel no need to confess them. According to Mowrer they may continue to get along that way until "unresolved . . . guilt comes to exceed . . . (the) capacity for self-affirmation and approval . . . ."[71] If the person involved does not deal with this guilt, the defense mechanisms of his mind will take over. When the defense mechanisms are no longer successful in hiding the guilt various degrees of anxiety and even mental illness may be the result.

Mowrer's program for dealing with guilt has two major parts involving first confession of past misdeeds to "significant others," and secondly, "charity by stealth."[72] The guilty person has broken community with others by his wrong doing. He cannot truly come out of his isolation and boldly face himself if he is unwilling to admit his guilt to those whom he has wronged. Any attempt at fellowship with those against whom he has offended cannot help but be mere sham as long as he is unwilling to be open about his failings toward them. Confession to God in prayer or to a pastor or counselor who is bound to secrecy is not enough. Confession needs to be made to the whole community. This is accomplished by confessing to the "significant others," those most directly affected by the misdeed and the

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[70] Bonhoeffer, pp. 112-113.

[71] Mowrer, Group, p. 90. The word in parenthesis is my own.

[72] Ibid., pp. 68, 93.

self-imposed isolation arising from guilt. Such confession involves the willingness to be open to everyone about what was done. This does not mean proclaiming one's sins from "the housetops," but rather the forsaking of all false fronts, the abandonment of hypocrisy.[73]

"Charity by stealth" is restitution made by the guilty person to the community and especially those injured by the misdeed. He tries to the best of his ability to undo any damage for which he is responsible. His actions become a type of atonement to society. Mowrer believes that it is important for the most effective removal of guilt that these works be concealed from others.[74]

It should be borne in mind that Mowrer, by his own admission, is not interested in the forgiveness of sins with respect to eternal salvation. He is concerned only with mental health in this life.

> I have no taste or talent for theological disputation and even less interest in what this or that school of thought has to say about what is required for the salvation of our immortal souls; but I am concerned, vitally and unabashedly, about men's souls in this world . . . .[75]

He rejects the doctrine of salvation by grace alone and faults the church for its Christocentricity.[76]

> A this juncture it is, of course, easy to get involved in a tedious theological debate as to whether salvation is by "good works" or by "grace alone." For myself, I have no desire to argue the point but will merely state that I, personally, take my stand with the Apostle James and Dietrich Bonhoeffer, against the Apostle Paul and Martin Luther . . . .[77]

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[73] Mowrer, Group, p. 96.

[74] Ibid., pp. 68, 92, 136.

[75] Ibid., p. 19.

[76] Ibid., p. 22.

[77] Mowrer, Crisis, p. 109. Cf. pp. 185-189.

For Mowrer, good works are the answer to a guilty conscience.

Mowrer has pointed up some of the weaknesses of psychoanalysis and of Christianity (as it is lived daily) with regard to dealing with guilt. Donald F. Krill, a psychiatric social worker says of Mowrer,

> it is obvious that Mowrer has made important contributions in his criticism of psychoanalysis, his stress on the reality of guilt and moral conflict in neurosis and psychosis, and in studying new techniques for dealing with mental illness. His criticisms of the church and suggestions for broadening and deepening the healing ministry are also valid.
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> The problems created by Mowrer, however, are of serious concern. He wants to undermine all of psychoanalysis in his attack of its mistakes and limitations--a case of the baby going out with the bathwater.[78]

While it would appear very doubtful that Mowrer has discovered the solution to all mental illness by means of his theory and while his theology is man-centered rather than Christ-centered, he does point up the importance of the fruits of true repentance in the life of the penitent sinner.[79] Likewise, he also reminds the Christian church of the importance of the communion of saints. The Church does need to be concerned about providing more opportunity for confession, not only by parishioner to pastor, but also confession by parishioner to his fellow believers individually or in groups. Christians need to be trained to rally around the fallen person in order that he be restored to fellowship and rescued from his isolation.

Belgum's Functional Confessional

Lutheran theologian, David Belgum, who studied under Mowrer, has outlined an approach to the guilt sufferer. He is especially concerned

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[78]Donald F. Krill, "Psychoanalysis, Mowrer, and the Existentialists," Pastoral Psychology, XVI (October 1965), 36.

[79]Matt. 3:8.

with the person who has been assured of the forgiveness of sin via the spoken absolution and the sacraments of Baptism and the Lord's Supper, and who finds reassurance only momentarily. He goes away from the pastor's office rejoicing after having been pronounced forgiven, but soon that good feeling wears off and the guilt feelings return. What is the real problem in such a case? Belgum comments,

> forgiveness . . . is not . . . an end in itself. It is provided by others, by God and neighbor. It is a condition and it is a means. If forgiveness is symbolized at all in the Office of the Keys, it would be the turning of the key in the lock. But the sole purpose of turning a key in a lock is to unlock the door and enable one to go into the next room, i. e. to pass out of bondage into freedom. It is not enough to be stuck or fixated in a key-turning syndrome. The goal is not forgiveness, but the restored fellowship with God and neighbor and self for which forgiveness paves the way. And fellowship involves the willingness of both parties.[80]

If there is to be a true restoration to community, both fellowmen and the forgiven sinner will need to act. God's act in Christ can only take on real meaning as it becomes a part of relationship with others. The counselee experiences the forgiveness of others as with renewed commitment (or newborn faith, if it did not exist before) he lives out his vocation. He is committed to serve God through his fellowmen.[81] How can the pastor help to bring this about?

Here Belgum's suggestions are helpful.[82] See figure 1. The center circle represents the ego of the sinner. The outer circle symbolizes fellowmen. The ego has walled itself off in egocentric isolation by means of sin, pride, and hypocrisy. The Church works to bring the grace of God to

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[80] David Belgum, Guilt: Where Religion and Psychology Meet (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963), p. 25.

[81] Eph. 4; Rom. 12.

[82] Belgum, pp. 118-141.

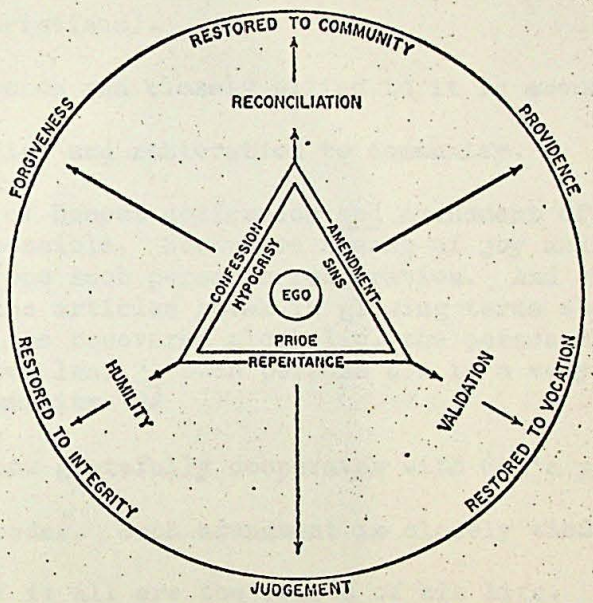

Figure 1. Essential Elements in a Functional Confessional.*

*David Belgum, Guilt: Where Religion and Psychology Meet, (c) 1963. Reprinted by permission of Prentice-Hall, Inc., Englewood Cliffs, New Jersey.

bear upon the sinner, calling him to repentance, confession, and amendment of life. When the sinner responds positively, the ego meets judgment with repentance and confesses its sin. This means humility and a restoration to integrity as to the ultimate destiny of the individual in relation to his responsibility to God and fellowmen. His confession is met with forgiveness by a representative of the community (pastor or fellow Christian or a group of Christians).

Following confession and closely allied to it is amendment. This makes for reconciliation and restoration to community.

> The combination of honest confession and amendment of life makes reconciliation possible. Scripture speaks of joy and singing among the angels over one such person's restoration. And even popular newspaper and magazine articles speak in glowing terms about the rehabilitated prisoner, the recovered alcoholic, the person who has openly "turned over a new leaf," Such persons are in a very real sense "restored to community."[83]

The forgiven sinner now gratefully cooperates with God's providence or plan for the social order. Such amendment is closely tied with his repentance. The results of it all are the fruits of his life. The whole process of repentance-confession-amendment is thus shown to be valid. With a thankful heart the forgiven person wants to go to work for God and fellowmen. He needs to be helped to a restoration to vocation, to the committed service to others. Involved in every phase of the restoration is God working through the means of grace, God's Word and the sacraments.[84]

Hypocrisy plays such a major part in the lives of men. Church members are especially susceptible.[85] The person caught up in sin may find in the

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[83] Belgum, pp. 121-122.

[84] Ibid., pp. 122-123.

[85] Ibid., pp. 6-16.

local congregation only a group of people who strive to give the outward appearance of holiness. He can detect no sense of sin on their part. It seems that he alone has fallen. Even after having confessed to the pastor this person may still fail to have any sense of community with the individual members, who may remain virtual strangers to one another (especially in large congregations). The acquaintances which are made and the relationships which are developed are often on an all too superficial level. How is one going to find a sense of community in such a congregation?

Both Mowrer[86] and Belgum[87] suggest making use of the method of Alcoholics Anonymous in which rehabilitated alcoholics give themselves into the service of helping other alcoholics work through and conquer their problems. Christians, as members of the Body of Christ, are to be continually ministering to one another.[88] Actually the Church used the method long before Alcoholics Anonymous, but that organization now serves as a reminder to the Church to make use of what it possesses. The Church ought to make greater use of restored individuals to assist the fallen in bearing their burdens and conquering their problems. This would be a change from the usual practice of giving the responsibility for working with other people to the "righteous" and the "respectable" members who often fail to understand the fallen. No one is in a better position to understand the problems of another than one who has been through the same agony himself and has conquered through Christ and the Christian community.

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[86] Mowrer, Crisis, p. 46.

[87] Belgum, p. 133.

[88] Rom. 12:4-21; 1 Cor. 12; Gal. 6:1-10; Eph. 4; James 5:16.

Such a plan could accomplish numerous objectives. (1) Both persons involved would gain a sense of community. They would know that they belonged to the "community of the concerned" rather than being fringe members or less of the "clique of the righteous." (2) The troubled would gain a sense of being sought. (3) The restored person would tend to lose himself in his vocation of service. (4) The whole process would work for the rehabilitation of both. The basic ideas of this plan appear to have great promise for aiding in the guiding of the fallen from isolation through the entire process of rehabilitation to full restoration to community. Such brother to brother ministry is the very relationship set forth in the New Testament.

The Biblical View of Death

In preparation for the consideration of pastoral care to the terminal patient the first portion of this chapter has been devoted to an overview of the problem of guilt. The latter portion of this chapter shall consist of an overview of man in the face of death from the Biblical and scientific viewpoints.

The connection between the fact of guilt (sin) and death is made very explicit in Scripture. "For the wages of sin is death."[89] "Sin when it is full-grown brings forth death."[90] Since all men have sinned, all must die.[91] Death makes no exceptions. As Pieper asserts, death cannot be attributed to man's nature. Man was not made to die, but to live. He

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[89] Rom. 6:23.

[90] James 1:15.

[91] Rom. 5:12.

has forfeited that eternal life by his sin and receives death as punishment.[92]

Death is far more than the termination of biological life in the human body. It has a threefold nature. Dogmaticians speak of spiritual death, temporal death, and eternal death. Of spiritual death Pieper says,

> It is the death of the soul, . . . i.e., the disruption of the communion of the soul with God. Only by the communion with God, for which it was created, does the soul live--by cleaving to, believing, trusting, and loving God. But sin breaks this communion abruptly.[93]

Scripture refers to death in this sense when Paul, the apostle, writes, "And you he made alive, when you were dead through the trespasses and sins in which you once walked . . . ."[94] Temporal death is death in the sense of which it is usually spoken, the departing of life from the human body.[95] The ultimate stage of death is eternal death.

> Spiritual and temporal death will be followed, unless the guilt of sin is removed from the heart and conscience by faith in Christ, by eternal death . . . . Eternal death is not the annihilation of man, the cessation of his existence, but his eternal existence in torments . . . .[96]

Man was created for life, for full communion with God, the giver of life. By man's rebellion he cut himself off from that life giving communion. The result is isolation and loneliness. Death in any form is not annihilation, but separation from the goodness of God.[97]

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[92] Pieper, III, 507-509.

[93] Pieper, I, 535,

[94] Eph. 2:1.

[95] Pieper, I, 536.

[96] Ibid. Cf. Matt. 25:46; 2 Thess. 1:19.

[97] Paul Meehl, et al., What, Then, Is Man? (St. Louis: Concordia Publishing House, 1958), p. 51.

The guilt of sin, the resulting separation from fellowship with God, and the threat of even greater separation from Him lie at the base of man's anxiety. Mehl and associates comment, "Anxiety, having its roots in the fact of man's alienation from his God, cannot be abstracted from an ethical and theological concern."[98] They later point out,

> Anxiety . . . . acts as a restriction upon every man in all his relationships. It begins at birth and stays with man in the hour of his death: man is anxious because he is afraid of his God. He needs to appeal to God for a clear conscience.[99]

Thus, the consideration of guilt plays a very important part in the pastor's ministry to the dying. Guilt, anxiety and death cannot be separated. They are the fruit of sin. Guilt, whether conscious or unconscious, plays a very major role in the life of every man. The dying person is no exception.

As mentioned earlier in this chapter, God's answer to man's need is Jesus Christ who has taken away the guilt and punishment of man's rebellion by bearing this load Himself. Since man has been declared righteous before God, the isolation has been broken. Man can once again live in full community with God.[100] Paul, the apostle, rejoices over death's defeat,

> "Death is swallowed up in victory."
> "O death, where is thy victory?
> O death, where is thy sting?"
> The sting of death is sin, and the
> power of sin is the law. But thanks
> be to God, who gives us the victory
> through our Lord Jesus Christ.[101]

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[98] Ibid., p. 54.

[99] Ibid., p. 56.

[100] Eph. 2.

[101] 1 Cor. 15:54-57.

Death, which is separation from the goodness of God, is no longer to be feared because Christ has broken that separation and made communion with the Creator a reality. In Christ death is not the end, a flight into non-being, or the beginning of eternal isolation. It is rather but a passage-way to full communion with God unhindered by the imperfections of this life.[102]

Man's Attitudes toward Death

Although man may think about death as being the end of his being, the fact is that he does not really think of himself as no longer existing. According to Freud,

> Our own death is indeed unimaginable, and whenever we make the attempt to imagine it we can perceive that we really survive as spectators . . . . (I)n the unconscious everyone of us is convinced of his own immortality.[103]

Beyond death is the great unknown. Although there are many who seek solace and meaning in religion, the majority prefer to resort to a denial of death, pretending that it is not there.[104] The attitude is that "life is preferable to whatever may follow it, and one should not look forward to death unless he is in great pain."[105] Society in general, including the medical profession, looks upon death as a dark symbol that ought not

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[102] 1 Thess. 4:13-15; Rev. 21:1-4.

[103] Sigmund Freud, "Thoughts for the Times on War and Death," Collected Papers, edited by Ernest Jones (London: Hogarth Press, Ltd., 1925), X, 304-305.

[104] Gregory Zilboorg, "Fear of Death," The Psychoanalytic Quarterly, XII (1943), 468.

