

# Pastoral Care Course

This course has been written for those involved in pastoral visiting and caring. It is based upon over 40 years of experience in pastoral ministry but also contains information distilled from research into advisory materials.

## PASTORAL CARE OF THE SICK

### **A. Biblical basis**

#### 1. The NT Teaching on the Body of Christ

**1 Corinthians 12:25-26** “...the members ... have the same care for one another. If one member suffers, all suffer together....”

**Note the important place of the congregation. It is to be a:**

- i. *Fellowship of Love*  
mutual concern leads to healing
- ii. *Fellowship of Worship*  
by word and sacrament we are brought into healing contact with God.
- iii. *Fellowship of Reconciliation*  
forgiveness restores to fellowship with God which is the goal of healing
- iv. *Fellowship of Prayer*  
prayer is a most potent healing force.

“The Church is not meant to be a body of healers but rather a healing body... it is the church not the individual which is the extension of the incarnation.”

Note these two important Bible verses:

#### **i. The Second Greatest Commandment**

Matthew 22:39 “You shall love your neighbour as yourself”

#### **ii. The Commission of Jesus**

Matthew 10:1, 8 “And he ..... gave them authority .... to heal every disease and every infirmity ..... Heal the sick, raise the dead, cleanse lepers, cast out demons ....”

### **B. The place of lay visitors**

The 1968 Lambeth Conference said, “The various patterns of ministry, ordained and lay are .... equal; we cannot rightly speak of an ‘inferior office’ if that office is where God wants his service to be.” The Biblical responsibility is laid on the *whole* church to be a caring community.

The local church leadership may recognise and officially commission lay visitors. In some dioceses lay pastoral visitors are trained and commissioned.

## **C. Unhelpful attitudes**

### **1. Superficiality**

Do not trot out religious clichés or texts.

### **2. “Professional” Approach**

The efficient “What can I do for you?” approach can be cold and off-putting. The sick person doesn’t always primarily want a problem solved or advice given.

### **3. Rushed Approach**

Some people breathlessly apologise they have only a few minutes. The sick person may insincerely reply that it doesn’t matter whilst being hurt. Incidentally, very sick people need to be spoken to slowly as mental alertness may be reduced.

### **4. Easily shocked Approach**

Don’t show any shock at what a sick person says, nor any revulsion at what you are told or see. Remember the patient is a *person*, a fellow human being.

*[Much of the following sections D-G refers mainly to HOSPITAL VISITING]*

## **D. Qualities required**

### **1. Humility**

You may feel very inadequate. So do the professionals at times.

“The pastor ... sits down beside the incurable to whom science can offer no alleviation or hope and whom medical treatment has to pass by, as beside one infinitely precious to God. He talks to the mentally sick although what he says does not seem to penetrate into his lonely crazed world. He prays beside the dying who lies in a coma and has already cast off the moorings of this world. If the Pastor proclaims a hope that is not of this life, he must often feel as ineffective as the disciples watching the crucified Saviour, powerless to remove him from the Cross. But still he stays. It is his vocation to stand by crucified humanity; he stays as he would at the foot of the Cross..... There is meaning in the Pastor’s presence, even though, from the scientific standpoint, he may have been regarded as useless.” (*Pastoral Care in a Changing World* by Erastus Evans)

In the 18<sup>th</sup> century William Law wrote: “When you visit the sick, or well awakened, or dully senseless, use no precontrived knowledge, or rules, how you are to proceed with them, but go as in obedience to God, as on his errand, and say only what the love of God and man suggests to your heart, without any anxiety about the success of it; that is God’s work. Only see that the love, the tenderness and patience of God towards sinners, be uppermost in all that you do to man. Think not that here severity and then tenderness is to be shewn; for nothing is to be shewn to man, but his want of God: nothing can show this so powerfully, so convincingly, as love.”

### **2. Warmth**

Accept the sick person just as he is with all his difficulties and problems. We should be “cheerful but not cheery, friendly but not patronising, pleasant but not boisterous, sympathetic but not pitying, interested but not curious.”

Archbishop William Temple translates “I am the good shepherd” as “I am the shepherd, the beautiful one” i.e. we should display *attractive* goodness.

A sense of humour is helpful if it is natural and spontaneous and not a cover-up of our insecurity.

A good prayer is: “Lord give me such a sense of your love that I will always appear joyful. But don’t let me become hearty and annoyingly bright when the people I’m with are miserable and want gentle and understanding love.”

Don’t try to get a sick person to “snap out of it” if they are depressed or anxious.

### 3. Sympathy

The key to pastoral visiting is “empathy” which means “the feeling of one personality into another until some state of identification is achieved.”

We may have to listen to tedious stories but must never show boredom.

Beware saying glibly “Yes, I understand, I’ve gone through it myself.”

We must become really involved with them.

Here are some helpful quotations from a Hospital Chaplain:

“We cannot pray for the sick behind locked doors. We must go out and share the often costly and painful experience of healing with them, confident that God goes with us and his healing power is sufficient to cover our deficiencies. We cannot save ourselves or others from the cost of healing; the way of Jesus was the way of sharing the experience with men and women, not of protecting them or himself from them. We must lose our lives if we would save them.”

“He will be sensitive to the hopes and fears of the patients, and it is important for him to know how to bear the pain and suffering of those he comes to tend. To feel what they feel is a very difficult exercise, but unless he becomes involved in their very predicament, their tensions and their anxieties, much of his work will remain only on the surface. If he is to help suffering people he must be prepared to suffer himself.

