PHENOMENOLOGICAL SYNTHESIS OF PASTORAL CARE AND COUNSELING AND ITS RELATION TO THE TERMINALLY ILLS AMONG NIGERIAN CHRISTIANS

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Abstract
The task of pastoral care and counselling is crucial and indispensable for Nigerian Christians who are terminally ill, as well as their family and friends. It has been observed that the fear of death sometimes complicates the situation or hasten the death process of the terminally ill. This paper thus argues that an understanding and synthesis of the qualities and functions of a pastoral caregiver is vital to the death phenomenon associated with terminal illness and contributes to the sustenance or healing of the terminally ill. This paper employs a phenomenological approach to research. The findings include the imperative task of pastoral caregivers in addressing and managing the emotional trauma of the terminally ill, who often pass through five stages of shock, catharsis and depression, negotiation, drama of cognition and commitment. It was found out that the pastoral caregiver must have adequately worked on himself, his fear and feelings concerning the issue of death in order to help a terminally ill effectively. It is then that the qualities of a pastoral caregiver can be expressed through prayer, ministry of presence and reconciliation (as a "broker"). This article thus recommends that a minister should be conversant with the basic psychological needs of a dying person, the existential reality of pain and death and the emotional process of grief. A pastoral caregiver should be sensitive to the theological and ethical questions of the dying client. Prayer should not be used as a "magical wand" to remove the "spell" of death. Admittedly, God can decide to heal a terminally ill, but the caregiver must be careful never to play God in the use of prayer for the patient**.**

Introduction

The treatment of sick people in Africa is usually accompanied by care from family and friends and medical attention. The intent and extent of the caregivers often increase or become heightened when it is discovered that the sick fellow is suffering from a terminal illness. They sometimes seek spiritual support and care in addition to the existing efforts and do appreciate unsolicited pastoral care provided for the terminally ill. Research attempts have been made to address the effects of terminally ill patients and the burdens of informal caregivers, among other issues (Buyinza 2021, Fu, Li, Fang et al. 2021). However, this research explores the fundamental issues related to terminal illness and how those issues affect the "being" of the ill, the caregiver and the "immediate" community. The psychological, religious and medical challenges associated with terminal illness will also be briefly considered.

Much more importantly, a phenomenological synthesis of pastoral care and counselling will be explored to present the role of the pastor as a caregiver in the delicate situation of terminally ill patients. The theological

and philosophical concepts of death will be evaluated, and basic pastoral and scriptural tools helpful in handling this delicate issue will be identified and put into proper perspective. It must, however, be noted that this paper is not seeking to exhaust all the nitty gritty involved in ministering to the terminally ill. The debate will be left open for further investigation and exploration. The following fundamental questions shall thus be addressed - what are the resources of theology considering death? How should care be provided for the dying and the caregivers? What practical and intellectual resources are there for the pastor to call upon?

Conceptual Clarification

Though it may be technically challenging to accurately describe or conclusively determine the meaning of “terminal illness”, it often refers to the case of complete hopelessness, which is not fully empirical and experientially consistent with the medical reality of late. It must, however, be noted that from medical prognosis to a considerable extent, certain medical cases may be safely described as terminal. Terminal illness within the illness situation to this paper will therefore refer to health or illness situation over which both the patient and the medical caregiver exercise diminishing control and that which, with every available technology and observable sign, show no sign of recovery (Hospice, 2023).

Presupposed Human Attitude towards Death

A general overview of human perception of the reality of death will be a good bedrock for treating this topic of providing pastoral care and counselling for terminally ill clients. A patient who has been told that his /her illness is terminal is, in much respect, like a criminal who hears the judge pronounce the sentence of death. It must be noted that all generally accept the fact of mortality of the human, but very few people contemplate the reality of dying or death. Many picture death as a gruesome subject one should not think or talk about. Contemplating one’s death or mortality can exacerbate whatever latent hypochondriacal tendencies one has. Socrates posits:

> To fear death is nothing other than to think one is wise when one is not, for it is to think one knows what one does not know. No man knows whether death may not even turn out to be the greatest of blessings for a human being, and yet people fear it as if they know for certain that it is the greatest of evils (McKay, 2022).

In line with Socrates’ assertion, it is imperative for man to understand the concept and approach of death while he lives to understand life itself. Hence, when human beings understand the essence and blessings of death rather than approach or perceive it as an ultimately evil experience, it will be possible to truly understand life.

Interestingly, in contemporary times, more escapist thinking and attitudes toward the reality of death have been developed. People are trying to either ignore or protect themselves against this reality and, hence, living in self-deception about death. It is easy to accept the evasive and pacifying attitude that death is really not relevant to life or sidestep the problem with the comforting cliché. There is a tendency to think of people dying as a mirage or perceive it as a distant future experience until the individual or a close relative is involved in a terminal illness and facing death threats.