[105] Barney G. Glaser and Anselm L. Strauss, Awareness of Dying (Chicago: Aldine Publishing Co., 1966), p. 3.

be stirred or touched.[106] Feifel reports regarding the opposition he faced while engaging in some pilot studies of the attitudes of patients toward dying,

> I remember reflecting how paradoxical it was that the problem was turning out to be not the patient, but the physician; and that the researchers, propelled most likely by the same anxieties regarding death that the physician felt, should end up on the opposite side of the fence.[107]

This "head-in-the-sand" attitude toward death contributes nothing toward realistic preparation for the inevitable event. As Jackson observes,

> In the Middle Ages when a plague came the people killed their dogs. This increased the danger of the plague, for they should have dealt with the rats rather than the dogs who helped to destroy the rats. The inability of modern man to develop a realistic attitude toward death is largely due to the fact that he seems unwilling to approach the problem directly. . . . When a society faces the implications of its lack of a philosophy of life and death, it is in a better position to evolve one. The inability to evolve a realistic view of life and death merely increases the potential for destructive behavior. In the individual it often takes the form of self-destruction. In society it may produce a generation that glorifies its capacity for self-destructive action at the same time that it ignores the meaning of this self-destructive potential. So we see the development of men with a diseased soul living a marginal existence resistant to truth about himself and his motives. He resists the responsibilities for true socialization, and in return becomes increasingly lonely and more deeply neurotic as he destroys the social roots of his emotional health. Unfortunately it appears that too often the intellectuals in society have been the leaders of the movement toward nihilism and away from the expression of the natural healthful feelings toward self and others. In place of rituals that give meaning to life, they institute the rituals that deny it. In place of values that enrich the life of the soul they practice the values that deny its worth.[108]

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[106] Herman Feifel, "The Function of Attitudes Toward Death," Death and Dying: Attitudes of Patient and Doctor (New York: Group for the Advancement of Psychiatry, 1965), p. 633.

[107] Ibid.

[108] Edgar N. Jackson, Understanding Grief (New York: Abingdon Press, 1957), pp. 56-57.

The pastor needs to be mindful that pressures, both subtle and overt, will be placed upon him to conform to this spirit of denial. Psychotherapists like Eissler are concerned about the unhealthy psychological results of such denial. He says, "Not much can be expected here from the churches."[109] He views the churches as having little more to offer than medieval imagery and the fear of death, and thus only increasing the need for mechanisms of denial.[110] The pastor should be comfortable in facing death realistically himself and in helping others to also meet it in the same way. The pastor who effectively communicates the comfort of the Gospel of Jesus Christ to the individual needs of the dying will not be encouraging denial and will be dispelling fear.

As psychoanalyst, Gregory Zilboorg, points out, "No one is free of the fear of death."[111] What is this fear? What is behind it? What causes it? Strange as it may seem since death is a universal phenomenon, it is very difficult to get a terminal patient to talk about his own feelings regarding his personal death, as Weisman and Hackett also testify. "Even when they couch their language in terms of death, psychiatric patients usually are referring to problems of living."[112] Fear of dying

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[109] K[urt] R. Eissler, The Psychiatrist and the Dying Patient (New York: International Universities Press, Inc., 1955), p. 294.

[110] Ibid.

[111] Zilboorg, p. 466.

[112] Avery D. Weisman and Thomas P. Hackett, "Predilection to Death: Death and Dying as a Psychiatric Problem," Psychosomatic Medicine, XXIII (May-June 1961), 233.

is not an evil in itself. It is essential to self-preservation, to the protection of life. This same fear, however, when it gets out of control, can kill. People have been known to die from no other apparent reason than the fear of death.[113]

Gardner Murphy has summarized man's usual attitudes toward death.[114] There are some people who believe that death is the end of all existence, and as far as can be determined show no evidence of any fear of death. No doubt the decline of the belief in an after-life, especially in a belief of hell has had its influence upon such fear.[115]

Man's fear of death is conditioned by his age. Eissler says,

> Man is born prone to death. Amazingly unprotected by nature against death, depending entirely upon the good will and wisdom of his environment, it is a marvel that he survives the initial phase of his existence at all. . . . (T)he whole of modern medicine was necessary in order to make this survival a probable event. . . . Dying is an easy matter, the rule, so to speak, and not the exception for the infant. The same is true of the final stage of senile dementia. Thus at the beginning and at the end of life--the end being defined here as a stage of exhaustion of life's potential--the organism bends itself toward death, surrendering without struggle.[116]

Psychiatrist Charles W. Wahl points out that thanatophobia (fear of death) may show itself in children as early as the third year. He says, "Its appearance seems to be contiguous to the development of concept formation

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[113]Margaretta K. Bowers, et al., Counseling the Dying (New York: Thomas Nelson and Sons, 1964), p. 38.

[114]Gardner Murphy, "Discussion," The Meaning of Death, edited by Herman Feifel (New York: McGraw-Hill Book Co., Inc., 1959), pp. 333-335. G. Murphy was director of research at the Menninger Foundation, Topeka, Kansas at the time of writing.

[115]Daniel Pickering Walker, The Decline of Hell (Chicago: University of Chicago Press, 1964), p. 262. Cf. entire book for fuller discussion of the subject.

[116]Eissler, p. 63.

and the formation of guilt, both of which greatly antedate the Oedipus complex."[117] Thus in the very young before their mental capacity has developed and again in the aged who have reached the stage of senility thanatophobia may be absent.[118]

The majority of people give evidence of the fear of death in one form or another as long as the time of death is still in the future. Weisman and Hackett reason that if man in his mind always survives as a spectator whenever he thinks of his own death, the fear of death must involve more than the fear of no longer existing.[119] "Despite the inevitability of death, fear of death is a phantasy of dread that has characteristics of a clinical phobia, rather than that of a fear-avoidance response."[120] They hold that "the inner core of the death phobia is a symbolic equivalent of such problems as abandonment, desertion, banishment, loneliness, dependency, pain, guilt, retaliation, and so forth."[121] An examination of the fears inseparably connected with thanatophobia seem to bear this out.

First, there is the fear of what is happening to the body and one's loss of control over it. A human being cannot help but identify with his body. What happens to his body truly happens to him. Closely associated with the fear of destruction of the body is fear of the indignity of going

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[117] Charles W. Wahl, "The Fear of Death," The Meaning of Death, edited by Herman Feifel (New York: McGraw-Hill Book Co., Inc., 1959), p. 21.

[118] Bowers, et al., p. 50.

[119] Weisman and Hackett, pp. 245-247.

[120] Ibid., p. 245.

[121] Ibid., pp. 246-247.

through the "messy" process of gradually losing control.[122]

Specific types of diseases are likely to bring their own variety of emotional outlook on death. The cancer patient feels the threat of loss of control over the unclean malignancy that is slowly consuming him.[123] He tends to be evasive and rejecting of his illness. Physician Arnold Hutschnecker found that most cancer patients avoid asking the doctor directly, "Do I have cancer?"[124] Those who die suddenly, as for instance while hemorrhaging, may show terror right up to the moment of death.[125]

The second type of fear is the fear of isolation, of being alone. Psychiatrist Janice Norton reports the case of a dying patient who was afraid of dying because she "knew no one there."[126] Irwin Greenberg, a psychiatrist, makes reference to basic death anxiety as being really separation anxiety.[127] Feder reports that isolation and the threat of being alone is a greater threat than death itself.[128] The patient is leaving behind all his earthly ties, the only real physical fellowship he has ever known. This severing of relationships amounts to a real bereavement

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[122]Bowers, et al., pp. 19,37.

[123]Samuel L. Feder, "Attitudes of Patients with Advanced Malignancy," Death and Dying: Attitudes of Patient and Doctor (New York: Group for the Advancement of Psychiatry, 1965), p. 617. S. L. Feder is a psychiatrist.

[124]Arnold A. Hutschnecker, "Personality Factors in Dying Patients," The Meaning of Death, edited by Herman Feifel (New York: McGraw-Hill Book Co., Inc., 1959), p. 239.

[125]Bowers, et al., p. 18.

[126]Janice Norton, "Treatment of a Dying Patient," The Psychoanalytic Study of the Child (New York: International Universities Press, Inc., 1963), XVIII, 552.

[127]Irwin M. Greenberg, "Studies on Attitudes Toward Death," Death and Dying: Attitudes of Patient and Doctor (New York: Group for the Advancement of Psychiatry, 1965), p. 629.

[128]Feder, pp. 615, 618.

experience in the dying person.[129]

The third kind of fear is the fear of the unknown. An unknown, untried experience always arouses a certain amount of anxiety. Death is no exception, especially since it seems so final. Having never died before, the patient is afraid.[130]

Fourthly, men fear death because they fear punishment.[131] As was mentioned above, Wahl sees a connection between the time when a child first shows a fear of death and the evidence of the formation of guilt feelings.[132] Many people have a fear of either temporary or permanent punishment after death. Guilt feelings and the fear of death are closely connected. Scripture makes the connection inseparable.[133]

The fifth type of fear is the fear of what may happen to the patient's family or other dependents.[134] Feifel also reports having observed this kind of fear.[135]

Finally there is the fear of failure. Man bases his hope on the future. There are always those unfulfilled responsibilities he hopes to fulfill, certain projects he wants to undertake, certain goals he hopes to reach. The terminal patient must face the fact that his time on earth is almost over. In all probability, he is going to have to leave many of

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[129] Bowers, et al., pp. 105-106.

[130] Norton, p. 555.

[131] Murphy, p. 334.

[132] Wahl, p. 21.

[133] James 1:15.

[134] Murphy, p. 334.

[135] Herman Feifel, "Attitudes toward Death in Some Normal and Mentally Ill Populations," The Meaning of Death, edited by Herman Feifel (New York: McGraw-Hill Book Co., 1959), p. 121.

these goals unfulfilled, these tasks unfinished. He fears that he has failed to fulfill his responsibilities. He fears death because his work is not finished.[136]

The healthy man in the midst of life is likely to have a greater fear of death than the person who is dying. Hutschnecker says,

> we can say that the fear of death is present far more often with the living than with the dying. At a time when a man is strong and mighty, and by the law of averages, still far from his estimated end, he seems to fear death most. The fear of death that often afflicts man in his middle years is obviously the fear that his own impotence or frustrations may prevent him from making the mark he considers necessary to satisfy his own standards.[137]

Many fears regarding death are really of the dying process rather than of death itself.[138] Weisman and Hackett report that

> Condemned men have been known to attempt suicide in order to avert the process of dying, which is the period of waiting until the moment of execution. The temporal process of dying is evidently more fearsome than death itself.[139]

The fear of death, in many instances, may not be of death at all, but rather of the process leading up to it.

As has been pointed out, man's fear of death seems to be greatest when he contemplates his own death from a distance in time. Fear of death often vanishes when the patient actually has come to his dying moments.[140] The human body seems to prepare the mind so that when the time comes it is normal for men to have a positive motivation toward death.[141] Weisman and

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[136]Murphy, p. 335.

[137]Hutschnecker, p. 248.

[138]Feifel, Attitudes, p. 126.

[139]Weisman and Hackett, p. 244.

[140]Bowers, et al., p. 18.

[141]Daniel Cappon, "The Psychology of Dying," Pastoral Psychology, XII (February 1961), 42. The author is a professor of psychiatry.

Hackett note that panic is a rare occurrence among patients facing death.[142] In addition to the tendency of the human body to prepare the mind for death, it is also true that the hospital medical staff will often keep the patient heavily sedated with drugs as he nears death, thus preventing awareness of what is taking place.[143] Hutschnecker says,

> Whatever the cause of death in a patient may have been we can say that, by and large, the man or woman who is about to die has made peace with himself. He has fought out his battle with life in his own specific way before he is overcome by, or submits to, his fatal illness.[144]

The pastor should expect to find the patient manifesting his greatest fears and concerns about death during the earlier days or weeks of the terminal period rather than during the last few hours before death.

Attitudes toward death on the part of terminal patients which appear often enough to be classified are listed by Bowers and co-authors. They are the predilection to death, the escape from death, the appropriate death, the normal death, and the denial of death.[145]

Predilection to death patients described by Weisman and Hackett each correctly anticipated their own deaths. They calmly looked forward to the end of their earthly lives.[146] "Death held more appeal for these patients than did life because it promised either reunion with lost love, resolution of long conflict, or respite from anguish.[147]

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[142] Weisman and Hackett, p. 240.

[143] Glaser and Strauss, p. 40.

[144] Hutschnecker, p. 247.

[145] Bowers, et al., p. 41

[146] Weisman and Hackett, pp. 232-256.

[147] Ibid., p. 254.

For these patients death was more appropriate than life. Patients of this type normally show little or no depression and do not give evidence of any suicidal intention. In the cases described death resulted from natural causes.

Another common attitude toward death is the attempt to escape from it. This may be by means of magical thinking, suicide, stark terror or religious solace.[148]

When told that their disease will probably be terminal some patients seek escape in magical thinking. "Sometimes this is encouraged by the implication of miraculous qualities for religious rituals. At other times persons will be overwhelmed by the claims of religious sects who promise healing . . . ."[149] An example of such thinking in the area of medicine can be seen in the case of a physician facing death by cancer. Upon learning of his terminal condition he began taking a drug he knew to be absolutely valueless as a treatment for cancer. Hoping against hope, he resorted to the drug contrary to his better knowledge.[150] The patient begins "grasping at straws" and seeking help from sources he would otherwise consider quacks and frauds.

Some see suicide as the way out. The intentions of the suicide seem to be a paradox. "The suicide always appears to be denying subjective death, even in the act of inflicting objective death."[151] He is very often

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[148] Bowers, et al., p. 45.

[149] Ibid., p. 48.

[150] Leon Saul, "Reactions of a Man to Natural Death," Psychoanalytic Quarterly, XXVIII (1959), 384-385.

[151] Bowers, et al., p. 47.

trying to deal with guilt by punishing the offending portion of himself or by punishing society who will mourn his death. He desires to be master over his own death and to use it to his advantage. Death will not get him, he reasons, he will be the master of death.

When other methods fail, the patient may manifest stark terror, reacting like the body does in time of danger, mobilizing all forces for flight from death.

Many find escape from death in religion. Sociologist Bronislaw Malinowski felt that all religion springs from the need to control death or the events surrounding it.[152]

Are professing Christians less fearful of death than those who claim no religion? Psychiatrist Daniel Cappon conducted a survey at a general hospital in Toronto, Ontario in the fall of 1959 to seek out possible relationships between the state of fear of death and the state of faith in the patient. Patients surveyed were physically intact but fearful people. Included in the sample were a representative number of Christians and non-Christians. It included both Protestants and Roman Catholics.

> The question to be tentatively answered was: Is a manifest or latent and implied fear of death helped or even eliminated in people who profess a belief in God and/or in after-life and/or in resurrection of the body?[153]

The results according to Cappon,

> the strict statistical facts seemed to indicate that statements regarding fear of death were independent of statements of faith in God,

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[152]Bronislaw Malinowski, "Death and the Reintegration of the Group," Theories of Society, edited by Talcott Parsons, et al. (New York: The Free Press of Glencoe, 1962), II, 947.

[153]Cappon, p. 41.

> in after-life, or in resurrection of the body. Statements of fear of death were also statistically independent of type of religion or the lack of it, of age and of sex.[154]

It should be noted that, as far as can be determined from Cappon's report, "fear" and "faith" were determined simply by what the patients answered in response to the survey questions. Both fear and faith would become very nebulous.

Feifel has found that the religious person is often more fearful than the unbeliever.

> The religious person, when compared to the nonreligious individual, is personally more afraid of death. The nonreligious individual fears death because "my family may not be provided for," "I want to accomplish certain things yet," "I enjoy life and want to continue on." The emphasis is on fear of discontinuance of life on earth . . . rather than on what will happen after death. The stress for the religious person is twofold: concern with afterlife matters . . . as well as with cessation of present earthly experiences. . . . (E)ven the belief that one is going to heaven is not sufficient to do away with the personal fear of death in some religious persons. This finding . . . may well reflect a defensive use . . . of religion by some of our subjects.[155]

If one's religion is mere outward formality, or if one finds in religion a denunciation of his sins, but fails to find peace with God, it should not be surprising that such religion does not take away the fear of death. On the other hand, Christians tend to be more mindful of judgment and of the afterlife. The reality of life after death and eternal damnation adds a dimension ignored, rejected, or repressed in the unbeliever.