Dear Lord and Father of mankind  
Forgive our foolish ways.....  
Let sense be dumb, let flesh retire....  
Speak..... Speak ..... Speak  
O God, but how?  
Help me not to run away  
This time.  
Help me to feel, to share, to know  
Their pain and not my own.

Entering into the valley of the shadow with his patients, it is impossible for the chaplain not simply to go down hand in hand, but for both to walk through that same valley; then they will fear no evil, for God will be with them. Without this realisation the chaplain will either be forced to adopt a cold objective approach, remaining aloof and uninvolved, or become so immersed that he will be totally unable to deal with such situations. Unless he is at all times conscious of his own insufficiency for such a ministry or self-oblation he will soon falter and fail. He will be adequate only when he accepts his own inadequacy.”

*Pastoral Care in Hospitals* by Norman Autton

**“It is not so much a matter of knowing what to say or what to do, but how to feel alongside a sick brother at the bedside, how to feel with him and communicate this feeling to him.”**

*Pastoral Care in Hospitals* by Norman Autton

“The lay visitor tries to understand step by step along with his patient, sensing what he is feeling. His task is to climb into the private world of the patient, and look at the world through the

patient's eyes. In this way he will be ministering to the whole person, in the totality of his sickness, in the reality situation in which he finds himself."

We must not just respond to what the patient says but also discern the feelings which underlie what is said. Is there depression or fear behind talkativeness or bravado? The look in his eye can convey a great deal including tiredness or wanting to be left alone.

Don't be noisy in the presence of a sick person as they are often sensitive to noise. And don't talk about personal things loudly in a ward.

#### **4. Listening Ear**

Active listening, we have seen, involves understanding what the patient is saying and what he is feeling. We must allow him to say what to say in his own way and time.

Dietrich Bonhoeffer wrote, "Many people are looking for an ear that will listen. They do not find it among Christians because these Christians are talking when they should be listening. But he who can no longer listen to his brother no longer listens to God either: he will be doing nothing but prattle in the presence of God too."

Two principles should be borne in mind:

**Don't ask questions only requiring a "yes" or "no" answer.**

Do ask questions about the patient's *feelings*. i.e. "How are you feeling about having the operation tomorrow?"

#### **5. Confidence**

We need to be confident in order to inspire confidence. We must be in command of the situation otherwise we can transmit our anxieties. Hence we must personally come to terms with pain, suffering and death.

"He will sensitively feel the emotional pulse of the patient, discovering thereby his emotional reaction to what is happening to him. It will be essential for him to remain neutral emotionally, yet avoid being coldly objective. The patient must be met on his own level with warm responsiveness."

*Pastoral Care in Hospitals by Norman Autton*

Our prayers must be calm and confident. A very tense chaplain once asked a patient "Shall I say a prayer?" The reply was, "Yes, certainly, if you think that it will help you."

If we bring confidence, peace and security into the situation the patient will feel able to open up to us.

#### **6. Spirituality**

What we are matters far more than what we do and will communicate itself to the sick person.

We must beware that shyness does not inhibit the introduction of spiritual matters at the right time.

"He is not at the bedside merely to give a cheery word, necessary as this might sometimes be. He is there for one reason only - to express by loving action the connection that God is light, and that every good gift and every perfect gift is of the Father in whom there is no variation or shadow of turmoil. He is there to articulate what God is like. He does not bring Christ, rather does he reveal

Him. He is there to mediate to the sick person the reality of God's love and his whole message will arouse hope and proclaim the good news of the Gospel... "Come unto me, all..... whose load is heavy; and I will give you relief." (Matt 11 :28)

## **7. Discretion**

If a friend asks the visitor details of the patient's illness he should say he does not have the full details and refer them to the patient's family.

NB Nurses are duty bound not to reveal any such details and should not be embarrassed by our asking for them.

## **E. Worries of the patient**

A hospital ward is "Where boredom is interspersed with drama and tragedy, loneliness is relieved by the companionship of strangers, the hopefulness of the convalescent contrasts with the hopelessness of the dying, the strangeness of the new environment is succeeded by the security of a known routine, anxiety, hilarity and embarrassment intermingle with monotony."

### **1. Feeling of Helplessness**

The patient is not free to go where he pleases, is dependent on young nurses and has little privacy.

### **2. Concern re illness**

He may be wondering what it is and how long it will last? Will he have an op? What will after effects be? Will his handicap be distasteful aesthetically?

### **3. Worry about Family**

### **4. Sense of Guilt**

He may be asking why has it happened? Should I have gone to the doctor earlier? Is it a punishment?

### **5. Fear of Pain**

Pain makes a person withdraw into himself and lose interest in others. Some may become bitter; others submissive.

### **6. Fear about Diagnosis**

He may be asking will it be incurable?

### **7. Fear of Surgery**

There is no such thing as a *minor* op to a patient! Before the op the patient may feel loneliness and isolation with a fear of the unknown. The visitor must help bring out these feelings and reassure him. Prayers may be said and a promise of church prayers given.

NB Best time to visit is evening before op not on the morning of the op. After surgery there may be despondency. Keep the visits brief. Physical touch will say far more than words.

### **8. Fear of death**

## **F. Helping people with special needs**

### **1. Visiting sick children**

There seem to be three initial phases which a young child passes through on entry to hospital:-

*Protest* - the child expects mum to come when he cries and is confused and frightened.

*Despair* - he may have periods of prolonged hopelessness when he becomes withdrawn and apathetic.

*Denial* - This can be misleading if, for example, he begins to take an interest in surroundings but is covering up negative emotions.

It is wise to have a word with the Sister to see how the child is coping. The family will need a good deal of support - - they may feel guilty about the child's illness thinking they are responsible or should have done more at home for him. Don't upset them in front of the children though.