It is observed that this attitude is carried on into many Christians's religious experiences, thus making holistic ministry to the terminally ill patient difficult. The recent misinterpretation of “faith” in the Christian circle has added a new dimension to the evasive attitude or denial of the reality of death or its fear. It has

become less popular to prepare people to hopefully embrace death properly. The common saying now is, "I will not die but live to proclaim the goodness of God" (Psalm 118:17, Singg, 2009; Agbiji, 2013). The great challenge is first to develop the right attitude toward death before even pastoral care and counselling for terminally ill patients can be possible or effective. What, then, should be the "existential-ontological" and theological understanding of death?

Ontological and Theological View of Death

It is observed that the philosophical view of death, which is helpful to the evangelical theological position, is the "existential–ontological" concept of death. The ontological concept debunks the escapist notion of death, that it is in the distant future or something or someone out there but right now and even a very part of the structure of human existence (Igwe, 2021).

The truth about death from an ontological existential sense is not just a point or a moment or an event; it is an ever-abiding and built–in structure of existence (Hanson 2017). Death is seen as the power for man 'to be' and not just to 'cease being'. The assertion is then correct that human beings are dying as long as they exist. Death is an insuperable or unsurpassable possibility. It is not something humans can opt out of; rather, he is 'thrown' into it; it is given with his very being or existence (Nguyen, 2018; Stanford, 2023).

Philosophically speaking, there is again the mysterious aspect of death because human existence points to something beyond itself, ultimately to the fuller mystery of being itself. Since death reveals that humans need more than their structure to understand their being or existence, death, therefore, becomes the key to the truth that a human being must transcend themselves for him to fully understand or be he. The seemingly nothingness revealed by death is rather a screen behind which the being itself hides. Death leads humans beyond him; it brings us into our completeness or wholeness. If yes, then death, even philosophically viewed, is not inherently evil in the final analysis but something to be desired with the fondest yearning (Oripeloye & Omigbule, 2019; eGrove, 2021).

In Christian thought, the human being is depicted as being in transit, and the ultimate goal of his being has been transcendental value. Death, although severe human from his terrestrial relationship, equally translates him into a metaphysical relationship of permanence (Onwuatuegwu 2023). The foundational truth of the Bible is that the transitory human is sustained by the realisation that his life is an unmerited gift from the one who alone has an unending life. An inseparable part of that gift is death. To despise death is, therefore, tantamount to despising life itself. Death is, therefore, the passage for humans to join the 'eternity' (Aquilina, 2023; McKay, 2022).

Psychological Reaction to the Threat of Death

It is of great importance to carefully examine the psychological dynamics of people's reaction to the threat of death or a factual awareness of dying, especially in the case of a terminal illness. This is an excellent tool for the pastoral caregiver in understanding the emotional or psychological situation of the dying person, and this will significantly inform the caregiver on how to handle the client more effectively.

The terminally ill patient goes through certain emotional stages and coping mechanisms. It must first be noted that these stages may not necessarily follow each other panoramically. They are rather responses, which fluctuate from time to time depending on the energy level the ego has to work with. Carl A Nighswonger (nd) has identified certain psychological stages or dramas the terminally ill patient or dying person usually goes through, and they are below elucidated.

Psychological Experiences of Terminally Ill Persons

The first psychological experience of the terminally ill person upon the reception of the news is Shock**.** Denial and panic are two coping mechanisms that will initially come to the rescue of the situation. Denial is a psychic anaesthetic to an unbearable reality. It allows the patient to pretend not to hear the news or accept the truth emotionally. This initial response to shock is healthy because it helps one to muster inner forces to cope with an overwhelming situation. When denial, however, becomes prolonged, it becomes dangerous to the emotional state of the ill (Kyota & Kanda, 2019; Gauri Chanchan, nd).

Panic is the alternative response to shock. When panic is expressed, all structure and reality checks become lost, and the patient will resort to impulsive, uncontrolled and unrealistic behaviour. The situation invariably becomes fluid, and this may lead to self-destruction or psychosis (Trauma, 2022).

The second stage is that of Catharsis and Depression. These set in immediately, and reality begins to be established. Catharsis is an outward manifestation of one's feelings of anger. Most often, the anger is directed toward oneself, a loved one, a caregiver or God. When catharsis is not expressed or cocked, the feeling is turned inward and may achieve neurotic proportion stopping the drama in depression (eGrove, 2021).