C. F. W. Walther, a nineteenth century Lutheran theologian, reminds pastors that it is to be expected that the great majority of Christians are afraid to die.

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[154] Ibid.

[155] Feifel, Attitudes, pp. 121-122.

> Many preachers picture the Christian as a person who does not fear death. That is a serious misrepresentation, because the great majority of Christians are afraid to die. If a Christian does not fear death and declares that he is ready to die at any time, God has bestowed a special grace upon him. Some have expressed this sentiment before their physician told them that they would not live another night, but after that they were seized with a terrible fear.[156]

As was pointed out earlier in this chapter, no man is free from sin. Guilt and fear are its by-products. Even believers who trust Christ for the forgiveness of their sin must constantly do battle with doubts and the temptation to sin.[157] Such doubts and fears are to be expected in the crisis of preparation for death.

Professionals from the fields of the behavioral sciences also speak favorably of the strength the sincerely religious person derives from his faith. Bowers and associates remark, "Possibly the easiest patient to work with in his ultimate crisis is the sincerely religious person who believes that 'the eternal God is a dwelling-place' (Deut. 33:27)."[158] Murphy also comments about the hope and the desire for death that has often been observed in dying Christians.[159] While magical thinking (including religion as a magic cure), suicide, and stark terror are unhealthy, unrealistic, and false attempts to escape from death, faith in Jesus Christ as Savior is a healthy and true means, in fact the only means of escape from death.[160]

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[156] C[arl] F. W. Walther, The Proper Distinction Between Law and Gospel, translated from the German by W. H. T. Dau (St. Louis: Concordia Publishing House, 1929), p. 313.

[157] Rom. 7:13-25.

[158] Bowers, et al., pp. 110-111.

[159] Murphy, pp. 335-336.

[160] John 14:6.

Whether or not the patient can view his coming death as being an appropriate one for him will effect his entire attitude toward it. The concept of an "appropriate death"

> is usually associated with a way of life. The captain who chooses to go down with his ship, the kamikaze pilot who rides his plane into its target, the philosopher who drinks the hemlock rather than compromise his way of life, the religious leader who accepts a cross rather than an altering of the values by which he lived, all share this idea of an appropriate death. In each case the feeling of the appropriate nature of the death objectively seems to rob death of its subjective terror.[161]

Weisman and Hackett, who are the primary source of this concept, comment,

> Quite apart from the process of dying, the concept of an appropriate death is consistent with the hypothesis that our attitude toward our own death is a phantasy of idealized survival in a condensed or disguised form.[162]

They sum up the concept in the following way,

> Our hypothesis is that, whatever its content, an appropriate death must satisfy four principal requirements: (1) conflict is reduced; (2) compatibility with the ego ideal is achieved; (3) continuity of important relationships is preserved or restored; (4) consummation of a wish is brought about.[163]

An appropriate death implies a sense of success on the part of the patient in forging a meaningful link between those who have come before him and those who shall follow after him. He feels he has satisfactorily fulfilled his responsibilities. He himself, or at least what he has accomplished will live on.

Another common attitude toward death, according to Bowers and associates, is the viewing of death as normal.

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[161] Bowers, et al., p. 48.

[162] Weisman and Hackett, p. 247.

[163] Ibid., p. 248.

> It may involve no specific morbid state, but rather be the end result of a gradual withering away of the vital forces until so little is left that life is no longer sustained. With many aged persons this may be the case. There is little struggle or alert consciousness, and the ebbing vitality flows out, so that the terminal event is quiet, often takes place in sleep, and without severe personal or social implications. Sometimes the patient when faced with medical intervention to prolong life will say "Please just let me go naturally."[164]

Unless the patient is unable to use his mind fully because of sedation, senility, or a state of unconsciousness, ordinarily a rather traumatic period of preparation takes place before the patient becomes so accepting of death.

Finally, there is the very common attitude of denial. Society and the professional groups who minister to the patient are usually very quick to support such an approach to death. This denial is often twofold. It consists of a denial of the reality of death. The patient wants everything to proceed as it had while he was still able to take an active part in it. He may, for instance, want to make plans for a future vacation trip with his family as though he would be around to accompany them. The second aspect of denial is the belief on the part of the patient that he is the exception and death will never get him. Since many people in the western world resort to a denial of death all of their lives, it is not surprising that many continue to cling to this unrealistic attitude even when they are at death's door.[165]

Death is viewed by theologians and professionals in the behavioral science fields as the key to the meaning of life. Scharlemann says of death, "life can be understood only if this greatest of all crises is taken

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[164] Bowers, et al., p. 50.

[165] Bowers, et al., pp. 50-51.

into full account."[166] Eissler says of the moment of death in relation to life, "On this moment of termination will depend the value and the meaning of the entire scale."[167] Feifel comments, "A person's thinking and behavior may be influenced more than we recognize by his views, hopes, and fears concerning the nature and meaning of death."[168] Man cannot live life to the fullest until he is willing to meet death at any time.[169] When the terminal patient is truly prepared to meet death he is also ready to meet life with renewed vitality. In most cases such a patient is then better prepared to live life to the fullest than ever before. Not all supposed terminal patients die when expected. Some recover to live for many years. Whether they live or whether they die, properly prepared patients are ready to live their remaining days to the fullest of their ability. Man's attitude toward death is highly important for life.

Attitudes of the Medical Profession toward Death and the Dying

Since the pastor will be working in close co-operation with the members of the medical profession as he ministers to the dying, it is important that he have some understanding of the usual attitudes of the profession regarding death.

No one is really prepared to minister to the dying unless he has made peace with his own death. Feifel, who has taught at the University of Southern California School of Medicine, says,

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[166] Scharlemann, p. 113.

[167] Eissler, p. 52.

[168] Feifel, Attitudes, p. 116.

[169] Feifel, Function, p. 639.

> But I would submit that some physicians often reject the dying patient because he reactivates or arouses their own fears about dying--that, in some, guilt feelings tied up with death wishes toward one's own parents may play a role, not to speak of the wounded narcissism of the physician, whose function it is to save life, when he is faced with a dying patient who represents a denial of his essential skills. I think it would prove interesting to pursue the relationship aspect of choice of occupation here--where the "saving of life" is paramount, with the personal attitudes concerning death in physicians. In truth, most healthy people feel anxious and guilty at seeing someone else die. Being faced directly with the existential fact of death seems to cast a blight on ego functioning.[170]

August Kasper, a psychiatrist who has also served as assistant clinical professor at the University of Southern California School of Medicine writes,

> The doctor should know more about dying and death than any other man. . . . Yet, I am not impressed with either the volume or profundity of medical thought concerning death or dying people. It is as if this one certainty of life were to be avoided not only by vigorous positive thought and action, but also by giving it, as an event, no more attention than one gives to a period at the end of a moving, impressive novel. . . . Doctors might be presumed to have shown more interest in the event which they labor to forestall, or, in their hearts, to prevent. Such a presumption is not warranted by any obvious evidence in medical literature.[171]

Kasper blames society, which has in some ways made the physician a high priest in the cult of "health and beauty forever,"[172] and the medical schools,[173] as well as the physicians themselves for this attitude and approach to death. The literature on this topic can be summarized under the following five points already referred to by Feifel and Kasper. These

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[170] Feifel, Attitudes, p. 122.

[171] August M. Kasper, "The Doctor and Death," The Meaning of Death, edited by Herman Feifel (New York: McGraw-Hill Book Co., 1959), p. 261.

[172] Ibid., p. 260.

[173] Ibid., pp. 261-262.

factors are usually referred to when discussing the tendency on the part of many physicians to withdraw from meaningful and helpful communication with the dying.[174] (1) The presence of death is a threat arousing ambivalent feelings in most people. Doctors find these same responses arising within themselves. (2) The dying patient often arouses the physician's fears regarding his own death.[175] (3) The dying patient may arouse within the physician guilt about death wishes toward his parents or other significant people. (4) The dying patient may present such a threat in terms of wounded narcissism of the physician that he withdraws. It is the doctor's function and goal to save life. Every death among his patients represents failure. (5) There seems to be a tendency on the part of a sizable percentage of physicians to have an above average fear of death. It is thought that such fears may often be one of the dominant factors in leading the doctor to his choice of occupation.[176] Although most, if not all physicians have to deal with these threats surrounding death, many doctors are able to rise above them.

The pastor should be aware of the difficulties physicians face in working with the dying not so that he may assume a judgmental attitude against the medical profession, but rather that he might be more understanding of their problems and thus be better equipped to work with them. The pastor will also have to work through many of these same problems within himself before he can be most effective with the dying. The denial of death and the breakdown in communication that so often takes place

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[174] Bowers, et al., pp. 53-56.

[175] Feifel, Function, pp. 633-634.

[176] Ibid.

between the hospital staff and the dying patient[177] should serve to emphasize the importance of the pastor's work with the patient. The clergyman may be tempted at times to think that the contribution he can make to the patient's welfare is minor when compared to that of the medical staff. Yet, as the medical school instructors themselves point out, physicians are very often not trained to deal with anything beyond the biological aspects of dying. The patient has great emotional and spiritual needs. The pastor and the Christian community have the means to minister to them. As will become more evident later in this study, the major work of the pastor is to serve as the agent for breaking through the barriers that isolate the patient from God, from himself, and from his fellowmen. The pastor is concerned with restoring the patient to full fellowship and the maintenance of communication within that fellowship. He plays a very vital role on the healing team.

Awareness of Terminal Status

Recent surveys have revealed that a majority of physicians prefer not to tell the terminal patient that he is dying. Doctors usually support this position with the argument that telling the truth can only lead to discomfort and depression. It is commonly assumed that the human being is not equipped to cope with the knowledge that death is immanent.[178]

Some people do not want to know that they are going to die.[179] This

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[177] Greenberg, p. 629.

[178] Thomas P. Hackett and Avery D. Weisman, "The Treatment of the Dying," The Journal of Pastoral Care, XVIII (Summer 1964), 65.

[179] Carl J. Scherzer, Ministering to the Dying, Successful Pastoral Counseling Series, edited by Russell L. Dicks (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963), p. 38. The author is a hospital chaplain.

should not be surprising since it is the tendency of western society to deny death. Hope is very important in a patient's struggle for life. If all hope of recovery is removed by telling the patient he will die, death may only be hastened. Some patients, after learning of their terminal condition will attempt suicide. Others may become mentally ill.[180] Many who work continually with dying patients are convinced that a high percentage of patients have forebodings of death.[181] Most people, it is claimed will die as they lived and dramatic last minute changes, such as a religious conversion should not be expected. These factors would seem to make a good case for not telling the patient of his condition. There is little to gain and much risk to the patient involved when the news is broken to him.

The issue is not as simple as it may first seem. "Dying is lonely, and closeness and warmth are the only remedies."[182] Many patients suspect that they are dying without being told. Beside the fact that many patients seem to have a premonition of death, observation and common sense will cause others to suspect the truth. The change in attitude and approach on the part of hospital staff and family, plus changes in schedule and hospital routine often give away the secret to the patient. Prolonged illness without noticeable improvement is a sign of impending death that is difficult to discount. The patient who really wants to know his condition is likely to suspect that he is terminal. His suspicions are only

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[180] Glaser and Strauss, p. 120.

[181] Cappon, pp. 37-38.

[182] Hackett and Weisman, Treatment, p. 68.

going to be increased when he notices that he cannot get a direct answer from anyone when he asks about his condition. The quick assurances he receives will not dispel his anxiety.[183]

Hypocrisy in human relationships always erects barriers, isolates and cuts off genuine communication. An individual may succeed for a time in living a lie in relation to another, but it is very unlikely that numerous individuals can agree to do this successfully. There are always going to be those on the hospital staff or in the patient's family who cannot present a convincing "front." Such hypocrisy will serve to cut off any meaningful conversation about the subject that is uppermost in his mind, that the indications are that he is going to die. The patient may get the feeling that he is alone in his struggle with death. Everyone else, though they betray the fact that they are hiding knowledge regarding his terminal condition from him, is acting as if death were nonexistent.[184] Illness tends to be a frightening and lonely experience. The patient must leave his home and be subject to institutional routine of a hospital where, of necessity, he becomes only one of many nameless sick persons. Much of his individuality, privacy, and dignity must give way to the common good. A sharing, trusting relationship between patient, staff, and especially his family can do much to make the ordeal easier. When it appears that death is "at the door," such support becomes more important and necessary than ever before. The refusal of medical staff, family and friends to openly share their knowledge that death is "right

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[183] Glaser and Strauss, pp. 47-63.

[184] Ibid., pp. 50-53.

around the corner" with the patient, may even hasten the patient's death.[185] Refusal to tell is supposedly for the patient's benefit, but it appears likely that it is often harmful.

The argument that telling the patient of his impending death will result in depression ignores the fact that, normally, depression is but the first stage in a generalized response which moves from depression to doing something about the terminal situation. The result may be either acceptance or denial. If it is acceptance it will probably lead to active or passive preparation for death, or to fighting the illness. There is, of course, always the danger that some patients may not move beyond the first stage. This is abnormal and if properly dealt with can usually be avoided.[186]

What should a pastor do when faced with a situation where the patient is not to be told he is terminal? He will be concerned that the patient be helped to make the best use of the time remaining to him to prepare for death. He will want to grant opportunity for confession and the sacraments. Having dealt with bereavement, he will know the importance of granting the family the opportunity to openly take leave of the patient.[187] He will be concerned about removing any barrier to full community between the patient, God and fellowmen. Anything that interrupts that fellowship and isolates the patient must be resisted.

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[185] Bowers, et al., p. 74.

[186] Glaser and Strauss, pp. 121-125.

[187] Ibid., p. 184.

It should be remembered that the dying person is a dying individual. The emphasis should not be on the "dying," but on the individual. This individual has never died before.[188] He has a right to manage his own dying.[189] "(T)here is no such thing as the way people in general feel about anything."[190] If a person chooses to use denial instead of facing death directly, trying to force an awareness of his terminal situation will be of little value. As Feder points out, there are some people "who will hear only what they want to hear."[191] On the other hand, if a person wants to know whether he is considered terminal or not, he will ask.

When it is decided because of a patient's psychological condition, or because of other valid reasons, that a patient should not be told, the pastor's ministry need not be hindered by such a situation. The proclamation of sin and grace prepares a man for death as well as for life. Even though the pastor ministers to the patient as if he were going to recover, he can at the same time be preparing him to die.[192] This is, in reality, what a faithful pastor does continually in his sermons.

Chaplain Granger E. Westberg has set down some principles which appear to be sound, for use by the pastor who is ministering to the terminal patient. (1) Treat each patient as an individual. Whether or not his

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[188] Barrie J. Shepherd, "Ministering to the Dying Person," The Pastoral Counselor, IV (Fall 1966), 16. The author is a campus pastor.

[189] Glaser and Strauss, p. 135.

[190] Howard J. Clinebell, Jr., Basic Types of Pastoral Counseling (Nashville: Abingdon Press, 1966), p. 61. The author is a professor of pastoral counseling.

[191] Feder, p. 620.