Beware of interfering with relationship between sick child and parents.

Older children may have more fears about hospital procedure especially just before the op., e.g. of not coming round from anaesthetic or the doctor making the wrong incision.

Physical touch e.g. clasping hand or laying on of hands, in anointing or blessing can be very meaningful to sick children.

### **2. Visiting the Chronically Ill**

This may only be temporary illness but requiring long convalescence or may be a permanent condition. He may well be lonely. His illness is not so dramatic as a critical illness hence he may receive less attention. He has time to brood and may be self pitying. Handicaps frustrate him and can lead to resentment and therefore aggression. This in turn may discourage visitors from coming regularly. The danger of the patient being institutionalised is significant. It is important to occupy such a person with manageable tasks.

### **3. Visiting the Critically Ill**

The patient is facing a crisis and possibly disaster. He experiences fear of the unknown, inability to think clearly and rationally, guilt about the past - sins of commission or omission (which may seem causes for his illness). He may become impatient because of the calmness of doctors, nurses etc. He may be depressed or unduly optimistic and may wish to talk about illness or may avoid subject. The visitor must radiate peace and seek to discover the patient's emotional state, then begin wherever he is at the time.

### **4. Visiting the Unconscious**

This is worthwhile. Just because a person cannot verbally respond does *not* mean he cannot hear and understand. Assume he can and speak naturally to him; say a prayer, read a passage of Scripture (especially a familiar one). Do not say anything in the presence of an unconscious person which you would not want him to hear. Prayer with the laying on of hands is still possible and helpful.

### **5. Visiting the Deaf**

Remember we are more embarrassed by deafness than the deaf person is himself. The facial expression of the visitor is important. The deaf person may lip read, so deliberate speech is required. The visitor may communicate in writing or learn the manual alphabet. These last two methods will avoid shouting personal matters for all to hear!

Psychological problems of deafness include:-

- a) Loss of physical wholeness

- b) Reduced confidence in sight as an adequate compensation
- c) No perception of background noise
- d) Loss of reality-contact with environment
- e) Irritation frequently caused between the deaf and hearing
- f) Intensification of existing psychological and other problems
- g) Reduced independence
- h) Reduced social adequacy
- i) Reduced self esteem
- j) Embarrassment through feeling conspicuous

## **6. Visiting Cardiac Patients**

Often the patient has the choice whether to have the op. Don't make his decision for him but help him weigh up the pros and cons. Time goes slowly and tests create anxiety. A patient needs someone to talk to in this period. Don't give clichés about not worrying. Often this means "Don't worry or you'll make *me* worry!" Remember to support his family.

## **7. Visiting Cancer Patients**

Avoid over-assurance and untruths. If you listen, you will probably get clues as to whether the patient wants to know his diagnosis. Let the patient take the lead in discussion and where necessary clarify any misconception.

## **8. Visiting the Physically Handicapped**

There may be an underlying depression, with feelings of anger, resentment and rejection. Where a limb has been amputated there will often be the reaction of grief and mourning similar to the reaction to loss of a loved one.

## **9. Visiting the Maternity Patient**

Reassurance may be required in the emotional time before the birth. Problems may arise and require counsel. An emergency Baptism of a dangerously ill child *can* be done by a lay person and is for the assurance of the parents not for satisfying some mediaeval superstition. The new mother may well need much more help practically after being sent home. Also post-natal depression is quite common.

## **10. Care of the Patient's Family**

The visitor may sense family strengths and weaknesses and often a family will value talking to a third party especially one who is not a professional. The time a patient is admitted is stressful and the nursing staff will have little time to reassure them. Relations may sometimes be afraid that the visitor is going to upset the patient. Remember they also may feel guilty about the patient's illness.

## **11. Care of the Resentful**

The problem of suffering will often be encountered. The visitor must be careful to show understanding and not give out glib clichés. The undeserved suffering of the Son of God is a good subject to bring up sensitively.

# **G. Practical considerations**

## **1. Short Visits**

The majority of lay (as opposed to professional) visits will be short because sick people tire easily. The patient maybe straining to pretend he is feeling no strain. Don't outstay your welcome. Ten minutes is a good guide but don't appear rushed.

## **2. Best Visiting Time**

It is etiquette to check with nursing staff (ideally the Sister) before visiting a patient although hospitals often now have very extensive visiting hours. Meal times are inconvenient as are mornings especially on surgical gynaecological wards. Mid afternoon and early evening are good times. It is best to visit a patient on the afternoon or evening before the day of his operation.

## **3. Stand or Sit**

If you sit beside the bed it puts you on a level with the patient which is good psychologically. But to sit means it can be more difficult to get away. The story is told of the Awful Fate of Melponemus Jones, the curate who had great difficulty in getting away from a pastoral call. He was too modest to tell a lie and too religious to appear rude. Consequently he spent six weeks in the house he first visited and eventually died there from "raging delirium"! Sometimes the only answer is "When you gotta go, you gotta go" waving and smiling as you leave!

## **4. Equipment**

Don't show any anxiety about equipment at the bedside, treat it as normal. Of course, never tamper with it either.

## **5. Prayer**

Don't be bound to pray or not pray. Be sensitive. Sometimes it may be better to promise prayer at church or in a group. If you do pray be simple and unobtrusive. Don't kneel as hospital beds are high so the patient will wonder where you've gone!

## **6. Literature**

Good literature is helpful, but beware of that which gives an "all will work out nicely" impression. Large print materials are important for the elderly etc.

# **MINISTRY TO THE ELDERLY**

## ***A. The problems of old age***

### **1. Being Set in Ones Ways**

Characteristics of earlier years become over emphasised in old age, e.g.

