Life after Cancer;
Approaching the Patient's Suffering from a Pastoral Perspective

By Archimandrite Cleopas Strongylis, Th.D.

1. PROLOGUE

I was 22 years old when a friend of mine, named Demetrios Diamantis, a fellow-student from the Theological School of Athens, died of cancer a week after his graduation. I was asked to offer my help during Demetrios' sickness. Because of my lack of experience in this type of situation I was unable to properly assist him.

When I came to Boston to further my theological education, at Holy Cross, His Grace, Bishop Methodios of Boston, suggested that I visit with the "Philoxenia" residents. The people of this facility have different types of illnesses, some of which have cancer. In order that I may help these people deal with their illness, I must have some type of understanding of the illness itself. This was what inspired me to research this topic.

This paper examines various aspects of cancer. One important factor in getting cancer is emotional stress. Such stress has the tendency to suppress the immune system, and may also lead to hormonal imbalances. These imbalances may increase the production of abnormal cells at precisely the time at which the body is least capable of destroying them. The main message of my paper is that since emotional states effect the immune system, they also contribute to an individual's health. By realizing his participation in the onset of the disease, a patient is taking his first step toward getting well again.

I feel the need to express my gratitude all those who in many ways have assisted me in my effort to complete the writing of this paper: I am deeply grateful for the guidance of His Eminence, Metropolitan Methodios of Boston, whose support and encouragement has been very helpful to me during my diaconate in "Philoxenia." I want to express my appreciation to Rev. Frs. Nicholaos Krommydas and Emmanuel Clapsis, and to Mrs. Sophia Nibi, for their excellent help, and advice, without which this paper would not be what it is today. Their interest and encouragement have been a great source of strength to me. Finally, I would like to thank Philoxenia's residends, who have shared so much of themselves with me and allowed me to share my self with them.

I dedicate my paper to all the above mentioned persons, for their invaluable guidance for my first approach to the cancer patient's suffering.

2. A P P R O A C H T O C A N C E R T R E A T M E N T

a. What is cancer?

An illness is not purely a physical problem but rather a problem of the whole person, that it includes not only body but mind and emotions. Emotional and mental states play a significant role both in susceptibility to disease, including cancer, and in recovery from all disease. The specialists believe that cancer is often an indication of problems elsewhere in an individual's life, problems aggravated or compounded by a series of stresses six to eighteen months prior to the onset of cancer. The cancer patient is usually a person with a deep sense of hopelessness, or "giving up." This emotional response in turn triggers a set of physiological responses that suppress the body's natural defenses and make it susceptible to producing abnormal cells. **(1)**

Cellular biology tells us that a cancerous cell is, in fact, a week and confused cell. A cancer begins with a cell that contains incorrect genetic information so that it is unable to perform its intended function. This cell may receive the incorrect information because it has been exposed to harmful substances or chemicals or damaged by other external causes, or simply because in the process of constantly reproducing billions of cells the body will occasionally make an imperfect one. If this cell reproduces other cells with the same incorrect genetic makeup, then a tumor begins to form composed of a mass of these imperfect cells. Normally, the body's defenses, the immune system, would recognize these cells and destroy them. At a minimum, they would be walled off so they could not spread. **(2)**

In the case of malignant cells, sufficient cellular changes take place so that they reproduce rapidly and begin to intrude on adjoining tissue. Whereas there is a form of "communication" between normal cells that prevents them from over-reproducing, the malignant cells are sufficiently disorganized so that they do not respond to the communication of the cells around them, and they begin to reproduce recklessly. The body normally destroys them. But if it does not, the mass of faulty cells, the tumor, may begin to block proper functioning of body organs, either by expanding to the point that it puts physical pressure on other organs or by replacing enough healthy cells in an organ with malignant cells so that the organ is no longer able to function. In severe forms of cancer, malignant cells break loose from the original mass and are transported to other parts of the body, where they begin to reproduce and form new tumors. This breaking off and spreading is called "metastasis." **(3)**

b. What causes cancer?