[192] Arthur G. Elcombe, Granger E. Westberg, et al., "Consultation Clinic: Fatal Illness," Pastoral Psychology, VI (February 1955), 42.

terminal condition should be discussed openly with him will depend upon his own unique situation and personality. Past experience with this person can be a helpful guide. (2) Discuss the religious and psychological implications of facing the future realistically with responsible members of the patient's family. (3) If the pastor is convinced that it would be best for the patient to openly face the reality of probable death, he ought to discuss the matter with the patient's doctor. It is the responsibility of doctor and family to make the final decision regarding making the patient aware. If the religious and psychological reasons for telling the patient appear to outweigh the medical reasons for not doing so, the doctor will probably understand and act accordingly. (4) If all agree that the patient should be told, there should be no formal announcement. The information should be given out gradually as the patient asks for it.[193] How one tells and the way he goes about it, is often more important than what one tells.[194]

The Needs of the Terminal Patient

The needs of the dying can be summed up under three main headings. (1) He needs to see meaning in life and death, and to understand where he fits into the picture. (2) He needs to have a feeling of usefulness and to know that he has fulfilled his responsibilities. (3) He needs to see himself in continuity in community.[195]

Throughout his days man is continually asking about the purpose of

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[193] Ibid., p. 46.

[194] Glaser and Strauss, pp. 123-125. Cf. Feifel, Attitudes, p. 125.

[195] Bowers, et al., pp. 8, 11-12, 15, 148, 163.

life. This is especially the case in days of crisis, and reaches a climax in the final crisis of death.

> Man's ultimate challenge is in his death, whether it has meaning or whether it is the final triumph of meaninglessness. In pain, a person can endure much more if it has meaning to him. . . . The quest for meaning gives to pain and death a direction and purpose.[196]

The patient needs to know who he is in relation to the purpose of life. He needs to know that he is important as an individual and that he has a unique position in the midst of humanity.[197]

Man is so constituted that he has a need to be useful to others. The sick person often feels that he is no longer useful, in fact he is a burden to others. The patient needs to be helped to see that he can render service to others even from a hospital bed.[198] As he looks back over his life he is mindful of unfulfilled responsibilities and failures. He will need help in resolving his guilt.

The removal of guilt is necessary so that man might see himself in continuity in community. He needs to experience full fellowship with his fellowmen and with God. He needs to know that he will in some way continue to live on after death.[199]

Summary

Man, created by God to live in community with God and his fellowmen, has rebelled and has thus isolated himself from God and others. As a

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[196] Ibid., pp. 162-163.

[197] Ibid., p. 146.

[198] Murphy, p. 335.

[199] Bowers, et al., p. 15.

result of the use of the defense mechanisms within him, he has succeeded in walling off the true nature of his guilt (as fact, responsibility, and feeling) from his own consciousness. Man is thus even isolated from a true confrontation with himself. The fruit of man's rebellion is death, death of soul, body, and finally eternal separation from the goodness of God. God, Himself, has acted in the person of His Son, Jesus Christ to break through that isolation. Christ, who became man with man, has taken away the guilt and punishment of human rebellion by bearing this load Himself. Man has now been declared righteous before God. The isolation has been broken! Death has become a passageway to eternal community with God in the fullest sense.

The responsibility of the pastor and of the entire Christian Church is to be the instruments by which the community between God and man becomes a reality. They are to be busy applying the forgiveness in Christ to man's guilty consciences. This needs to be done, not only in word, but also in deed as Christians minister to one another as forgiven sinners to other forgiven sinners.

Guilt is basically the fear of isolation, of being separated from the love of God and fellowmen. Death represents the realization of that isolation. Guilt and death are inseparably united. Where death is a threat, guilt is in the background. The treatment of guilt is an integral part of any relevant ministry to the dying. Although death has lost its power for the Christian, it still means temporary isolation from loved ones left behind. The assurance of God's forgiveness and love is made real via the concern of others through close community with the terminal patient. The work of the pastor with the dying is that of rescue from isolation and restoration to full community. The next chapter deals with

the dynamics of such pastoral ministry.

CHAPTER III

THE PASTORAL APPROACH TO THE TERMINAL PATIENT

The Pastor Looks at Himself

As the pastor prepares to minister to the terminal patient, he does well to look first at himself. The type of pastoral care he gives will inevitably be affected by his own attitudes, personality, and training.

In preparing for work with the dying, should the pastor look to psychiatry or away from it? Shall he cooperate with them as part of the team serving the terminal patient, or should he go his own way? Theologians, William Clebsch and Charles Jaekle remark,

> If wisdom for a transitional period in pastoral care is to be gleaned from the great pastoral tradition, that wisdom might be summarized in a few maxims: (1) Beware of easy alliances with specific systems of academic psychology, for their days are usually short. (2) Remain open to the insights of various and even conflicting psychological theories, for man's capacity for trouble is complex, intricate, and inventive. (3) Receive readily the popular vocabulary that describes human troubles, usually in earthly and concrete fashion, for the pastoral task is to help troubled persons and not merely to teach them a new terminology for their troubles. (4) Finally, revere the historic functions of pastoral care with their traditional modes and means, realizing that, while the relative importance of these functions changes from one time and place to another, all . . . have endured many revolutions in psychology both academic and popular.[1]

The pastor's self-image should be molded by his own tradition of shepherding and not from the more recent model of the psychotherapist.[2] He should

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[1] William A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective (Englewood Cliffs, N.J.: Prentice-Hall, Inc., 1964), p. 79.

[2] Howard J. Clinebell, Basic Types of Pastoral Counseling (Nashville: Abingdon Press, 1966), p. 39.

stand solidly on the time tested pastoral care practices of the Christian Church.[3] From this vantage point he seriously studies the theories and methods advocated by behavioral science. He will not hesitate to adapt and synthesize that which is useful. He will avoid merely imitating the helping professions indiscriminately because they have come up with some widely acclaimed theory which promises great results.[4]

While holding to his function as pastor, the clergyman will not hesitate to work in full co-operation with behavioral science professionals (such as psychiatrists, psychologists, and social workers) as a member of the healing team. As they work together they will often have occasion to refer a patient to the specialist whose training best equips him to deal with the specific problem.

> With the religiously indoctrinated patient the psychiatrist must have the humility to know that his work may be to prepare the patient for confession to his pastor, or for sacramental confession to his priest. For the patient whose repeated confession has never been emotionally valid because of unconscious guilt, the grace of absolution which he first receives in sacramental confession after many hours of work with a therapist is often a dramatic and heart-warming experience.[5]

It is the mark of a professional to know when to refer. It is also the mark of a good pastor. If the pastor shows himself to be trained and able to handle the problems arising in the lives of the dying, the psychiatrists will gladly respect his skill and give place to him, as Eissler points out.

> In view of the difficulty of the task of attending psychiatrically the dying, and in view of our ignorance about the psychology of

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[3]The four historic functions of pastoral care in the Christian Church are healing, sustaining, guiding, and reconciling. Cf. Clebsch and Jaekle, pp. 8-9.

[4]Clebsch and Jaekle, pp. 74-75.

[5]Margaretta K. Bowers, et al., Counseling the Dying (New York: Thomas Nelson and Sons, 1964), p. 11.

> death, the psychiatrist will gladly give way to the man of God, whenever the latter can reduce mental pain on the deathbed. . . .[6]

The pastor should have enough confidence in his God-given abilities and in the power of the Spirit of God who works through the Gospel he proclaims to hold his head up high among the members of the healing team.[7] He should have enough humility to know the areas where he is deficient and his co-workers excel, and make wise referrals. He should cultivate good relationships with them so that all concerned will feel free to share their problems, voice their concerns, and pool their knowledge. In this area, as in all others of his ministry, the pastor will seek to continually grow in knowledge and skill.

The pastor who would be most effective in his ministry to the dying needs to have worked through his feelings about his own guilt and death. The pastor who lacks the conviction that his own sins are forgiven may be too quick to close off the patient's attempt at confession of guilt by easy reassurances that such sins are nothing to worry about because God has forgiven them. Thus the patient may be deprived of the opportunity for a much needed catharsis. He may not be given the chance to bring out what is really troubling him because the pastor, by his quick assurances, has indicated that such a confession is really too painful for him to hear.[8]

The same is true of the pastor and death. The dying person needs the support of courageous companions who are willing to go down to the yawning

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[6] K[urt] R. Eissler, The Psychiatrist and the Dying Patient (New York: International Universities, Inc., 1955), p. 119.

[7] Physicians included.

[8] Newman S. Cryer, Jr. and John Monroe Vayhinger, editors, Casebook in Pastoral Counseling (Nashville: Abingdon Press, 1962), pp. 59-63.

gateway of "the valley of the shadow of death" with unwavering confidence in the Lord of Life and the Master over death.[9] The pastor cannot die with the patient, but to the degree that he is not prepared to die, should his time come during those moments, he will be hindered in his effectiveness.[10] The pastor's own faith in Christ as his Savior (or his lack of faith) is likely to show itself in the face of death, more than at any other time. It is highly important that he be a man of faith, secure in that faith.[11]

For the pastor, who, because of unresolved feelings regarding guilt and death or for other reasons, is afraid to allow free and open communication between himself and the patient, there are many masks available as defenses. It is well for a pastor to examine himself periodically to see if he is allowing these masks to come between himself and the patient. Bowers and associates speak of "the mask of set-apartness," "the mask of ritualized action," "the mask of a special language," "the mask of special attire," and "the mask of business."[12] The titles are self-explanatory except, perhaps, for the latter. The mask of business refers to the wall erected by the pastor who always gives the patient the impression that he is so busy that he visits the dying only at the cost of great sacrifice to himself. The fact that he took the time to come should be so significant to the patient that what takes place in the course of the call is of minor importance.[13]

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[9] John 14:6.

[10] Bowers, et al., pp. 8, 52-53, 145.

[11] Ibid., pp. 24, 68-69, 86, 147.

[12] Ibid., pp. 67-68.

[13] Ibid., p. 68.

Ritual is often used by the pastor as a defense against any genuine encounter with the patient. Scripture readings and prayers are salutary and hold a highly important place in the pastor to patient relationship. All too often, however, they are used more for the benefit of the pastor (who wants to feel that he has fulfilled his duty) than for the patient. "Canned" devotions, prepared by the pastor in his study, may answer questions the patient is not asking and be directed to feelings which are not present. The pastor who relies solely on such devotions as the means of providing pastoral care for the sick may not be speaking to the patient's real needs at all.[14]

> The pastor who puts his people first and is not afraid of them or their feelings is the pastor who can accept himself. He moves easily through life with little need for masks or defenses. He is the one who can sit quietly by the bedside for hours without saying a word, for he realizes that there are times when the protection of many words is unnecessary. For these persons even the ritualized acts are not walls, but rather are the avenues of approach that may become the stepping stones into shared feelings and genuine communication.[15]

The pastor should keep the needs of the patient as the focal point of his ministry, and periodically examine his techniques lest his own needs displace those of his people as the most important center of his attention.[16] He will often be urging his people to re-examine their values and goals. He himself should do no less.[17]

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[14] Ibid., pp. 67-68, 146.

[15] Ibid., p. 69.

[16] J. Barrie Shepherd, "Ministering to the Dying Person," The Pastoral Counselor, IV (Fall 1966), 20.

[17] Bowers, et al., p. 89.

The Pastoral Counselor Deals with Guilt

Every parish pastor is confronted by guilt in people from various ages and walks of life. The basic principles employed with the dying will be the same as the ones used when dealing with guilt in any other person.

When dealing with guilt, what the pastor is himself matters far more than anything else. As God's representative, it will be his goal to personify the love of Christ in his whole demeanor toward the counselee (the person who seeks his help). Thundering the law at the counselee may result in a confession, but it is not likely to be a fruitful one in terms of getting at the real guilt and restoring the counselee to community.[18] The normal reaction to the accusation of the law is a strengthening of one's defenses. The result will be isolation with higher barricades than ever before.[19] Physician Paul Tournier says,

> One who, under reproof, immediately hauls down his flag and accepts the verdict without discussion appears as sick. . . . A too-ready repentance is not repentance, but surrender. His perpetual mea culpa will bear no living fruit. . . .[20]

The first step, then, will be to establish a relationship with the counselee. In many cases the relationship will have been built by previous contacts. In other cases no prior relationship will have existed. Whatever the

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[18] Paul E. Meehl, et al., What, Then, Is Man? (St. Louis: Concordia Publishing House, 1958), p. 283.

[19] Paul Tournier, Guilt and Grace (New York: Harper and Row, Publishers, 1962), pp. 80-87.

[20] Ibid., p. 81.

situation, the pastor will endeavor to put the counselee at ease. Theologian Halford Luccock tells of a man who was rescued at sea after many days spent in a life raft. Looking back on the episode the man remarked, "My only hope was that I knew I was being sought."[21] In the pastor's whole relationship with the counselee that sought-out feeling needs continual communication through word and deed. This means being a real flesh and blood person who is touched by the weaknesses and infirmities of men rather than appearing as a judge set apart from the mainstream of life. Bruder describes the successful relationship as "being able to allow a little of the loneliness which is me to meet the loneliness which is you."[22] Like the father of the prodigal son the pastor patiently "watches" for the counselee's return.[23]

The next step is a reliving of the past (catharsis) by the counselee. There will be many things bound up in this reliving. The presenting problem has very likely not been guilt, but some unhappy relationship. Interwoven with any problem of living will also be guilt. The pastor listens intently and goes down into this person's own private hell with him.[24] As guilty deeds are confessed, he shows that he still accepts the person, guilt and all. The confession can be hindered if the counselee in any way senses that he is being rejected because of what he says.[25] The person

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[21]Halford E. Luccock, Communicating the Gospel (New York: Harper and Brothers, Publishers, 1954), p. 90.

[22]Ernest E. Bruder, Ministering to Deeply Troubled People (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963), p. 60.

[23]Luke 15:11-32.

[24]Lewis J. Sherrill, Guilt and Redemption (Richmond, Va.: John Knox Press, 1963), p. 144.

[25]Meehl, et al., p. 283.

will very often test the pastor with a confession of lesser guilt to see how the pastor will react before he dares to unload his real burden. To be most helpful, the pastor should be accepting in his total bearing. Words of reassurance mean little if it is not apparent otherwise that these words are sincere. In cases where valid guilt is buried beneath many defenses, it may take numerous sessions before the basic guilt is reached.[26]

The pastor should in no way close off confession, thinking that the process is too painful for the counselee.[27] This is a necessary part of restoration to community. The pastor represents both God and fellowmen. By confession the penitent breaks out of isolation. He no longer hides his guilt. Perhaps he has wanted to do this for a long time but has been afraid to do so. As a result of the accepting relationship with the pastor the counselee finally is able to lay bare his true self in all its stark reality and nakedness. As Meehl and co-authors point out,

> Self-knowledge really exists only to the extent that one does, or is able to communicate it in speech to another person. The psychotherapeutic value of making specific or even detailed confessions is therefore very great.[28]

Through confession the counselee turns his back on hypocrisy.

In the process of reliving his problem, the counselee may, after many sessions, still not be willing to make a confession. He may see the

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[26]Some individuals may fail to find relief through confession and absolution because of unconscious guilt. If the pastor does not have enough training to deal with such repressed guilt, referral to a psychiatrist may be the solution. The person should be referred back to the pastor once the basic guilt is laid bare. Cf. Bowers, et al., p. 11.

[27]Cf. Cryer and Vayhinger, pp. 61, 63.

[28]Meehl, et al., p. 69.

responsibility for the problem lying on the shoulders of others. He may blame his environment or his own biological heritage for his troubles. Forces over which he has no control are responsible (determinism). He may continue keeping up his defenses and thus remain in isolation from community. Once the pastor has established a good relationship so that the counselee senses that his pastor is really along side of him in this problem as an accepting friend, and not towering above him as a judging father-figure, the pastor will be able to apply the law in a beneficial manner. Spiritual surgery is often necessary in the process of getting at the heart of the problem, getting down to the basic guilt.[29] The counselee must see himself as personally guilty. He must not be allowed to fall for the false comfort of determinism. This can only hinder any return to community and wholeness. It takes a skillful "surgeon" to know how to handle the knife of the law in a beneficial manner. Willingness to face up to guilt is, however, a necessary part of the process of restoration.[30] Without it healing cannot take place. The law still holds a very important place in pastoral counseling.