- the selfish become very demanding
- the inquisitive become very prying
- the suspicious become very faultfinding
- the unforgiving become very bitter
- the ungrateful become very complaining

In the same way:

- the unselfish become very generous
- the circumspect keep their own counsel



- the faithful become very trusting
- the tolerant become very kind

Criticism of others by the elderly may be genuine but may also be caused by hurt feelings, a persecution complex or even desire to make trouble. A wise third party can help to de-fuse a difficult situation arising from this.

## **2. Being Lonely**

This is an inward condition and can happen even when a person is amongst others e.g. in nursing home. A person can be introverted, bereaved, neglected, unattractive. Their contemporaries are dead. They belong to the past. The present is changing and very fast moving. They have no intimate friends. Loss of hearing and sight make it worse. Lonely people need understanding companionship. They brood on small difficulties and misunderstandings until they loom large.

“No one came” was the day by day entry of an old lady who died alone at the age of nearly 100.

## **3. Feeling Insecure**

The elderly are more dependent on others and this obliges them to have great faith in people. It is vital therefore that such old people have a firm faith in the undergirding providence of God.

## **4. Having Regrets**

The elderly have a great deal of time to think and brood over past failings. They should be encouraged sensitively to count their blessings and assured of God’s forgiveness if they are penitent.

## **5. Having Fears**

The fears of the elderly are often bred by a sense of failure and maybe an over-emphasis on God as Judge in their early teaching. They also have fear of pain, physical deterioration and death, They need to gain the sure Christian hope. It is important that they can talk frankly and positively about their fears, especially fears about death and the hereafter.

## **6. Living in the Past**

Old people live in the past and especially look back to their hey days when they were in their 30’s and 40’s. But as age increases this period dims and childhood becomes very clearly remembered. It is quite normal for the elderly to talk about the past. We should be patient listeners. It can, of course, be very interesting. However a bad memory may make for repetition but, even then, we should still listen patiently. Senility may cause them to tell fanciful stories but again normally it is kindest simply to accept these.

Because they live in the past elderly people tend to be critical of the present. We should encourage them to be genuinely interested in the present, to praise what is good and to make only constructive criticism. This is important as it will prevent their developing an apathy towards the future as a result of opting out from life in the present.

## **7. Facing Retirement**

Retirement is a mixed blessing. Some enjoy it consistently. Others dislike all the loosing of ties and friendships at work, the feeling of uselessness, of not mattering any more. This can lead to bitterness. Retired people can be found outlets in the church and voluntary activities. Incidentally, a mother may experience a sense of “retirement” when her children finally leave home. Even the housebound can be found certain outlets. Elderly people should be treated with respect as fully adult human beings and not as children.

## 8. Coping with Physical Restrictions

Constant disability or pain can cause a person to feel life is tedious. They become dispirited. The side-effects of some medicines don't help. Helpless and bedridden people often worry about being a burden to others. They should be reminded that they helped others like this earlier and they are providing others with an opportunity to show Christian love. We must help them to face their restrictions and accept them in the love of God. Self pity and resentment are worse evils than any illness or disability.

## 9. Living with adult Children

With modern educational facilities the social gulf between children and elderly parents can be a problem. The mobility of modern young people (especially in their jobs) is an obvious drawback to elderly parents living with them. If the elderly are to live with their children the requirements are:

- a) A fairly large house
- b) A separate room or rooms for the elderly person, adequate for entertaining guests to tea (and facilities to make tea at least).
- c) An agreement that the elderly person does not have **every** meal with the family or spend **every** evening with them.
- d) A clear understanding if the child is married that the married couple run the house and are responsible for the upbringing of the grandchildren.
- e) An honest, frank but gentle approach to any cause of tension.
- f) A realisation that the marriage relationship ultimately takes precedent over responsibilities to elderly parents.
- g) Provision of useful activities for the elderly person both inside and outside home.
- h) Provision of relief carers so that the primary carer can have a life of their own.

## 10. Living in a 'Home'

If the elderly person must move into a retirement home, remember that to give up their own home and possessions is like losing part of themselves. They must be treated with compassion. It is important to try to remove ignorance and prejudice. Visit the home first with them. Try as much as possible to allow them to make their own decision to move into it.

## 11. Living in a Geriatric Ward

Remember that geriatric nursing is very hard and often unpleasant. Staff have little time for the social needs of patients. We must try to see that these needs are met.

## 12. Coping with Sickness

We should minister to the elderly sick, as to any sic person, expecting physical healing as well as emotional and spiritual healing. But for the believer death can be the greatest answer to prayer for healing: "For me to live is Christ and to die is gain."

We should patiently encourage elderly people to seek medical help when necessary. Gradual deterioration of sight, hearing etc., can go unheeded.

## 13. Mental Disorders

These tend to be increased by:-

- **The impact of loneliness**
- **The effect of infirmity** mainly deafness, failing sight, restriction of mobility, cardiovascular disorders, chronic bronchitis, chronic joint conditions, etc.
- **The consequences of retirement** which for some is an end to enjoyment, initiative, a sense of purpose and usefulness.

## **Five Common Disorders:**

### **a. Affective Illness**

#### **i. Depression**

This forms 90% of affective illness and includes symptoms of:

- Anxiety
- Agitation
- Apathy

There will often be sleeplessness, loss of appetite, gloom, hopelessness, constipation, guilt, bodily preoccupations and/or delusions. Admission to hospital is often needed but much can be achieved by spiritual help in the earlier stages. One very important cause is the “root of rage” which is linked with neglect, bereavement and frustration. This rage can be very bitter

#### **ii. Mania**

This takes the form of extreme over-activity, delusions of power, wealth and grandeur.