Cancer is a common cause of death in this country - about 25% of the population will eventually die of some form of cancer. **(4)** Cancer is caused by carcinogenic substances, or by genetic predisposition, or by radiation, or perhaps by diet. In reality, not one of these elements alone is a sufficient explanation for who gets cancer and who doesn't. Let's look at each separately, as they are described by Carl and Stephanie Simonton. **(5)**

Carcinogenic Substances: There are harmful substances, including analine dyes, asbestos, coal tars, and other chemicals that apparently are able to affect the genetic information in cells and thus produce cancer. These substances have become known as "carcinogens," or cancer-producing agents. Genetic Predisposition: Although genetic factors may play some role, we do not believe that by themselves they can explain the different patterns of cancer incidence throughout the world. It is important to consider the stressful changes that occur along with industrialization and integrate that information into our current thinking about cancer incidence. Radiation: Still another suspect in the lineup of possible cancer causes is radiation, since it is well known that radiation can cause mutations in cells, which could in turn reproduce and lead to cancer. We are all subjected to many sources of radiation. First, the earth is constantly bombarded from outer space with what is called "cosmic radiation." Another possibility being discussed lately is that fluorocarbons released from aerosol cans may be capable of destroying the protective layer of ozone in the atmosphere, leading to an increased exposure to ultraviolet radiation from the sun. There has also been considerable discussion of the harmful effects of X-rays and other radiation used in medical diagnosis and treatment. The evidence is still unclear, and caution is certainly reasonable. Diet: Including diet as a possible cause of cancer is relatively recent. Some researchers have suggested that the incidence of certain kinds of cancer may relate to the amount of fat in our diets. Cancer, like other degenerative diseases, may strike hardest the overfed. **(6)**

Everyone produces abnormal cells in the body from time to time, either because of external factors or simply because of inaccurate cellular reproduction. Normally, the body's immune system keeps close watch out for any abnormal cells and destroys them. For cancer to occur, then, the immune system must be inhibited in some way. **(7)**

Abnormal cells are present in everybody's body occasionally throughout life. So, whether abnormal cells are created by external factors or simply occur naturally, the crucial questions become: What lapse in the body's defenses allows these cells to reproduce into life-threatening tumor at this time? What inhibits the body's immune system from performing the function that it has performed successfully for many years? The answers to these questions bring us back to emotional and mental factors in health and illness. The same factors that may determine why one patient lives and another with the identical diagnosis and treatment dies also influence why one person contracts a disease and another does not. It is time to consider how the interrelationship of mind, body, and emotions may give us important new insights into the increased susceptibility to illness in general, cancer in particular, and into the question, "Why me?" **(8)**

It may be that we are unable to recognize the processes because we are not paying sufficient attention to the effect on the body of the mental and emotional aspects of human beings, including their beliefs about their illness, their treatment, and their chances for recovery.

c. The link between stress and cancer

There is a clear link between stress and illness, a link so strong that it is possible to predict illness based on the amount of stress in people's lives. Recent studies have begun to reveal the physiological process by which emotional responses to stress can create susceptibility to disease. These findings are of critical importance to cancer patients, for they suggest that the effects of emotional stress can suppress the immune system, thus shackling the body's natural defenses against cancer and other disease. **(9)**

The meaning of an event - even a stressful one - is construed differently from person to person. Loss of a job at age twenty will usually be less stressful that will loss of a job at fifty. The amount of stress varies with the individual. Stress may accumulate to the point that the individual simply can no longer cope and consequently becomes ill. But usually the relationship between stress and the individual's ability to cope is more complex. Holmes and Masuda acknowledge the significance of the individual's response in their analysis of why stress can lead to illness: "When life is too hectic, and when coping attempts fail, illness is the unhappy result." **(10)**

The body is designed so that moments of stress, followed by a physical reaction such as fighting or fleeing, do little harm. However, when the physiological response to stress is not discharged, then there is chronic stress, stress that is held in the body and not released. And chronic stress, it is increasingly recognized, plays a significant role in many illness. Dr. Hans Selye, an endocrinologist and director of the Institute on Experimental Medicine and Surgery at the University of Montreal, described the effects of chronic stress on the body. Selye has discovered that chronic stress suppresses the immune system which is responsible for engulfing and destroying cancerous cellsor alien microorganisms. The important point is this: The physical conditions Selye describes as being produced by stress are virtually identical to those under which an abnormal cell could reproduce and spread into a dangerous cancer. Not surprisingly, cancer patients frequently have weakened immune systems. **(11)**

Dr. George Solomon of California State University begun to specify the physiological mechanism by which stress could lead to a suppression of the immune system. When his work is

combined with that of Selye, a picture begins to emerge of how emotional stress can create the conditions under which cancer can occur. What remains is the need for a sufficient understanding of the body to describe the precise links between cancer and stress. **(12)**