If, by the grace of God, the counselee does arrive at a true self-awareness and gets to see himself as he really is, he will experience what Tournier calls the "guilt of being."[31] He will see himself in relation to the holiness of God. He will see sin not as so many misdeeds and the

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[29]Rom. 8:20.

[30]O. Hobart Mowrer, The New Group Therapy (Princeton, N. J.: D. Van Nostrand Co., Inc., 1964), p. 86.

[31]Tournier, p. 116.

guilt attached to them, but rather as being in a state of sin and guilt (as fact and responsibility) before his Creator. The reality of his withdrawal into self-centered isolation breaks upon him and he lays it bare in confession.

Having reached the bottom, having acknowledged his own responsibility for his sin, the counselee is now ready to experience the Gospel. The pastor has in his whole bearing been living the Gospel throughout his relationship with the counselee. He will certainly now speak the word of forgiveness. Absolution should be spoken either formally or informally. The means of grace, the "spiritual healing par excellence"[32] should be fully employed.

The central message of the pastor's entire ministry is that of absolution. The Gospel of Jesus Christ which proclaims that the sins of every man are fully and freely forgiven is nothing else than absolution.[33] The steps outlined regarding the pastoral care of the guilty counselee prior to the assurance of the absolution are not to be understood to imply that the counselee must first make himself worthy of the absolution by the depth of his sorrow over sin or by the completeness of his confession. Walther says,

> We tell the poor sinner to come and receive absolution, to believe that he has been forgiven when the words are pronounced, even though he were coming to confession fresh from committing the most heinous crime. We tell him that God requires of him nothing but that he accept what Christ by His meritorious life, suffering, and death has procured for him.[34]

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[32] Meehl, et al., p. 73.

[33] C[arl] F. W. Walther, The Proper Distinction Between Law and Gospel, translated from the German by W. H. T. Dau (St. Louis: Concordia Publishing House, 1929), p. 174.

[34] Ibid.

The pastor could pronounce the absolution as soon as the counselee walked into his office. If the counselee believed the pastor's words he would have accepted God's forgiveness. Nothing more is required on the part of the counselee. As has been previously pointed out, however, guilt isolates a man. As long as one hides his sins from God and from his fellowmen whom he has wronged, he will not be able to accept forgiveness. Man is so constituted that as long as he is not willing to be honest with himself, with God, and with his neighbor concerning his guilt, he finds it impossible to accept God's invitation to return to full community.[35] The purpose of the pastoral care leading up to confession and absolution is to bring the counselee to a full realization of the depth of his sin (if he is not already aware of it) and to assist him in a return to integrity by no longer hiding his sin, but bringing it all out into the open. The counselee has not thereby been made worthy of absolution, but rather has been prepared for it. The focal point in this entire process is absolution and not the confession. Although confession will be present where there is genuine faith in Christ, absolution is not in any way dependent upon it, or conditioned by it.[36]

The Pastor and the Terminal Patient

Since death represents the realization of the isolation threatened by guilt, it is to be expected that guilt, even though it may be repressed, is lurking in the background of the personality of every terminal patient.

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[35] Prov. 28:13.

[36] Walther, pp. 174-175, 191-192.

This does not mean that every patient will express concern about guilt or that they are even consciously aware of any such feelings. It does mean, however, that guilt is always a factor to be reckoned with in the ministry to the dying.[37] Man fears meaninglessness and isolation. He does not want to be a nobody forever separated from all that has meaning. Meaninglessness, isolation, and guilt cannot be parted. They hover as haunting specters near every death bed. The assurance of full community with God, man, and self is the great need of every dying man as well as the living.[38]

The pastoral care of the dying differs from every other pastoral relationship. Death deprives the pastor of any further opportunity to continue this care with the patient at another time or place. Time is irrevocably limited! Both pastor and patient stand at the brink of the unknown. Even though a pastor be in a situation where he ministers to thousands of dying during his lifetime, death still remains "the brink of the unknown" to him. In all other counseling and pastoral care situations support or at least knowledge can be obtained from someone who has gone through the experience, but not so with death.[39]

Flight into the unknown is always threatening, but it can be terrifying and disastrous where there are no goals, and where no goal-directed person comes to the rescue. "(T)he likelihood of a psychotic break is greatly lessened if therapist and patient are in active encounter and

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[37] Supra, pp. 33-36.

[38] Supra, pp. 40-43, 59-60.

[39] Bowers, et al., p. 28.

both are clear about their goals."[40] The terminal period of life is no time to be "lost at sea." An attitude conveying meaningless cheer and conversation consisting of goalless banalities on the part of the pastor does little for the patient. He needs meaningful goals.

To be most effective, the pastor will get to know the patient as an individual.[41] The patient is not "a case," "a cancer patient," "a heart patient," or "a dying man" (pastors are duty-bound to visit the dying). He is John Doe who has lived a unique life and has never died before. He desires to be wanted and needed for what he is and who he is. Many parish pastors have an advantage over the members of other helping professions. These pastors have known their patient and the environmental influences surrounding him for many years. The disease of the patient and the hospital atmosphere should not serve to blot out the individuality of this person. Pastors may take a lesson from Weisman and Hackett, who say regarding psychiatrists,

> The object of psychiatric intervention is to help the dying patient preserve his identity and dignity as a unique individual, despite the disease, or, in some cases, because of it. . . . The psychiatrist always asks himself what the patient would be like without the disease, and then tries to produce a therapeutic dissociation of the patient's self-image, ideal and actual, from the disease itself; the alternative is to permit the personality to die before the patient does.[42]

The patient ought to feel that the pastor recognizes and treats him as an

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[40] Ibid., p. 90.

[41] Ibid., p. 96.

[42] Avery D. Weisman and Thomas P. Hackett, "Predilection to Death: Death and Dying as a Psychiatric Problem," Psychosomatic Medicine, XXIII (May-June 1961), 253.

individual different from all others.

All that has been said about the establishment of a relationship with a counselee in the usual counseling situation applies in the ministry to the terminal patient with the exception of death's unyielding time limit. The patient needs to have confidence that the pastor is a trusted friend who will go all the way to the very entrance of "the valley of the shadow" with him.[43] He needs to feel that the pastor will not be shocked by anything he might say or do, and that although the pastor does not approve of his misdeeds, the man of God never rejects him. The ideal pastor transmits that "sought-out feeling" to the dying.[44] A good relationship can prevent or overcome severe anxiety and depression.[45] This does not mean that depression and anxiety will be absent. Depression is a very normal reaction to the news that one is not expected to live.[46] Anxiety is a characteristic associated with some diseases such as those of the heart.[47] The pastor can be of great assistance to the patient in overcoming anxiety and depression, when in the face of these reactions he does not withdraw but stands by the person all the way.

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[43]The clergyman should always follow through after building up a relationship. Psychoanalyst Norton tells of a pastor who deserted a dying patient after building up a relationship of trust. Janice Norton, "Treatment of a Dying Patient," The Psychoanalytic Study of the Child (New York: International Universities Press, Inc., 1963), XVIII, 543-544.

[44]Supra, pp. 68-70.

[45]Norton, p. 558.

[46]Barney G. Glaser and Anselm L. Strauss, Awareness of Dying (Chicago: Aldine Publishing Company, 1966), p. 121.

[47]Richard K. Young and Albert L. Beiburg, Spiritual Therapy (New York: Harper and Brothers, Publishers, 1960), p. 33.

The meaning and the experience of death and the days prior to it differ according to the age of the person. Bowers and associates comment,

> Death is quite a different thing for the older person, who is easily aware of the completeness of his life, than for the young or middle-aged person, who is just as aware of the unfinished quality of his existence. The elderly person is often quite willing to go in peace and he resents interference with the process for which he has prepared himself. . . . The young person clings desperately to life, seeks all the aid he can find, and willingly sacrifices privacy and dignity to that end.[48]

Children often wonder if their illness has come as a punishment for something they have done. They need reassurance.[49]

In addition to having meaningful goals and being accepted as a unique individual, the patient needs to be dealt with as a part of his broader environment.[50] He is a product of a family and is an influence upon them. His rescue from isolation and the strengthening of community will be affected by them. Pastoral encounter with the family is important.[51]

The pastor should not be surprised if he encounters hostility on the part of the terminal patient. Shepherd says,

> resentment can occasionally find its expression in overt hostility to the minister as the representative of God who is taking away life. It is easy for a clergyman to appear to a dying person as a black, hovering vulture with only one interest, that of scavenging his soul. . . . (A)ll that one can do is accept the hostility, understand it and attempt to go beyond it in love to the point where

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[48] Bowers, et al., pp. 18-19.

[49] Ibid., p. 113.

[50] Martin H. Scharlemann, Healing and Redemption (St. Louis: Concordia Publishing House, 1965), p. 30.

[51] Bowers, et al., pp. 8, 69.

> the patient can recognize that, just as you do not label him as a dying person, so he does not have to label you as a "predatory clergyman."[52]

Thus the patient may transfer to the pastor feelings intended for God, for another pastor, or for clergymen in general.

The pastor can also expect to feel the anger of the dying because he belongs to the living who are going to continue to live after the patient dies. What Hackett and Weisman have to say about doctors can be applied to others who minister to the sick.

> Even when the relationship between doctor and dying patient has been established in truth and when a climate of open discussion prevails, it is a taxing and trying job to treat those about to die. The physician should be prepared to cope with an initial anger when the prognosis is disclosed, an anger directed toward him and toward medical science as well. He will have to adjust to a constant feeling of helplessness, unable to do anything but sit and listen and talk when there is something he can say. The physician must contend with the guilt evoked by the questioning glance of the dying, with the unspoken question, "Why should I die while you live?"[53]

Eissler[54] and Bowers[55] also speak of such ambivalent feelings between the living and the dying. Anger concerning the unfairness of early death is to be expected in the case of the young adult.[56]

Death means separation and, whether the pastor is dealing with loved ones left behind by one who has died or whether he is dealing with a person who is about to die, grief is a factor with which to reckon. Grief does not belong solely to those left behind.

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[52] Shepherd, p. 21.

[53] Thomas P. Hackett and Avery D. Weisman, "The Treatment of the Dying," The Journal of Pastoral Care, XVIII (Summer 1964), 69.

[54] Eissler, pp. 149-150.

[55] Bowers, et al., p. 116.

[56] Norton, p. 550.

> Therapeutically, one aspect of our work with the dying patient relates to his grief reaction. . . . While the relative of the dying man stands to lose the affection and companionship of a single loved one, the dying man stands to lose the affection and companionship of everyone. Also, he relinquishes his work, his possessions, and perhaps his chance to see his children grow up. Thus his grief is infinitely more severe and overwhelming. . . . Possibly those of us who counsel the dying patient may well take into consideration this grief reaction on the part of both the patient and his family. Then we can work with it in a manner similar to the way we work with the grief reaction in different circumstances.[57]

Eissler feels that dying would be easier if the terminal patient could go through a period of pre-mourning, breaking all earthly ties before death.

> Their plight would be eased if by pre-mourning, so to speak, they had divorced themselves from their love objects, accomplishing this aim shortly before their demise. Then at the time of dying they would have withdrawn their interest from the world and could accept death. . . .[58]

Eissler goes on to point out, however, that under normal circumstances this cannot be accomplished because the loved objects are still present and continue to be perceived by the senses.[59] The devoutly religious person has an advantage in this respect. Eissler continues,

> Devoutly religious people apparently can go through such sequences. They divorce themselves from all they love in this world and charge the image of God with the libido thus freed. In the moment of dying they have bid farewell to the world and are exclusively devoted to the expectancy of the new world, which they believe they are on the verge of entering.[60]

The patient who is aware that he is dying is also a person experiencing grief. While his situation is somewhat different from that of the living who shall remain to mourn his departure, his grief is no less real. The

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[57] Bowers, et al., pp. 105-106.

[58] Eissler, p. 181.

[59] Ibid.

[60] Ibid.

grieving person needs to arrive at a point where he again lives for the present and the future, rather than regressing to the past.[61] Since the dying Christian believes that there is life after death, he has an advantage in resolving his grief which the non-religious person does not possess.

When one is mourning the loss of a loved one grief work involves working through the memory of former relationships with the departed. This is especially the case where there was unresolved guilt arising out of a conflict in that relationship.[62] Death, being so final, has a way of calling man to account for repressed guilt and suppressed emotional responses.[63] The unfinished and the unresolved in life's relationships loom up to threaten the patient who realistically faces the "fractured relationship"[64] situation posed by death.

If grief is to be resolved in a healthy manner, it is important that the mourner not lose contact with reality. While the reality of death may result in a mourner's insensitivity to his surroundings, such a condition is no cause for alarm if it is only temporary. It is a very unhealthy situation when the mourner refuses over a prolonged period of time to face up to the reality of death.[65] Sooner or later the bereaved needs to face

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[61] Edgar N. Jackson, The Pastor and His People (Manhasset, N. Y.: Channel Press, Inc., 1963), p. 68.

[62] Edgar N. Jackson, Understanding Grief (New York: Abingdon Press, 1957), pp. 89-90.

[63] Ibid., p. 30.

[64] Jackson, Pastor, p. 68.

[65] Jackson, Understanding, p. 18.

reality and go through the work of mourning. If he does not he will bear the consequences in his personality.[66] Any retreat from reality is a retreat from one's surroundings and, therefore, also a retreat from community into isolation.

The same danger faces the dying person. He may face the reality of his coming death, make preparations to take leave of his beloved fellowmen and possessions, and work through unresolved guilt. On the other hand, he may choose to deny death, try to pretend that he shall go on living as usual, and refuse to recognize reality. When he does this contrary to better knowledge on his part, while both he and his family know he will probably die, he chooses isolation instead of community.

The pastor can learn much regarding work with the terminal patient by studying what the literature has to say about the basic principles underlying the care of the bereaved. Jackson has outlined three such principles.

> First, every effort must be made to keep . . . reality . . . in clear focus. . . . This is the source of much emotional illness, and must be met by deliberate efforts to reinforce the sense of reality.
>
> Second, expression of the deep feelings engendered by acute loss must be encouraged. The feelings are a definite part of the personality. They must be treated with respect and accepted for what they are. . . . This is the point where physical and emotional symptoms develop, for the effort to skirt around the feelings does not eradicate them, but makes it necessary for them to find expression in more indirect and less satisfactory ways. . . .
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> Third, efforts must be made to give the kind of group support that accepts reality and strongly affirms the value of life and the importance of tomorrow. . . .

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[66] Carroll A. Wise, Pastoral Counseling (New York: Harper and Brothers, Publishers, 1951), pp. 206-210.

> The importance of these three factors is that they relate to all levels of consciousness, and not to the conscious mind alone.[67]

It should be borne in mind that there are differences between the normal bereavement situation and that of the terminal patient who is aware of his imminent demise. The bereaved often have a life expectancy of many years and may be in good health. Any pathology occurring as a result of the patient's refusal to face reality will soon be terminated by death. The patient may already be so psychologically ill that he is unable to face reality. What has been said about treating each patient as a unique individual needs to be emphasized here. The goal is rescue from isolation and not the blind following of principles. If thoughtfully applied to the situation of the individual terminal patient, they can be valuable.