### **b. Senile Disorder**

This is caused by deterioration in the brain leading to

- Disintegration of intelligence
- Dulling of emotions
- Diminution of initiative

Memory fails except for events in childhood. Sleep is broken and the elderly person may potter around the house doing repetitive, aimless and often inappropriate acts. Relatives may be suspected of “crimes”. The elderly person may retreat into childhood and not be able to carry on normal conversation. There may be abnormal sexual behaviour and deterioration of personal habits. (NB This is not to be confused with normal failings of old age - it is an illness.)

### **c. Arteriosclerotic States (Hardening of arteries)**

The elderly person will experience loss of memory, restlessness, night wandering, confusion. They will also experience rapid swings of mood e.g. deep fears followed by laughter. However their judgment, personality and insight will often remain intact and their bizarre behaviour will therefore distress them. There is often a marked fluctuation of their state from day to day. Death finally results from cerebral, kidney, heart failure or chest infection.

### **d. Delirious States**

The elderly person’s attention is fleeting, their thinking disconnected, and they may experience delusions and hallucinations. (Incidentally this can happen temporarily after operations.)

### **e. Late Paraphrenia**

This is a persecution complex - friends, relatives and neighbours are suspected and accused. Police, ministers, royalty are sometimes bombarded with complaints. The elderly person believes poison is being pushed through walls, the TV is sending out death rays or that people are using magical or occult powers against them. However their memory, reason, concentration and attention may remain unimpaired.

## *Pastoring the Mentally Ill Aged Person*

1. Aim to alleviate their loneliness without invading their privacy.
2. Remember there can be a root of anger in old age, some of it caused by frustrations resulting from infirmities.
3. Remember that retirement may deprive a person of a sense of purpose in life.
4. Ensure that you *love* the elderly person.
5. Treat the **whole** person not just the symptoms.
6. Convey the whole Gospel (including the hope of heaven).
7. Emphasise the adequacy of Christ, the Word, the Sacraments, the community and forgiveness.

### ***B . The purpose of old age***

More people are living longer into their late eighties and nineties. Many younger retired people may be very active. But as age advances:

#### **1. Being not Doing**

The idea that goodness of character should benefit old age follows from the belief that life has a purpose - to glorify God. "Old age is the last lap of purposeful human existence." i.e. it is character-building in preparation for life hereafter. "Old age is a state for being rather than doing." The elderly person's focus should be shifting to the next life and sitting loose to, but not neglecting, this life. "What matters is being patient, being gracious, being tolerant, being wise, being penitent, being in faith, being at peace; and until all this is perfectly achieved there is always a purpose in life and an opportunity." (Quotes from H. P. Steer) It has been said that "religion is what a man does with his solitariness". An old person should offer themselves daily to God and seek to "practise the presence of God."

#### **2. Maintain Interests**

They may be able to do simple gardening (e.g. keep a window-box or care for indoor plants), sewing, keeping a diary, reading. An old person can be a prayer partner or even a prayer warrior if someone takes the trouble to enlist their help.

### ***C. Visiting the elderly***

1. **The visit should be by appointment.** This is a good method as the old person has something to look forward to and can be prepared for the visit.
2. **The visitor should always show respect.** Respect is shown by being a good listener and taking their conversation seriously. Remember that an old person is thrilled to be asked for advice (even if, having weighed it up, in the end you don't follow it).

## **PASTORAL CARE OF THE DYING**

### ***Fear of death***

Freud said, "in the unconscious, everyone of us convinced of his own immortality ... we betray our endeavour to modify the significance of death from a necessity to an accident." St. Augustine

pointed to Christ's agony in the Garden as a comfort to those Christians who fear death. Subconscious fears and anxieties about death lead to a high percentage of nervous breakdowns and admission to psychiatric hospitals. The fear which needs to be overcome is fear without hope or assurance. There perhaps will always be the healthy "fear" which is a sense of awe in the face of death.

**Death is mysterious.** Even Scripture tells us little about it and the hereafter.

**Death seems lonely.** We must die alone. "Think what it is to be on thy death bed, when all the pleasures of life withdraw themselves, and bid thee eternally adieu. Then thou wilt be left alone, though thou art lord over millions, nor can any force of armed men defend thee from that mortal stroke." (T. Tryon) But we believe God will be with us even through death. And we shall be reunited with Christians who have gone on before. As Donne put it, "..... the dead and we, are now all in one Church, and at the resurrection shall all be in one Quire."

**Death is decay.** Many, especially those without faith, are afraid of "non-being". They see it as a humiliation and an insult. However George Herbert wrote:

"Death, thou wast once an uncouth hideous thing,  
Nothing but bones,  
The sad effect of sadder groans:  
Thy mouth was open, but thou couldst not sing.  
For we considered thee as at some six or ten years hence,  
After the loss of life and sense,  
Flesh being turned to dust and bones to sticks.  
But since our Saviour's death did put some blood into thy face:  
Thou art grown fair and full of grace ..."

**Death speaks of judgement** And deep down many people fear this.

**Death can be painful.** Experts claim that few people are afraid actually at the point of death, even though they may previously have been fearful. Also pain often lessens or disappears shortly before death. It is claimed by those who have returned from near death experiences that they were unaware of the struggle and turmoil they displayed to the distress of their relatives. Apparently some distorted features and convulsive movements can be caused by physiological release mechanisms within the body and are not a symptom of distress.

(Experts state that 90% of patients find relief of suffering immediately before death, and the other 10% often it is more the discomfort of vomiting etc., than pain. Even cases of terminal cancer pain can be controlled in almost every patient.)