The third stage, Negotiation, sets in at the intensity of guilt and shame in depression. This stage is usually characterised by the client alienation question – what is the use? (Selling out) Alternatively, one of attempting to negotiate a deal or hope that God can be persuaded to intervene. (Wajid, Rajkumar, Romate 2022, Carey 2023, Jabeen 2023). It must first be understood that seeking divine intervention is human and normal and may even help the patient in his/her readiness for the next stage. This must, however, be guided not to slip into the first stage of denial. This severe tension must be held tenaciously by the caregiver so as not to help the client develop false hope, which may be inimical to his/her psychological coping mechanism with the rest of the stages. Ruling out divine intervention is equally bad, like building false hope.

The next stage is called the Drama of Cognition. At this level, the patient becomes increasingly cognizant of his condition and faces realistic hope or despair. Some spiritually bankrupt clients are left with only the choice of despair, manifesting in stoic bitterness and hopelessness (Singg. 2009; Agbiji, 2013). On the other hand, the client could be helped to experience realistic hope by discovering some sense of meaning and purpose, which offers the possibility of personal fulfilment in his / her death. This hope is not necessarily that of getting well or cured. At this stage, the client finds relevant life perspectives in evaluating his/her life pilgrimage, past, present and future. The success of this stage is necessary as the foundation for the next stage (Khoo & Graham-Engeland, 2016).

The next stage is that of Commitment. This manifests in either acceptance or resignation. Consequently, realistic hope will help the patient move to the acceptance stage, but despair will culminate in resignation. Acceptance is the affirmation of realistic hope earlier experienced, while resignation is the emotional confirmation of the ultimate sense of despair. Affirming death with courage as the natural fulfilment of life and the completion of its meaning and purpose comes only as an expression of a spiritually rich, emotionally sound, and balanced individual. To be able to get to this level of acceptance, trust must be internalised, and faith must become more intrinsic; barriers of bitterness, unresolved grief, and previous hurt must all be cleared. The great task of the pastoral caregiver is to help the client experience congruence between what he believes about life and death and what he feels or experiences about living and now dying (La Crosse, 2023). Consequently, acceptance finally results in a sense of fulfilment, while

resignation culminates in a sense of forlornness, which is basically welcoming death as an end to the living hell. Forlornness is expressed in bewilderment, fear, frustration, fear and aloneness.

The Task of the Pastoral Caregiver

Clearly, it is imperative to state that ministering to a dying person is not an easy task. Caring for the dying is a very demanding, emotionally exhausting experience. In reality, no one wants to willingly consider death for himself/herself nor choose to be with persons who are dying. As a result of this herculean nature of caring for the terminally ill or the dying persons, ministering to the dying, therefore, requires knowledge, skill and self-awareness on the part of the pastoral caregiver (Dame & Louw, 2020).

It is also generally admitted that at this stage of dying, the pastoral caregiver becomes the most important caregiver to the victim. This is because the pastoral approach to caregiving is more holistic. The religious point of view that both life and death are held together enables the pastoral caregiver to provide emotional, psychological, and spiritual support to the terminally ill. Pastoral caregiving opens new ways of providing sensitive compassion at what is probably the most challenging moment in a person's life. The visitation of a pastoral caregiver to the terminally ill may include worship, prayer, healing, hospitality, care, counselling, and faith formation functions (Redding, 2012). To be able to give pastoral care to the dying effectively, the caregiver needs to know and do certain things stated below.

A. The Pastoral Caregiver's Person

The person ministering to the dying can only do this effectively when he/she has worked on his/her person. The person of the caregiver cannot be separated from his function. The caregiver must first be prepared to experience and examine feelings and attitudes about his/her death. The awareness of humanness is the most important resource a pastoral caregiver needs to help other humans be human to the end (Walter, 2020). The awareness is the fact that the living persons who are presently ministering to dying persons will also die sooner or later. The caregiver himself is not immune from dying. Therefore, the caregiver must first work through their feelings and fear. To dare to express one's humanness and to personally confront the fear of dying and the issue of bereavement is the first task of a pastoral caregiver.

It is important to note that pastoral caregivers often discover many things about themselves while ministering to the dying. Ministering to the dying allows one to discover the dynamics operating more clearly within him/herself and the client, and he/she is enabled to re-examine their feelings of selfhood and pastoral concern. As a result of this great personal discovery, the caregiver can then honestly "share" him/herself with the client in a sensitive listening relationship.