Normally the way to reality will be opened by an attitude on the part of the pastor that encourages the free expression of the patient's deep feelings. Such a pastor will serve as the "backboard" against which the patient can work out his new thoughts and feelings.[68]

Jackson's third point can be applied to the endeavor to strengthen the bonds of fellowship between the dying and those being left behind, those having preceded him in death whom he now anticipates joining, and God Himself. Jackson has also written,

> It is clear to the student of grief that this deep emotion grows from a fractured relationship. The pastoral role helps to support the person with fractured emotions until the healing powers within are able to set the person free of the past and prepare him for the future. This opportunity for quiet witness and continuous affirmation of the meaning of life reveals something not terminated by death; it is a generator of the values that are not touched by

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[67] Edgar N. Jackson, "Grief and Guilt," The Pastoral Counselor, I (Spring 1963), 37-38.

[68] Jackson, Understanding, p. 153.

> anything incident to the existence that is measured by space and time. The fractured relationships of time are healed in the values of the timeless, and the promise of a more abundant life in the spirit is not something for the future but is, rather, the achievement of the mourner who faces his grief and finds in it the power to become even now a Son of God, a joint heir with Christ.[69]

Again, Jackson is talking about the ministry to the bereaved who mourns a departed loved one. It can also be applied to the terminal patient preparing for death. The Christian has a future, an eternal one[70] as a joint heir with Christ.

Rescue from Isolation

As has been previously pointed out, the most important human element in pastoral care is what the pastor brings in himself. The Gospel which he brings is the power of God unto salvation.[71] The Word of God which he speaks is sharper than any two edged sword.[72] God's power does not depend upon man. The Gospel in the mouth of an unbeliever or insincere person can be the means of grace for some believing hearer.[73] All of this is true, and yet the faithful pastor will want to let the Word of God speak through him in its clearest tone. Only if he brings Christ within himself will he be able to do the best job in his pastoral care.[74] He should be

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[69] Jackson, Pastor, p. 68.

[70] Phil. 1:20-23.

[71] Rom. 1:16.

[72] Heb. 4:12.

[73] Phil. 1:12-18.

[74] Matt. 5:16.

a type of Christ incarnate so that Christ's concern for others radiates from him.[75]

It is this concern that seeks out the terminal patient and yet lets him retain his individuality that best characterizes the ministry to the dying. The concerned pastor is present to give his all to those who wish his support, but like his Lord, he will force himself on no one.

The needs of the patient and, therefore, the basic goals of the pastor's ministry to him were previously summarized.[76] They are (1) The need to see meaning in life and death; (2) The need to have a feeling of usefulness and to resolve his responsibilities and the guilt connected with them; (3) And finally, the need to see himself in continuity in community. These goals serve as a guide but also are not forced on the patient.

As Shepherd indicates, the pastor should not think that a successful pastoral ministry to the dying requires a formal confession of sin on the part of each patient.[77] Much guilt is resolved in an informal manner as the patient and pastor speak of the past and of Christ's forgiveness. The pastor also communicates forgiveness by his accepting manner.

W. E. Wygant, a protestant hospital chaplain, gives a good example of a ministry to the dying which served as the instrument of rescue from isolation.[78] The patient was Mrs. G., a 32 year old woman dying of cancer.

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[75] Gal. 2:20.

[76] Supra, p. 59.

[77] Shepherd, pp. 18-20.

[78] W. E. Wygant, Jr., "Dying, but not Alone,"; American Journal of Nursing, LXVII (March 1967), 574-577. See Appendix, infra, pp. 111-115.

Her husband was 35 years old. They had two children, Susan, six years old, and Charles, four. The physician had conferred with a consultant in psychomatic medicine and with the chaplain regarding the advisability of making the patient openly aware of her terminal condition. They made their decision as a team and the doctor tactfully informed the patient as gently as possible of her prognosis. By request of the doctor the chaplain was also present when the patient was told. At first she appeared quite capable of accepting her fate. She seemed to welcome knowing the tragic truth she had silently suspected for some time.

The experienced chaplain, knowing that adjusting to such a message is never easy, especially when the patient is in the prime of life and has a family, made himself available to the woman without forcing help upon her. He visited frequently. On the afternoon following the fateful revelation she was very depressed. She spoke only a few words, lay almost motionless, and wore a blank expression on her face. The chaplain recognized such depression as one of a number of normal reactions which can be expected when a person is told he will probably die of his disease. He proceeded to offer himself as a means of helping her through this stage of reaction.

His first step was to encourage her to use him as a sounding board for her emotions without in any way requiring this of her or invading her privacy. Since he had been present when the doctor told her, both were spared the pain of communicating the fact that they knew. The chaplain would be immediately associated with this knowledge. The chaplain was enough in control of his own emotions and had so resolved his feelings regarding his own death that he could be content to just sit silently beside her bed for long periods of time. When he felt it appropriate he said

simply, "It must hurt a great deal."[79] Though very hesitant at first, little by little she began to open up. Her speech was faltering and there were many periods of silence. The chaplain visited her frequently, never staying so long that he tired her, but staying long enough so that she knew he was ready to help her in any way he could.

In time she was able to verbalize such questions as, "Why should this happen to me? Why must I suffer like this? What have I ever done to deserve God's punishment?"[80] She was searching for the meaning of life and death. She was trying to understand where she fit into the picture. The relationship of her illness and probable death to her unfulfilled responsibilities troubled her. She talked about her children, her husband, her home, and what she wanted from life. As she did this she found the chaplain to be an accepting and understanding person who was truly interested in her welfare.

> As this young woman clarified her feelings and expressed them, she became calmer. It was then that we took up the task of searching together for understanding which would be meaningful to her. She got one of her first glimpses of understanding when she stated that somehow, even though she had no better explanation for her condition than she had had before, she felt better because she could talk about her fear, her anger, and her feelings of resentment. I asked if she could explain this. She thought for a long moment and said, in a tone close to amazement, "I think it's because I'm not alone. It seemed so awful, like a pit with no bottom to it, and there was only me. It's still awful, but the pit isn't so deep, and I do not feel so alone."[81]

She was passing from the isolation of depression into sharing community with a pastor, who representing both God and man, accepted her.

Gradually she began to see that her coming death was something that

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[79] Ibid., p. 574.

[80] Ibid., p. 575.

[81] Ibid.

was very important. It was important "because someone else thought it was important, and proved it by being with her."[82] The realization that she was important to the chaplain and that her death was important led to a discussion of values and of the position of God in her life.

> Anger toward God, she believed, was the root of her feeling. "What is your view of God? How do you conceive of Him?" I asked. In essence, she had difficulty reconciling a good God with her situation. Finally, she was able to separate, so to speak, God's will for her from the disease of cancer which had a very real, even though unknown, cause associated with this world. God came to be seen, not as a deity who was snatching her from her family, but one who, when disease stopped the body functions, would welcome her home. She then spoke about how angry she had been, and although she still did not want to die, it seemed better, somehow. I said that God must understand this, for we were all created by Him as human beings. "You know," she mused, "I think you are right."
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> At exactly that point, a prayer for absolution was offered and holy communion was celebrated.[83]

While this United Church of Christ chaplain might be faulted on theological grounds for his doctrine of absolution, for lack of any clear cut discussion of sin and grace, and the place of Christ in her life,[84] the general pattern of his ministry to her follows the principles set forth by the authorities. All that was discussed arose quite naturally out of the course of the relationship, assisted, of course, by the skill of the chaplain in helping her to vocalize her feelings. The chaplain did not take advantage of her condition by invading her privacy, threatening her with the law, forcing Bible readings and prayers upon her. He made contact with her at the point of conflict.[85] He ministered to her where it hurt. His

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[82] Ibid.

[83] Ibid.

[84] Mention is made of the risen Christ later in the article.

[85] James E. Sellers, The Outsider and the Word of God (Nashville: Abingdon Press, 1961), pp. 37, 85.

answers were not to nonexistent questions but to matters uppermost in her mind and vital to the resolving of her struggle.

> Books, scripture, and other such material are tools; they are things. They are important and valuable, but they also have an inherent danger. The danger is that a scripture passage as such does not help the patient; dealing with her feelings and using the tool to undergird or emphasize the feeling she has experienced, or identified, is what helps.[86]

Prayer, God's Word, and the sacraments should all be administered so that they make contact with the point of conflict. They should be perceived as God's answer to the patient's need and not as irrelevant ritual parroted by a "predatory clergyman."[87]

Summary

The pastor who wishes to be the most effective instrument for rescuing patients from isolation needs to first make peace within himself. He needs to strive for a working team relationship with the members of the other helping professions so that together they may do the best job in ministering to the whole person. He needs to have resolved his own guilt and to be prepared to meet his own death.

By being so accepting of the dying person that he no longer feels any need to hide his true feelings, the pastor makes a beginning at the attempt to lead the patient out of isolation. The patient perceives himself as being important as an individual to this pastor. The way is thus opened for the expression of numerous ambivalent feelings which the pastor accepts without condemnation.

The dying person is also a grieving person. He is in mourning over

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[86] Wygant, p. 577.

[87] Shepherd, p. 21.

the people and things he must leave behind. He is likely to feel guilt over unfulfilled responsibilities and unsatisfactory relationships. Guilt isolates. He may fear the unknown after death. Such fear also isolates. He needs help to express all of these fears and confess his guilt. The faithful pastor does not allow the patient to distort the reality of sin but helps him to view it for what it is in the light of God's law. If by God's grace he is successful, the patient is able to bring his sin which had kept him in isolation out into the open. Nothing is hidden. He is restored to integrity.[88] He is now ready to experience the absolution in word and deed. He is ready for full restoration to community. Such restoration is the subject of the next chapter.

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[88] Supra, p. 30, figure one.

CHAPTER IV

THE TERMINAL PATIENT IN COMMUNITY WITH GOD AND MAN

Forgiveness Means Restoration and Growth

The patient who has poured out his grief, his fears, and his guilt, who expresses faith in Christ as his only Savior is assured by the Christian pastor of the forgiveness of all of his sin. He is absolved. As a believing Christian he knows that the words spoken by the pastor are valid before God.[1] Being human he will need to experience the meaning of forgiveness from his fellowmen. God's act in Christ can only take on real meaning as it becomes a part of relationship with others.[2] The patient's guilt was incurred in relationship with others. The isolation that resulted from that guilt prevented and hindered fellowship with others. The undoing of these wrongs cannot take place in a vacuum apart from others.

It is always difficult for a person to admit that he has been wrong. As has been pointed out, the tendency on the part of society to deny the presence of death and to pretend that it does not exist, presents special difficulties for the dying. At the very time when the patient sorely needs the assurance and support of others, they tend to withdraw from genuine encounter with the issues of life and death which are so important to the patient. Even though the dying one is assured that the isolation resulting from his guilt is ended, the isolation imposed on him by others may appear

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[1] John 20:21-23.

[2] Supra, pp. 24-33.

to belie the words of forgiveness.

Death arouses so many feelings that when it is near isolation and separation between the living and the dying are common.[3] The case of Mrs. G. and her family, reported by Wygant, is a good example.[4] Like his dying wife, the husband was emotionally choked up with grief, anger, and guilt. Yet he found it impossible to share those feelings with her, even though she very much wanted to share. He had difficulty talking to his wife when he came to visit her. In reaction to this she experienced similar difficulty in talking to him. Wygant wrote, "She could talk to me, but not to him. And her husband could not talk to her."[5] They were helplessly isolated, desperately needing each other but unable to break down the barriers between them.

Man was made to continually grow. Biological changes take place within the body as long as there is life. Christianity teaches that man should continue to produce the fruits of faith as long as life is present.[6] Behavioral scientists point out the importance of hope and the prospect of future pleasure for emotional health.[7] Man has a need to constantly grow

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[3]Herman Feifel, "Attitudes toward Death in Some Normal and Mentally Ill Populations," The Meaning of Death, edited by Herman Feifel (New York: McGraw-Hill Book Co., 1959), pp. 115-116, 123.

[4]Supra, pp. 84-88. See Appendix, infra, pp. 111-115.

[5]W. E. Wygant, Jr., "Dying, but not Alone," American Journal of Nursing, LXVII (March 1967), 575.

[6]John 15:16; 2 Cor. 5:15; 1 Peter 2:2.

[7]K[urt] R. Eissler, The Psychiatrist and the Dying Patient (New York: International Universities Press, Inc., 1955), pp. 75, 77.

and to see the challenge of the future. This is as valid in the face of death as at any other time, for the meaning of death cannot be separated from the meaning of life.[8] The patient's real need is help in how to live and not how to die.[9] If he is prepared for life, he is also prepared for death. While those who see death as the end of existence must content themselves with living for the present with the future being limited to what memories and accomplishments shall live on after their death, the Christian has the obvious answer. He always has a promising future before him. He knows that he shall live forever with the Lord.[10] For that future he continually grows in anticipation of the joy to come.

The Pastor's Part in Restoration and Growth

The pastor best promotes restoration and growth by giving himself. Eissler advocates centering the treatment of the dying around what he calls the "gift situation."[11] This involves the actual giving of a much desired gift by the therapist to the patient.

> Then the gift will be experienced by the patient as the physician's giving him part of his own life, and the dreadful stigma of being selected for death while life continues outside will be converted into a dying together . . . greatly reducing the sting of death or transforming it into an impending rebirth which may convert the reality of death into its opposite.[12]

Norton feels that "the really crucial gift the therapist can give is that

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[8] Supra, pp. 50-51.

[9] Margaretta K. Bowers, et al., Counseling the Dying (New York: Thomas Nelson and Sons, 1964), p. 82.

[10] 1 Thess. 4:17.

[11] Eissler, p. 126.

[12] Ibid.

of himself as an available object."[13] No one is in a better position, among the members of the helping profession, to be this gift than the pastor. He represents both the concern of society and the concern of the Lord of life and death, the Good Shepherd who alone can accompany the dying through the "valley of the shadow" into life eternal.[14]

The Family Aids in Restoration and Growth

No other people are normally more important to the patient than his family. If they have the resources available within themselves, they can do more to restore and/or maintain the patient's sense of community than any other person or group. If they are unable to face death and choose to react by denying its threat, they can do more than anyone else to make the patient feel isolated and alone.

People who live together share guilt. Where there are human beings, there love does not exist without guilt. The threat of the separation of death brings this guilt to the foreground. Tournier says, "There is no life without conflict; no conflict without guilt."[15]

> Where any strong love relationship exists there are ambivalent feelings. One accepts the benefits and privileges of love gladly, but the obligations and responsibilities are not so easily borne. When the burdens outweigh the satisfactions things are said and done that are regrettable. When a terminal illness develops, the family is apt to be caught up in conflicting emotions and these show in relationship to the patient. . . . Ambivalent feelings always produce a certain amount of guilt. . . .[16]

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[13] Janice Norton, "Treatment of a Dying Patient," The Psychoanalytic Study of the Child (New York: International Universities Press, Inc., 1963), XVIII, 557.

[14] Ps. 23; John 10:1-18; 1 John 5:12.

[15] Paul Tournier, Guilt and Grace (New York: Harper and Row, Publishers, 1962), p. 75. Cf. p. 93.

[16] Bowers, et al., p. 57.

The ambivalent feelings will continue during the time of terminal illness. It is not unusual for family members to feel burdened down with responsibilities for the dying. He is a great inconvenience to them.[17] It is not even unusual for relatives to feel angry toward the patient for dying.[18]

On the other hand, the patient may feel hostile in response to unfair attitudes on the part of his family. He may feel that he is an unwanted burden on others in terms of time, care, and finances.[19] He may feel that his terminal condition has made him "untouchable."[20] He may worry about the welfare of his family.[21] If he is married, the possibility of his spouse remarrying may trouble him.[22]

The average person, having been subject to the general cultural retreat from the reality of death, will have to readjust his thinking and his feeling if he is going to be of any help to his dying relative.[23] The pastor can often be of service to the family in helping them to work through these difficulties. Shepherd says,

> In such a situation the task of the minister would be to work with both parties toward some form of honest reconciliation in order that the guilt, which might otherwise form a wall around the dying and act as a crippling influence on the lives of the survivors, can be resolved. It is possible, too, that in this way the patient will be

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[17] Newman S. Cryer, Jr. and John Monroe Vayhinger, editors, Casebook in Pastoral Counseling (Nashville: Abingdon Press, 1962), p. 59.