Many people who have had near death experiences claim pleasant "out of the body" experiences, visions of heaven etc. However these experiences are an unreliable guide in spiritual matters. Some researchers claim that certain patients manifest the symptoms of horrific experiences which are almost immediately forgotten (repressed) when they regain consciousness. It is important not to let such experiences prevent us from preparing a person for death by sensitively conveying the gospel.

### ***Should a person be told he is dying?***

Normally a close relative or the doctor will make this decision and it is important not to override their decisions. But if they ask advice, bear in mind:

Many feel a person has a right and urgent need to know in order to prepare for death. Studies reveal that far more people want to know the truth than is sometimes thought. Every patient should be told **what he really wants to know** and this should be clear to the experienced eye. Very few ask the direct question, "Am I dying?". It is wise to let the patient take the initiative in the matter and gently to encourage him to express his fears.

We must bear in mind that deceit

- i. is morally wrong.
- ii. creates distrust in the patient and later in the relatives, who may subsequently feel deception is being practised on them when they are ill.
- iii. gives little time for the patient to put worldly goods in order and discharge responsibilities.
- iv. is a strain on relatives who have to remember what they have said earlier.
- v. between a married couple brings an alien element into their relationship which has hitherto been based on trust.
- vi. inhibits a spiritual counsellor from preparing the person for death.
- vii. is a strain on the patient if he knows he is dying, but is practising deceit for the benefit of the family.

However, there may be some people who just do not want to know and we must respect this.

**Who should tell them?** Probably the person closest to the patient (doctor, minister, nurse, husband or wife) is the best person to break the news. This person ought to be with the patient extensively afterwards.

#### **What should be said?**

- i. Don't say anything which may encourage depression or anxiety unnecessarily. (Miracles *can* happen.)
- ii. Don't say too early - there is no reason to. Nor too late when the patient is too weak.
- iii. Don't minimise the gravity of the situation.
- iv. Encourage positive action by the patient rather than a fatalistic idleness.

If it is not hard to tell the person they are dying we are probably not the right person because we are not entering fully into the situation.

Often a dying person will pass through a "little death" which is akin to bereavement at the prospect of leaving a loved one behind.

### ***Caring for the dying***

- i. To be able to care properly for the dying, we must come to terms with our own death as a certainty. Our unresolved conflicts about death will undermine our effectiveness.
- ii. It is more important what a visitor is than what he says. He should display a calm and serenity that stems from a relationship with Christ. He should unhurriedly listen to the patient and pick up the non-verbal communication which can take place.
- iii. A dying man is a different person from what he was before he knew he was dying. Therefore we must not make assumptions about his needs.
- iv. Primarily security and companionship are needed. The dying person needs a calm listener to whom he can off-load his feelings. He needs an active listener who will prayerfully and skilfully ask questions to help him articulate his needs.
- v. Because of dashed hopes and unfinished tasks he may feel guilty and disappointed with himself.
- vi. There will be sadness over leaving his family and friends.
- vii. There will be helplessness in the face of the awesome approach of death. For a strong personality this will be more difficult.
- viii. There may be resentment at undeserved suffering.

- ix. We should lead the patient gently to:
- faith in Christ
  - expressing any necessary penitence
  - putting his affairs in order (e.g. making a will)

## ***Caring for the relatives***

- i. They may feel guilty (because of a sense of helplessness or failure) or even suppressed anger. Such unhealthy feelings won't help the dying person to have a healthy attitude towards death. The visitor should help them to face up to these feelings and deal with them.
- ii. We should advise them to avoid showing stress and so upsetting the dying person. He can so easily feel abandoned if the family are too upset to help and support him.
- iii. Brief regular visits are better than longer visits.
- iv. It is good to warn the family as much as possible about physical, mental and emotional changes which are likely to take place in the patient.
  - v. If they feel helpless - remind them just to be there - as Mary was at the Cross.
- vi. They will need counselling if they wish for death to come soon in order to relieve the suffering of the patient and then feel guilty about this afterwards.
- vii. Be aware that some relatives who are caring for the dying person may feel a sense of relief if the care has begun to prove too burdensome (but may feel guilty about this understandable relief).

## ***Euthanasia***

This is a highly emotional subject when, for example, a wife is watching her dying husband going through agony. Sensitivity is called for. Sometimes a machine has to be switched off when the person attached to it is simply being mechanically maintained in a "vegetable" existence. Sometimes powerful pain killers administered with the motive of relieving pain can hasten the end. Neither of these cases is an example of euthanasia.

Euthanasia is deliberately and intentionally taking the life of a seriously ill person. In spite of the emotional trauma it is morally wrong.

1. Each human life is sacred.
2. The time of a person's death is in God's hands not ours.
3. Miracles (or, to use a medical term, "spontaneous remission") do sometimes happen even at the last moment.
4. Euthanasia for the very seriously or terminally ill is a slippery slope which would lead to:
  - euthanasia for the less seriously ill, the handicapped or those who are a burden on their family or on society
  - fear and distrust of doctors by seriously ill people.

However there are cases where it is appropriate to request the medical authorities to discontinue drugs and only administer liquid nutrition.

## **PASTORAL CARE OF THE BEREAVED**

We need to come to terms with death in order to be able to give mature help to the bereaved.

Grief is a process of realisation of the fact of loss. This process takes time and, while it can be assisted, anything that forces a premature facing of reality in the early stages of bereavement is likely to produce difficulties.