B. **The Ministry of Presence**

One of the most important and critical ministries the pastoral caregiver gives is the ministry of presence. Personal caring contact is indeed the most important comfort we can give a terminally ill client. The presence of the caregiver alone is an effective tool in ameliorating the patient's suffering. It is an established fact that the hallmarks of those dying are the feeling of loneliness and abandonment; the presence of the caregiver in this regard is considered therapeutic (Agbiji 2013, Sprinder nd). The dying person must be dealt with in nonverbal terms before a verbal mechanism can be employed. What the terminal client needs most is someone to be with him. Conversation is not critical at this point but the presence of a caring person. At times, particularly when there is absolutely nothing physical to do for the dying person, just being with him, hearing his despair and sensitively sharing our emphatic feelings can be most beneficial.

C. **The Ministry of Prayer**

The caregiver can make good use of the tools of prayer and theology as instruments of healing, enabling persons to live their last moments with a sense of wholeness and meaning. These spiritual tools, if not rightly used, can equally put distance between the caregiver and the dying person. Prayer can be wrongly used to give the dying person false hope or a sense of guilt, and this may invariably hinder the person from adequately preparing to face death (Redding, 2012).

Praying with a dying person in some significant way helps deal with the problem of isolation and alienation. In prayer, however, the patient will feel another person as warm, close, safe to touch and hold, available to share feelings, and capable of experiencing mystery and transcendence. Praying with a dying person is, therefore, a way of allowing the client to experience a sense of intimacy while reducing the risk of further isolation, alienation, and fear of ego loss (Kalas, 2009). Prayer should, however, not be misused in violating the patient's defences, stripping away what the conventional good manner, change of subject matter and other defences could have effectively kept covered (Walden, 2023).

The more critical issues of concern regarding the usage of prayer by the pastoral caregiver include the timing of the prayer, the content of the prayer and the follow–up of each prayer. The caregiver must be very sensitive to the appropriate timing of prayer and what is said during prayer. It will be dangerous for the caregiver to have any “canned” prayer used in all situations. Well-articulated prayer must be specifically relevant to a specific situation and should be able to give the patient a sense of intimacy and hope. Again, prayer as a sign of departure or at the end of the caregiver’s visit is not the most appropriate. Praying with a sick or dying person should go with the caregiver’s willingness to stay and respond to the feelings and words of the patient whom the prayer has touched (McDowell, 2018).

D. **Pastoral Caregiver as a “Broker”**

Pastoral caregivers go beyond just ministering or caring for the sick; it has a lot of dynamics and multifaceted interrelatedness with other caregivers and even the “immediate” community. The caregiver, in order to be effective, must not see himself/herself as the only one caring for the sick person but instead work together with the health professionals and even the more prominent family of the sick person. The minister must acknowledge the role of other caregivers and also the importance of the family. The caregiver must recognise the support network for the dying and their family and best serve as an intermediary or broker.

To a large extent, the minister can serve as a “broker”, connecting the patient services of the health practitioners (hospital) with other individuals and groups in the community who can supplement service to clients and families while clients are in the hospital. There are a lot of social services for the clients out there that can be brought on board by the intermediary role of the pastoral caregiver. It is, therefore, imperative that the minister should acquaint him/herself with the social work resources of the hospital and the community (Redding 2012).

Conclusion and Recommendations

This paper has examined the psychological stages associated with the news and care of terminally ill patients. The general human attitude to death, the ontological and theological view of death, and the psychological reaction to the threat of death were discussed in the context of and in reference to the terminally ill. The five stages of shock, catharsis and depression, negotiation, drama of cognition and commitment were identified and highlighted. The task of pastoral caregivers in addressing and managing

the emotional trauma of the terminally ill (and, by extension, family and friends) was then presented from a phenomenological approach. It was found out that the pastoral caregiver, who is essentially a gospel minister in this context, must have worked adequately on himself, his fear and feelings concerning the issue of death before the caregiver can efficiently and effectively help a terminally ill. The qualities of a pastoral caregiver must be expressed through prayer, ministry of presence and reconciliation (referred to as broker).

The minister must, therefore, have a grip on the basic psychological needs of a dying person and the emotional process of grief. Armed with the psychological and theological tools, the minister will become more effective in providing relevant care for the dying. A pastoral caregiver should be sensitive to the theological and ethical questions of the dying client. They must be an active listener and be available. The caregiver must also facilitate communication between the dying person, the family, and the health and social worker. Caring for the dying is a herculean task that constantly calls for more examinations, investigation, information, and exploration. The minister can draw from the scripture passages relevant to giving hope to the dying, and these passages must be used rightly. Spiritual resources must not, however, be used to run away from the practical, existential reality of pain and death but instead to help the client see the temporariness of pain and death. Prayer should not be used as a "magical wand" to remove the "spell" of death. Admittedly, God can decide to heal even in impossible situations, but the caregiver must be careful in the use of prayer, never to play God.

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