[18] Bowers, et al., p. 63.

[19] Cryer and Vayhinger, pp. 54-59.

[20] Bowers, et al., p. 106.

[21] Carl J. Scherzer, Ministering to the Dying, Successful Pastoral Counseling Series, edited by Russell L. Dicks (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963), p. 45.

[22] Norton, p. 551.

[23] Bowers, et al., p. 60.

> helped to a sense of completeness in his dying, a sense of having been able to tie off the loose ends and make his peace with the world.[24]

It is this need for communication, for "washing through" the past, for preparing for the separation of the future that makes a realistic facing of death so important for both family members and the patient. If this is not done the results could be a more difficult, lonely death for the patient and a much more guilt laden period of bereavement for the survivors.[25]

When the terminal illness continues over an extended period, when both patient and relatives are aware of the probability of death and openly face the situation realistically as a group, the experience is likely to be therapeutic for family and patient. The patient is made to feel free to express the thoughts which are uppermost in his mind without feeling the necessity to shield his relatives from death.[26] The relatives are able to work through much of their grief work while the patient is still alive. They can express their guilt feelings to the patient instead of trying to atone for them after his death by lavish funeral arrangements.[27] The dying and the living can thus meet death in community.[28]

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[24] J. Barrie Shepherd, "Ministering to the Dying Person," The Pastoral Counselor, IV (Fall 1966), 21.

[25] Bowers, et al., p. 62.

[26] Feifel, Attitudes, p. 123.

[27] Bowers, et al., p. 62.

[28] Ibid., p. 58. Cf. Barney G. Glaser and Anselm L. Strauss, Awareness of Dying (Chicago: Aldine Publishing Co., 1966), p. 184.

The case of Mrs. G. and her family, reported by Wygant, illustrates the struggle which some families have to work through before they are able to confront their feelings surrounding death.[29] The patient's husband became so afraid of his own feelings of grief, fear, and anger, which he was unwilling to express in her presence, that for a time he found it impossible to visit his wife. Finally after a period of numerous counseling sessions he thought he could visit her if the chaplain accompanied him.

> We went to the wife's room together. They simply looked at each other without speaking. Finally I suggested, "You know, you two are already communicating your feelings to each other without saying a word. And you both think you know what the other feels, but you don't really. Wouldn't it be easier to know what each of you is thinking? You can check it out in words, you know."[30]

At this point husband and wife began to break through their isolation. "First, the young wife told her husband that she felt angry because she had to leave him. Then she admitted her fear, and he admitted his. Finally they cried together."[31] This family was so shackled by the course of denial they were trying to pursue that they were also isolating their children from much needed love. Six year old Susan finally confided in the chaplain. She said, "I don't have a mommy any more. . . . She went away and left us."[32] No adequate explanation had been given the children

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[29] Supra, pp. 84-88, 91. See Appendix, infra, pp. 111-115.

[30] Wygant, p. 576.

[31] Ibid.

[32] Ibid.

about the mother's absence from home. In the face of evasive answers, the children concluded that they had been deserted! This situation was also worked through by the chaplain with both parents and children. When an appropriate time came the children were brought to the hospital to see their mother. The mother took the children in her arms and hugged them. Both mother and father assured the children of their love. As the husband had feared, the experience was very exhausting for the mother. "But as the little girl walked out, holding my hand, she said, 'See, my mommy does love me and Charles.' I looked back and saw that Mrs. G.'s face was like the sun."[33] When the time came, the mother died a peaceful death in community with her family and with God.

The Church Aids in Restoration and Growth

The Christian is not only a member of his own family but of a much larger family, spanning the age of man's history since the beginning of time, including the living and the dead, connecting past, present and future. This family is the household of God, the Lord Jesus Christ being the most distinguished member of that group. Every Christian was at one time "separated," "alienated," "having no hope," "without God." Christ broke down "the dividing wall of hostility" that isolated man from himself, from fellowmen, and from God, that they might be one body with Him. Hostility has been brought to an end. This body "joined and knit together" "makes bodily growth and upbuilds itself in love."[34]

The local congregation is a part of this extended family. If it is functioning properly, by its very nature it puts forth every effort to

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[33] Ibid., p. 577.

[34] Eph. 2:11-22; 4:16.

promote restoration and growth.[35] A good church like a good marriage satisfies "heart-hungers."[36] Mutual edification and fraternal correction have been the principles of the Christian way of life both in the New Testament and in the Church Fathers. They have continued so down to the present time.[37]

Isolation and annihilation are foreign to the Church. The threat of such a condition coming upon them, however, is ever present with those who still live on earth. Loneliness and fear often beset the Christian but he knows that ultimately he shall triumph. Scharlemann says,

> Being in continuity with God's acts of redemption, man is in a position, in his whole being, to relate towards something beyond his death. He is able to have a history and so transcend the death of families and of nations.[38]

Every Christian looks to the resurrection from the dead,[39] and eternal life.[40] Although it is evident from the words they use to describe the cases that Weisman and Hackett look upon any survival after death as a myth, they do testify to the value of such a hope. "(T)he phantasied

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[35]Rom. 12:9-18; Gal. 6:1-2; I Thess. 5:11; James 5:14.

[36]Howard J. Clinebell, Jr., Mental Health Through Christian Community (New York: Abingdon Press, 1965), p. 25.

[37]John T. McNeill, A History of the Cure of Souls (New York: Harper and Brothers, Publishers, 1951), pp. 327-328.

[38]Martin H. Scharlemann, Healing and Redemption (St. Louis: Concordia Publishing House, 1965), p. 67.

[39]Phil. 3:11.

[40]Rev. 21.

survival provided enough incentive to make death worth dying for."[41] The dying can be encouraged by the thought of the community he shall enjoy after death with his Lord,[42] with his sainted loved ones who have preceded him in death, and with the famous men and women of faith from Biblical and church history.[43] Although death means temporary separation from the living, it also means community in perfect fulness in the Church Triumphant. Death does not mean isolation for those who are in Christ.

Every congregation would do well to examine its ministry periodically to see whether or not it is being truly a therapeutic community[44] to the sick and the dying in their midst. As Scharlemann observes,

> the very presence of illness provides the opportunity for corporate service. Sickness is not merely a negative force; it may be the means which God has chosen in a particular instance to help the patient on the one hand, and to present Christ-in-need to the congregation, on the other. When men and women offer their services to the sick in their midst, they are presenting their lives to Christ. They enter that wholeness, so to speak, into which they have been drawn by faith. Here is the fellowship of the body of Christ which is the means of loving one another and having all things, including sickness, in common. In their service to the sick, church members become little Christs; and we reach the remarkable conclusion that sick visitation is a joining in and a proclaiming of the visitation of love in Christ whereby we show we are all saved to a new life of union in the love of God.[45]

Structured as it is to deal with guilt, death, and isolation, the Church

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[41] Avery D. Weisman and Thomas P. Hackett, "Predilection to Death: Death and Dying as a Psychiatric Problem," Psychosomatic Medicine, XXIII (May-June 1961), 251.

[42] 1 Thess. 4:17.

[43] Weisman and Hackett, p. 252.

[44] Scharlemann, p. 100.

[45] Ibid., pp. 100-101.

is the community best equipped to deal with the spiritual and emotional needs of the dying.

Worship has always been present in the Church. It cannot be otherwise for without any relationship with God the Church could not be. "Worship . . . is the response of the creature to the Eternal."[46] Clinebell writes,

> God is best known through concrete personal life and through transactions of the spirit with the people around oneself, including those present symbolically and in memory. . . . Worship is relating. It is finding God in personal encounter. It is a return from the far country of estrangement. . . .[47]

Thus the worshiper has broken out of his shell. Worship diminishes narcissism. It gets one out of the center. God and others become the objects of our attention rather than ourselves.[48]

Worship makes for whole and integrated personalities. Clinebell says,

> Worship is integrating because it encourages persons to center down while looking up. . . . Centering down, finding oneself, taking a long look at one's life--these are healing experiences, particularly in the context of a unifying faith and an accepting fellowship.[49]

In worship, in communion with God, men can find their place in the pattern of the universe.

Occupying a very important part of Christian worship is God's message to man. For this message men look to the Bible where God speaks to life's problems. Jackson observes,

> The Bible makes available the wisdom of the past for the needs of the present. In language that has survived the test of time because it has said effectively what needed to be said to suffering and searching

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[46] Evelyn Underhill, Worship (New York: Harper and Row, Publishers, 1957), p. 3.

[47] Clinebell, p. 57.

[48] Ibid., pp. 67-68.

[49] Ibid., p. 60.

> humanity; it continues to speak to our age. . . . Here a sense of oneness with struggling, suffering humanity through the ages, not in futility and defeat, but rather in faith and the achievement of meaning and value, sustains life. The security of being part of something bigger and more permanent than the self is a foundation upon which shattered feelings can be rebuilt.[50]

Here in the Word of God man can find the meaning of life and death. Here the dying can find meaning for his suffering and strength to meet the trials of his terminal illness.[51]

The sacraments are also extremely important as vehicles of God's grace. Scharlemann writes,

> By Baptism the individual becomes a member of Christ's body. That is to say, he is joined to a therapeutic community in which the members both heal and receive healing by such tasks as carrying each other's burdens and interceding for each other at the throne of grace. At the same time, of course, Baptism draws the individual into the death and resurrection of Jesus Christ (Rom. 6:3-6), incorporating him into those acts of God which have nothing less than the redemption of the world in mind. Such a change in his relationship to the world around him helps him in overcoming the destructive effects that attend self-assertion and consequent isolation.[52]

Although Baptism is the sacrament by which a person is joined to God's kingdom, its significance is lifelong. Theologian John T. Mueller says,

> What, then, shall comfort us in the trials and troubles of our life on earth? Scripture points us again and again to Holy Baptism as the source of all consolation, since Holy Baptism is nothing else than the application of the Gospel of God's grace in Christ Jesus. . . . We may fail God, but God will never fail us. We may sin, but God's covenant, which He established with us in Holy Baptism, will never be broken on His part.[53]

During the days of terminal illness and in the hour of death the Christian

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[50] Edgar N. Jackson, Understanding Grief (New York: Abingdon Press, 1957), p. 117.

[51] Bowers, et al., pp. 22-25; Matt. 28:20; Heb. 13:5.

[52] Scharlemann, pp. 64-65.

[53] J[ohn] T. Mueller, "Holy Baptism," The Abiding Word, edited by Theodore Laetsch (St. Louis: Concordia Publishing House, 1955), II, 421.

is reminded by the remembrance of his baptism that he is one with God and the household of the redeemed.[54]

Holy Communion, unlike Baptism, is the sacrament for repeated administration to the same individual. It is rich in symbolism depicting the oneness of God with man, and man with his fellowmen. Of this sacrament Scharlemann writes,

> Holy Communion, like Baptism, is a healing sacrament. When the apostle Paul speaks of our partaking of the body and blood of the Lord (1 Cor. 10:16,17), he describes this action as a sharing with each other in these sacred mysteries. The stress of the term he uses (koinonia) is just as strong on the horizontal as on the vertical relationship created by the act of taking part in the Lord's Supper. It is here that men and women draw close together to each other in corporate action as they express their fellowship with the Head of that community of which they were made a part at Baptism. Those who gather at this table come together to heal each other in body and soul; for where there is love for one another, the sickening power of envy, hatred, and malice is broken.[55]

The dying communicant can find in the Sacrament a reminder of his oneness with the believers in his congregation. He is reminded of his unity with Christians of all ages who have partaken of the sacred elements since Christ first instituted this holy supper. This becomes all the more meaningful since he knows he shall soon join those who have gone before in death. Here in the Body and the Blood is the assurance of the forgiveness of sins. Here is remission for all his failures to fulfill his responsibilities in life. Here is rescue from isolation. Here is continuity in community.[56]

When used in a meaningful way to supplement and strengthen relationship rather than substitute for it, rituals and symbolism can be very

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[54] Paul Meehl, et al., What, Then, Is Man? (St. Louis: Concordia Publishing House, 1958), pp. 71-72.

[55] Scharlemann, pp. 65-66.

[56] Supra, p. 59.

valuable tools for ministry to the dying.[57] They speak to the unconscious as well as to the conscious levels of the patient's personality. Belgum writes,

> The power of symbols to evoke emotions and ideas is well known to every pastor who has ministered to a semiconscious patient lying motionless and apparently unreachable for days, and whose lips move or eyelids flicker at the confession of the Creed, the praying of the Lord's Prayer, or the pronouncement of the Benediction.[58]

Clebsch and Jaekle,[59] Clinebell,[60] and Scharlemann[61] also testify to the importance of symbols and rituals. Symbolic words and acts have a way of speaking to the whole man which spontaneous words seem impotent to accomplish. The rich symbolism of the Old Testament indicates its importance.[62]

The Christian congregation has the responsibility of prayer.[63] The dying should certainly be included, As Scharlemann notes,

> The prayers spoken for the sick in the public services of the people of God provide an opportunity and a way of naming the persons who are ill. Here all the members have the means of assuming the burdens of those who have become sick. The whole congregation joins in public intercession as well as in naming the sick in the private devotions carried on by the individual members or conducted in the respective families in the congregation.[64]

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[57] William Hulme, "Sacramental Therapy," Journal of Pastoral Care, V (Summer 1951), 28.

[58] David Belgum, The Church and Its Ministry (Englewood Cliffs, N. J.: Prentice-Hall, Inc., 1963), p. 23.

[59] William A. Clebsch and Charles R. Jaekle, Pastoral Care in Historical Perspective (Englewood Cliffs, N. J.: Prentice-Hall, 1964), p. 70.

[60] Clinebell, pp. 65-66, 75.

[61] Scharlemann, p. 90.

[62] Ex. 13:8-10; Lev. 23; Joshua 4:20-24; 22:26-28.

[63] 1 Tim. 2:1-2.

[64] Scharlemann, pp. 105-106.

If the terminal patient is made aware of these prayers, they will also serve to give him a sense of community with his congregation.

Although the local congregation has the means to stand by the lonely with the power of God which rescues from isolation, it often happens that Christians neglect what they have. Regarding the loss of fellowship in the institutionalized church, theologian Hulme writes,

> The original meaning of the Church is synonymous with this fellowship; in the Apostles' Creed the communion of saints is in apposition to the Holy Christian Church. The trouble with many churches today is that they have lost this fellowship; people can enter and leave and never be conscious of any communion of saints; the group spirit is gone. The bond of union symbolized by the Sacrament is an empty form in too many churches.
>
> What has happened to the churches has had its effect on the church member. Personality problems develop in the atmosphere of interpersonal isolation. Those who have these problems feel alone in the midst of people. This withdrawal into themselves is both a cause and effect of their problem. What they need is a sense of belonging--of feeling a part of the group. If they should experience the communion of saints their problem would be reduced.[65]

The congregation alert to the needs of its people will take steps to make certain that the sick are not neglected.[66] As Scharlemann says,

> Any visitation by elders or members of welfare committees may be undertaken as acts of the whole church. As Christ identifies Himself with the sick patient, so the church embodies Him in the visit of its members declaring the Word to each one who is ill.[67]

All of the means of grace, plus prayer, ritual and symbolism should be employed in this ministry.

Points to be considered might include the following items. (1) Use

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[65] Hulme, p. 26.