In visiting the bereaved we must be honest and positive about emotions. We should not hesitate to show upset in the presence of the bereaved if we too are affected by the grief. Children should

not be shielded from adults' grief or their own (unless the former is abnormal). Some people will cry and sob, others express their feelings in other ways. The important thing is for feelings to enter the consciousness.

## ***The possible stages of grief***

**Coming to terms with bereavement is a lengthy process and often includes various stages. These stages do not happen in a neat and orderly fashion. The bereaved person may not experience some of them at all. More than one may happen at the same time. Or they may switch backwards and forwards between them. If they don't understand this is normal it can be quite confusing and frightening. If they experience them, it is quite normal.**

They may feel exhausted simply coping. Or they may be fearful about things which never worried them in the past..

**The following stages can take place in coming to terms with bereavement:**

1. **DENIAL:** The bereaved person can't believe their loved one has died. The bereaved person may be stunned, dazed and overwhelmed. They may even collapse. They keep thinking they will see them or hear from them and that they're not really dead. Everything seems unreal and remote. They feel lonely and numb. The funeral, although painful, may help to make the death real. This needs to happen before they can start to come to terms with bereavement.

In general the first 24 hours is too soon for strangers to call. It is best simply for the Counsellor to "be there" and sympathetically accept the bereaved person's feelings. Rest is good for shock so help quietly with the practical arrangements and protect the bereaved from over-intensive people. Any words should simply express acceptance of the shock feelings. Don't praise their courage, it may discourage emotional release. Don't try to reason with the shocked person.

2. **ANGER:** The bereaved person may find they are angry with God, with the doctors, with the hospital or other people. They might even be angry with their deceased loved one. This happens even to people who have been happily married. They should be encouraged to tell God about their anger, including if they feel angry towards him. They should be encouraged to tell a trusted friend who is prepared to listen.

There must be an emotional release but some bereaved people seek to prevent it. Some are frightened by the intensity of their own emotions and imaginings. They may feel they are going mad. It is important not to force the bereaved person to face facts too soon. This can lead to acute depression.

An 'outside' visitor can probably help at this stage more than the family who may be too 'choked up' themselves.

Do not be over sympathetic as this encourages negative self pity. And do not try to stop a person having to go through this emotional release by e.g. saying, "There's a lot to be thankful for", "Time will heal", "Others are worse off" nor by encouraging activity to prevent grief.

If the bereaved finds it difficult to express emotions help them by saying "You're still feeling lost" etc. Or you may invite them to talk about the deceased. It is probably best not to suggest directly that they express their emotions.

When the grief comes out it is best just to listen and "accept" what is said. Only simple Christian statements are helpful at this stage.

3. **BARGAINING:** For example, the bereaved person makes promises to God in order to try to avoid the pain of grief



4. **DEPRESSION:** The bereaved person reflects on what could have been. Everything might seem pointless and hopeless. They feel apathetic. Life is empty. They may feel irrationally guilty and exaggerate memories of ways they think they failed their loved one. Sometimes they will feel others are avoiding them or don't want to talk about their bereavement. They may even lose the will to live. They should be encouraged to talk to a trusted friend who is prepared to listen and to talk to God about it.

5. **ACCEPTANCE:** The bereaved person will eventually reach the point where they are able to "let go" of deceased: to commit them to God. At this stage they can begin to live their own life however different it is from life as it was or would have been with their loved one. They make the choices not their deceased loved one.

All these reactions are normal at the time, but they will pass and they will find themselves gradually beginning a new chapter of life.

Fear may also be a problem: fear of loneliness; fear of not being able to cope with practical jobs, finances, moving house; fear of death.

### ***Physical symptoms***

There can be various physical signs of bereavement which are normal, usually temporary

symptoms e.g.

- A feeling of "falling apart/coming unstuck".
- Loss of appetite (in a few excessive appetite)
- Heavy feeling or pain in abdomen
- Palpitations and sense of fullness in the chest.
- Dryness of mouth and difficulty in swallowing.
- Tightness in the throat or a choking feeling or a need to sigh.
- Lassitude
- Migraine Headaches
- Insomnia
- Inability to sit still or concentrate.
- Extreme restlessness
- Nervousness
- Fears of nervous breakdown
- Feelings of panic
- Nightmares
- Muscular weakness
- Trembling
- Fatigue
- Loss of working capacity
- Dizziness and fainting
- Blurred vision
- Excessive sweating e.g. sweaty palms
- Shortness of breath

Grief can aggravate serious even potentially fatal illness and there is a higher death rate amongst the bereaved than the non-bereaved.

## ***More on specific emotional reactions to bereavement***

1. **Pining** This is a persistent and obtrusive wish for the person who is gone, a preoccupation with thoughts that can only give pain. The bereaved often literally looks for the deceased and expects to see him.

Pining involves:

- i. Alarm, tension.
- ii. Restless movement.
- iii. Preoccupation with thoughts of deceased.
- iv. Loss of interest in self.
- v. Paying attention to those places where they think the deceased might be.
- vi. Calling for the deceased

2. **Depression** This is inevitable. Don't try to cheer the bereaved person up or rush them into activities to take their mind off things. Frequent short visits are helpful with readiness to help practically and to listen. Only after the depressive stage can recovery begin. Depression is contributed to by lack of sense of role, sexual frustration, the absence of security which comes from sharing responsibilities and possibly poverty. Apathy may be an obvious factor. A widow has lost her role - she is no longer a wife, 'we' has become 'I', 'ours' has become 'mine', 'family', 'home', 'marriage', and 'old age' have different meanings. The bereaved may feel they, not the deceased, have been ejected from the world into a new threatening world

3. **Loneliness** A deep inner loneliness can be helped by a good listener. Also the bereaved discover that people who were previously friendly and approachable become embarrassed and strained in their presence. Expressions of sympathy seem superficial and offers of help are not followed up. "Mourning is treated as if it were a weakness, a self-indulgence, a reprehensible bad habit instead of a psychological necessity." (Gorer)

4. **Confusion and Helplessness.** Inability to make decisions and feelings of helplessness are normal and temporary. Provide assistance where necessary. Many decisions can be postponed. The bereaved is threatened by the world and tends sometimes to find security in retreating into their home and admits only family members with whom they feel secure. The bereaved person tends to continue to act in many ways as if the lost person were still recoverable and to worry about the loss - turning it over in their mind. Freud called this "grief work" and said its purpose was to prepare the bereaved for the full acceptance of his loss.