[66] James 5:14.

[67] Scharlemann, p. 103.

of the laying on of hands to symbolize God's healing power.[68] (2) Holy Communion brought from the altar to the sick following each congregational celebration accompanied by an elder or other congregation representative;[69] (3) Use of visiting committees previously trained in the art of ministering to the dying so that they may be most helpful to the patient;[70] (4) The development of appropriate liturgies and rituals to be used with the dying that would aid both the patient and those who call to break through the barriers of denial and guilt which serve to isolate the living from the dying.[71]

And Then for Work to do for Thee

He who has found that life's real meaning lies in service, service to God by serving his fellowmen, will want to devote his remaining days to that service. The writer to the Ephesians reminds Christians that, "we are His workmanship, created in Christ Jesus for good works, which God prepared beforehand that we should walk in them.[72] The Christian's spiritual and emotional growth is to continue until death. The terminal period does not call a halt to giving and usher in a period of only

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[68] James 5:14.

[69] Scharlemann, p. 66.

[70] Ibid., pp. 103-104

[71] Clebsch and Jaekle, pp. 71-73.

[72] Eph. 2:10.

receiving. Every individual has something of himself to give as long as there is life. Christ and the martyr, Stephen, are examples of this concern for others even until death.[73]

True repentance brings with it the resulting fruits.[74] Where sin has damaged relationships and harmed the fellowman, restitution will be made where ever possible.[75] Having been led back into community by the concern of the Church, the restored person will want to have opportunity to be a part of the "rescuing squad" of that fellowship. Until the individual again becomes an active part of the concerned community, the real purpose behind the act of forgiveness has not been accomplished.[76] The return to service completes the process of restoring the person isolated by guilt.[77]

The patient, who feels that he can render no service in his condition which may leave him physically helpless, can be reminded that as long as he is conscious there is opportunity for service. There is always the ministry of prayer.[78] The people around can be served by the attitude and reaction of the patient. Many a dying patient has been able to do more for the living by his quiet witness of faith, than they have been able to do for him.

> The person dying in faith who shares his faith and devotion with his family and his community performs a most meaningful emotional service. To die in faith is a witness of God's love which brings courage and hope to the whole community. Pope John was a recent example of this.

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[73] Luke 23:26-34; John 19:26-27; Acts 7:60.

[74] Matt. 3:8.

[75] Luke 19:8.

[76] 2 Cor. 5:15.

[77] Supra, p. 30, Figure 1.

[78] 1 Thess. 5:17; 1 Tim. 2:1-8.

> One of us knew a very simple, uneducated country Negro who accepted his death from cancer as an opportunity to bring God to his neighbors. To come upon him unaware and to participate in his prayer for the people around his bed was a deep and unforgettable experience. In dying in faith he brought new faith to all who knew him.[79]

Such a person dies in community.

Summary

Those who would be most effective in aiding in the restoration of the patient to community and in growth within that community will first resolve their own conflicts with guilt and death. Family members who work through their guilt and grief with the patient while he is still alive can be of the most assistance in helping him face death. The Church has all the resources necessary for dealing with death and overcoming it. The faithful employment of these means, by God's grace, can bring wholeness to the patient. The patient is helped to live a useful life until death takes him. Thus, family, friends, pastor and fellow Christians accompany the dying to the very "valley of the shadow." The patient goes this way still growing in his care for others. He leaves the present community and work for the eternal service in everlasting community with the Church Triumphant.

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[79] Bowers, et al., p. 156.

CHAPTER V

CONCLUSION

In Retrospect

God has made man for community, but man has chosen to rebel against his Creator. This rebellion has isolated man from himself, from fellowmen, and God. The final isolation is death, where man is forever separated from love. God has rescued man from this loveless isolation by sending His Son to be the holy, suffering substitute for mankind. Death has been deprived of its power. Temporal death still remains as a vestige of the former domination. The Christian does not need to fear it, for it is now the passageway to eternal community in perfect completeness.

Western society is caught up in a denial of death. Terminal patients, their families, the members of the medical staff, and pastors find themselves easily swept along by this trend. Since all men are guilty before God and death is the final culmination of guilty activities, denial of such a result is a tempting way of dealing with death. Denial only makes for higher barriers between the living and the dying. It increases isolation. While the dying, by biological process, is inclined to accept death, the living continue to shy away from it. Unless an effort is made to overcome it, a widening gulf in human relationship tends to come between them during the terminal period. Thus, the dying is left alone, even though he may be physically surrounded by people. Sensing this isolation, the patient often withdraws into himself.

The pastor can help the patient meet death by offering himself as a "sounding board" against which the dying may test out his feelings and be

aided to come out of isolation to face reality.

It is highly important that the pastor have previously resolved personal guilt and his feelings regarding his own death. All who work closely with the dying will be more effective if they have resolved these sensitive areas in their own lives.

Having been accepted as he is by Christ, the pastor shows Christ-like acceptance of the dying person. This acceptance should ideally be so unlimited that the patient feels no need to hide anything from his pastor.

The pastor remains open to all of the feelings of the patient, especially to the confession of guilt. When guilt does show itself, the pastor will help the person to feel free to bring it all out of isolation.

When guilt has been "washed through" by confession, and faith in Christ is indicated, the pastor will bring the absolution by word and sacrament.

The faithful pastor will also remain open to be an instrument by which the family of the dying might be aided in facing their own guilt and assisted in working through their feelings about the death of the patient. Having done this, they will be better equipped to be of service to him during his remaining days.

If it is true to its mission, all of the resources of the Church through Word and sacraments will be employed to the fullest extent in aiding the patient to restoration to fellowship and growth in community with God and man.

Being accompanied to death's door by his fellowmen, the dying patient learns to appreciate more fully the truth that God goes with him not only to the brink of death, but all the way. "Even though I walk through the valley of the shadow of death, I fear no evil; for thou art with me; thy

rod and thy staff, they comfort me."[1] Christ, the Good Shepherd,[2] who has conquered death, supports the dying through his ordeal and leads him to fulness of joy where there are pleasures for evermore in the company of the redeemed.[3]

For Further Study

Further study should be given to dealing with unhealthy displaced and false guilt in the dying so that the pastor may be equipped to minister to these himself rather than referring them to others.

A more detailed appraisal of the group method employed by Alcoholics Anonymous and its usefulness in pastoral care should be undertaken.

Methods aiding in the development of better person to person ministry by parishioners within the congregation should be studied. Small cell groups that would minister to the sick and dying in their group could be the object of research. Another possibility is the use of group work techniques with terminal patients by pastors in large congregations with many terminal cases or by chaplains in hospital settings.

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[1] Ps. 23:4.

[2] John 10:1-18.

[3] Ps. 16:11.

APPENDIX:

Dying, but not alone

by

W. E. Wygant, Jr.[1]

Mrs. G. was a 32-year-old woman with a 35-year-old husband and two children--Susan, six years old, and Charles, four. The physician believed that she should be told about her condition, and conferred with the hospital consultant in psychosomatic medicine and with me, the hospital chaplain. We agreed that the patient should be told and that I should go with the doctor since I had visited this patient frequently. As gently as possible, the doctor told her the facts about her illness.

She seemed to accept the doctor's statements quite well. She asked for certain details about her condition, and these were given in direct terms. When we left, she thanked the doctor for telling her what she had silently suspected for some time.

Although she seemed to accept her situation and even seemed to welcome knowing the truth, I decided to return to her room in the afternoon. As I walked into the room I saw her lying on her right side, staring out of the window. She said, "Hello," but did not change her position. Her voice had an empty, hopeless ring to it and her expression was almost blank. I returned her greeting and drew up a chair.

Neither of us said anything for a long time. Finally, I said, "It must hurt a great deal." She made no immediate response, but eventually said, "Yes, it hurts." My response was, "Can you describe how it hurts, something of what you feel?" Still lying on her side and staring out the window, she tried. Her attempt was halting. It came in short, muddled sentences. She was confused about many things. She said she felt "frustrated." She was worried about her husband and their children. I told her that she need not face it alone if she wanted me to stand with her. I promised to come back the next day. She made no response and after a few moments, I left.

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There were many such sessions after that. Gradually, by testing them out on me over and over, she clarified her feelings. She came to ask, "Why should this happen to me? Why must I suffer like this? What have I

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[1]Reprinted with permission from the American Journal of Nursing, LXVII (March 1967), 574-577. Only selected excerpts are reprinted here.

ever done to deserve God's punishment?" In other sessions, she told me all the reasons she had to live: she loved her husband; she hungered to care for her children; and they had just bought a new home in which she had lived for one short month. All these things and more, caused her to desire life, and now she knew that her life was to be quite short. Why?

As this young woman clarified her feelings and expressed them, she became calmer. It was then that we took up the task of searching together for understanding which would be meaningful to her. She got one of her first glimpses of understanding when she stated that somehow, even though she had no better explanation for her condition than she had had before, she felt better because she could talk about her fear, her anger, and her feelings of resentment. I asked if she could explain this. She thought for a long moment and said, in a tone close to amazement, "I think it's because I'm not alone. It seemed so awful, like a pit with no bottom to it, and there was only me. It's still awful, but the pit isn't so deep, and I do not feel so alone."

. . . . . .

From this time on, she grew in an understanding of the importance of relationships. She first grasped the point that her approaching death was important because someone else thought it was important, and proved it by being with her. Several times as I entered her room for our talk, she said, "My, I'm important--you're so punctual." And I always said, "You <u>are</u> important." One day after just such an exchange, she added, with a new note in her voice, "Am I, really? Why?"

It was a good question. This led us to a search for values in life itself. She saw value in her life--we named many of them, one by one. She saw a value to her in her family, and she hoped she had been valuable to them. I pointed out that she could be valuable to them, right now, for the near future was going to be difficult for them. She soberly recognized this, but admitted that she felt she could not give them the help they needed. "I feel so awful myself," she said.

Anger toward God, she believed was the root of her feeling. "What is your view of God? How do you conceive of Him?" I asked. In essence, she had difficulty reconciling a good God with her situation. Finally, she was able to separate, so to speak, God's will for her from the disease of cancer which had a very real, even though unknown, cause associated with this world. God came to be seen, not as a deity who was snatching her from her family, but one who, when disease stopped the body functions, would welcome her home. She then spoke about how angry she had been, and although she still did not want to die, it seemed better, somehow. I said that God must understand this, for we were all created by Him as human beings. "You know," she mused, "I think you are right."

At exactly that point, a prayer for absolution was offered and holy communion was celebrated. She seemed to savor each word of the service and when it was over, she lay quietly for some time. Then she said softly, "I think I can sleep now." In like manner, other points were brought up and dealt with. In each instance, the goal was to help her gain experiential understanding and then to reenforce it with intellectual concepts, in

many cases underlining experience with symbols of the church which, in her case, were pregnant with meaning.

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During these sessions with the young wife, it became obvious that her husband, too, was having difficulty; and because he was troubled, his wife found his visits difficult. She could talk to me, but not to him. And her husband could not talk to her.

One day I met the husband as he came out of his wife's room, introduced myself, and suggested that we have coffee together. Over coffee he admitted how hard it was for him to visit his wife. "I have to force myself to come," he said. We discussed this, and I discovered that he had many of the same problems his wife had except that his problems were related to his feelings. He felt cheated by life as he thought of the prospect of losing his wife. He loved her and, of course, did not want her to die and leave him.

I suggested that he come to my office the next time he came to visit his wife and he said he would like to come before he went upstairs to his wife's room. This was the beginning of many visits during which we dealt with his feelings of anger and frustration, very much as we dealt with the young wife's reactions.

For a short time during these visits with me, he found it impossible to visit his wife. But I discussed this with her, and her husband sent her flowers and cards nearly every day. For both, it was a difficult time--a time they dealt with to the best of their ability.

In one session, the husband discussed a disturbing situation at home. The two children were being difficult and he was unable to cope with them. The climax came one day when he attempted to discipline Susan and found he could not do so. He suddenly realized that Susan resembled her mother a great deal. He dropped all intent to punish her and left the room. Thereafter, he felt uncomfortable whenever she was near.

He also found it increasingly difficult to deal with Charles. The children, thus, were being rejected by their father. I suggested that he bring the children to the hospital with him on the next visit. By this time, he was again visiting his wife and the children were left with me.

The children and I drew pictures and colored them together. Several times during these visits, Charles climbed into my lap and cuddled there. He showed every evidence of feeling lost and insecure. One day, as Susan sat at my desk coloring and as I held Charles on my lap, she said, "I don't have a mommy any more." When I asked what she meant, she replied, "She went away and left us." There was more talk and I discovered the little girl believed her mother had left home and had not returned because she did not love them. Susan was told that I had seen her mother, that she had often told me how much she loved both of them, but that she was sick and could not come home. We talked about this several times.

Here, a significant episode should be described. In the process of working through the husband's feelings concerning his wife's impending death, he had become so involved at one point that he found it impossible to visit his wife. As he became more comfortable with his feelings and his understanding of them, he believed he could visit her if I went along.

We went to the wife's room together. They simply looked at each other without speaking. Finally I suggested, "You know, you two are already communicating your feelings to each other without saying a word. And you both think you know what the other feels, but you don't really. Wouldn't it be easier to know what each of you is thinking? You can check it out in words, you know."

First, the young wife told her husband that she felt angry because she had to leave him. Then she admitted her fear, and he admitted his. Finally they cried together.

The husband then turned to me and they both apologized for their tears. I moved to the opposite side of the bed and took their hands in mine. "Doesn't this bother you?" the wife asked. I had asked them to be honest and open with themselves; I could not be less with them. "Of course it does," I said, "because I am human just as you are. But I am not afraid of your fear of death."

. . . . . .

In our individual sessions, and in some sessions with her husband present, the wife and I talked of many things. . . . We searched for scriptural insight; not just reading passages as panaceas for psychic pain, but searching the passages for meaning brought to the fore by our experience of relatedness together. Because of this experience of working through her feelings, she said one day, with a sigh, "You know, when Jesus said, 'Come unto me all ye who labor and are heavy laden and I will give you rest,' He gave me a great promise, because I know it's true--I feel better." We searched for other truths which her experience had verified for her. The concept of the risen Christ came to have much meaning for her, because in it she found that, even now, flat on her back and often in pain, she herself was not defeated. She had gone through a tremendous inner struggle with her own feelings and her relationship to her husband, and she had won. "Nothing," she said, "can ever really hurt me now--just as the resurrection experience teaches; only I can ever defeat me." She also marked the passage in her Bible, ". . . I am the resurrection, and the life: he that believeth in me, though he were dead, yet shall he live: and whosoever liveth and believeth in me shall never die . . . ."

. . . . . .

One day, the husband said he thought the children were feeling much better because he was feeling better; he could, therefore, more comfortably spend time with them and give them support. The wife said, "I wish I could see them. Do they know?" The husband looked to me for help. I pointed

out that few children of their ages understand the intellectual concept of death, but that the children certainly knew the meaning of a sense of loss because they were experiencing it.

This is why when the children and I talked, I did not mention death. Instead, I tried to deal with their feeling of loss, a feeling which was part of their experience.

The mother continued. "Could I see them?" she asked. Her husband demurred, feeling that it would be too difficult for her, but she insisted. Looking at me, she said, "I think I must try to help them if I can."

Arrangements were made with the nursing and hospital administrators for the children's visit. They stayed with their father and mother for about fifteen minutes. In that time, the mother was able to hug them and tell them she loved them. Their father was able to echo this.

The mother looked terribly tired after the children had gone. But as the little girl walked out, holding my hand, she said, "See, my mommy does love me and Charles." I looked back and saw that Mrs. G.'s face was like the sun.

That young mother died a peaceful death; she also left a beautiful legacy for her husband, for her children, and for me.

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