### **Such "grief work" includes**

- (i) Preoccupation with thoughts of deceased
- (ii) Painful repetitions of the loss experience
- (iii) An attempt to make sense of the loss.

Whilst the bereaved feels that the deceased is recoverable, anything that brings home the loss is a major threat. Hence to try to stop someone grieving prematurely can meet with an angry reaction.

The visitor should not conceal his own helplessness where he feels it. This will be more helpful than a superficial omniscience.

5. **A Sense of Guilt.** The bereaved person may feel they should have done more for the deceased. Encourage them to express their feelings fully and simply listen to them. Don't try to reason with them at the early stages. They need to work through these feelings.

6. **Hostility.** This may be very intense and appear days after the shock. It may be largely unwarranted. Again good listening rather than reasoning with the bereaved person is best. But don't encourage the hostility by "appearing" to agree with it. Anger is a regular experience, especially during the first month, later it gives way more to depression. An angry response may be given when relatives try to stop the bereaved grieving whilst he still feels the deceased is

recoverable. The bereaved may feel hostile towards the deceased for deserting him. Obviously hostility can create family misunderstandings, quarrels and splits leaving the bereaved hurt and deserted. Hostility towards God must be sympathetically accepted in the very early stages.

7. **Hallucinations.** “Seeing” the deceased is a common experience, although the bereaved may at times not be able to visualise the deceased. Sometimes it is not until the grief has lessened that the bereaved can visualise the deceased. They remember better because they have partly got over it. Many sense the presence of the deceased. Some have even felt the deceased is inside them.

8. **Identification.** It is quite possible for the bereaved to take on characteristics, interests, etc. of the deceased. This relates to the feeling that “half of myself has gone”. Even symptoms of the deceased’s last illness can be reproduced in the bereaved.

### ***Idealisation of loved one***

This often happens and may be related to guilt feelings. A wife may have had great difficulties in her relationship with her husband, but after his death she may speak as if he were almost perfect.

### ***Turning point***

This will normally come. For some it is when turning out the deceased’s belongings, with others when they redecorate the living room or rearrange the furniture. It may be an anniversary or a visit to the cemetery. Society now has no defined periods of mourning. It would be good if somehow a bereaved person knew when it was “decent” and “proper” to cease the period of mourning. Friends and family should encourage this when appropriate, but no two people are alike and the time needed for mourning varies.

### ***Children***

Children should not be shielded from grief (unless it is acute). We give toddlers toy guns, yet conceal the death of granddad! Children tend to go through three stages of bereavement:

- i. **Protest:** the child feels confusion and fright that the relative is absent.
  - ii. **Despair:** increased hopelessness overwhelms the child making him withdrawn and apathetic.
  - iii. **Denial:** The child represses feelings for the deceased. (NB. If children feel that parents fear death and won’t discuss it, this intensifies the child’s anxieties).
- a. Children under 5 usually do not view death as irreversible - it is departure or sleep.
  - b. Children between 5-9 often personify death - the “death-man”.
  - c. Children over 9 see death occurs in accordance with laws of nature.

Note the following points:

- (a) Beware of saying “Jesus has taken him” as this may encourage a child to blame Jesus for the death. What the child needs is the assurance of security and love.
- (b) A child may suffer guilt - feeling responsible for the deceased’s death. It is important to let them freely express such guilt and any hostility to the deceased too.
- (c) A child’s stunned reaction may seem like indifference. But they should not be pressed to conform to adult expectations in their reactions. The fact that a child at the time shows no obvious emotional disturbance is no evidence that they are not deeply affected, rather the reverse.
- (d) For a widow to be left with young children can help to give a purpose to life. But sometimes it adds to her burdens too much and she can come to resent them. Beware lest a widow treats her

son as a “substitute husband” emotionally.

## ***Pathological grief***

Pathological grief is:

- i. Grief that is long delayed in beginning (over 2 weeks from the bereavement ).
- ii. Grief that becomes severe and prolonged.
- iii. A marked change in behaviour pattern e.g. becoming introverted (unsociable) or over active.
- iv. An overwhelming depression, maybe with threat of suicide  
(Don't be afraid to ask directly about this, - e.g. "has it been so bad that you have thought of killing yourself?" This question could save a life. There may be a sense of total uselessness and apathy).
- v. Marked hostility and resentment which shows no lessening but increases, with general suspicion of everyone.
- vi. Obvious hallucinations (not passing fantasies which are normal) or complete loss of contact with reality.
- vii. Complete denial that the death has taken place.
- viii. The bereaved not speaking over a long period of time, and being unable to break away from fixed patterns.
- ix. Manic-depressive reaction (elation alternating with depression).
- x. A continual stage of panic which no counselling can remove.
- xi. Alcoholism.
- xii. An excessive display of symptoms from last illness of deceased.

*[N.B. There are good prospects of Pathological Grief being healed. Professional help is normally needed.]*

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