One of the finest studies on emotional states and cancer was reported in *A Psychological Study of Cancer*, written in 1926 by Elida Evans, a Jungian psychoanalyst, with an introduction by Carl Jung. Based on her analysis of one hundred cancer patients, Evans concluded that many cancer patients had lost an important emotional relationship before the onset of the disease. Evans believed that cancer was a symptom of other unresolved problems in a patient's life, and her observations have since been confirmed and elaborated on by a number of other researchers. **(13)**

Dr. Lawrence LeShan, an experimental psychologist by training and a clinical psychologist by experience, is the foremost theorist of the psychological life history of cancer patients. In his recently published book, *You Can Fight for Your Life: Emotional Factors in the Causation of Cancer,* he reports findings similar in many ways to those of Evans. **(14)**

Another element of LeShan's description, that cancer patients tend to be prone to feelings of hopelessness and helplessness even before the onset of their cancer, has been confirmed by two other studies. Drs. A. H. Schmale and H. Iker observed in their female cancer patients a particular kind of giving-up, a sense of hopeless frustration surrounding a conflict for which there was no resolution. The researchers pointed out that this does not mean that feelings of helplessness cause cancer - their patients appeared to have some predisposition to cervical cancer - but that the helplessness seemed to be an important element. **(15)**

E. M. Blumberg demonstrated that the patients with fast-growing tumors were more defensive and less able to defend themselves against anxiety. In addition, they tended to reject affliction, even though they wanted to. The slow-growing tumor group showed a greater ability to absorb emotional shocks and to reduce tension by physical activity. **(16)**

Dr. B. Klopfer believes that when too much energy is tied up defending the ego and the patient's way of seeing life, the body will not have the necessary vital energy to fight the cancer. **(17)**

d. The steps of cancer onset

Carl and Stephanie Simonton identify five steps of a psychological process that frequently precedes the onset of cancer:

1st: The decisions made in childhood limit a person's resources for coping with stresses. By adulthood, most of these childhood decisions are no longer conscious. The same ways of acting have been repeated so many times that awareness of our ever having made a choice is lost. But unless these choices are changed, they become the rules of the game of our life. Every need to be met, every problem to be solved must be handled within these limited choices made in early childhood.

2nd: The individual is rocked by a cluster of stressful life events.

3rd: The stresses create a problem with which the individual does not known how to deal.

4th: The individual sees no way of changing the rules about how he or she must act and so feels traped and helpless to resolve the problem. Most of our patients acknowledge that there was a time prior to the onset of their illness when they felt helpless, unable to solve or control problems in their lives, and found themselves "giving up." They saw themselves as "victims" - months before the onset of cancer - because they no longer felt capable of altering their lives in ways that would resolve their problems or reduce their stresses. Life happened to them; they did not control

it. They were acted upon rather than actors. The continued stresses were final proof to them that time and further developments would not improve their lot.

5th: The individual puts distance between himself and the problem, becoming static, unchanging. On the surface the patient may seem to coping with life, but internally life seems to hold no further meaning, except in maintaining the conventions. Serious illness or death represents a solution, an exit, or a postponement of the problem. Most patients, however, will recall having had feelings of helplessness or hopelessness some months prior to the onset of the disease. This process does not cause cancer, rather it permits cancer to develop. It is this giving up on life that plays a role in interfering with the immune system and may, through changes in hormonal balance, lead to an increase in the production of abnormal cells. Physically, it creates a climate that is right for the development of cancer. **(18)**

A mind-body model of cancer development, described by Carl and Stephanie Simonton, is the following: "The messages that the hypothalamus receives from the limbic system are then translated in two important ways: First, part of the hypothalamus - that part most responsive to human emotional stress - participates in controlling the immune system. Second, the hypothalamus plays a critical role in regulating the activity of the pituitary gland, which in turn regulates the remainder of the endocrine system with its vast range of hormonal control functions throughout the body. In the mind/body model, emotional stress, mediated by the limbic system via the hypothalamus, produces a suppression of the immune system, which leaves the body susceptible to the development of cancer. The hypothalamus, responding to stress, triggers the pituitary gland in such a way that the hormonal balance of the body - mediated by the endocrine system - is changed. The result of such an hormonal imbalance can be an increased production of abnormal cells in the body and a weakened ability of the immune system to combat these cells. With this sequence of physiological changes, optimal conditions are now created for cancer growth. That is, at the same time the body's defenses against intruders are lowest, the production of abnormal cells is increased. The result can be a life-threatening disease." **(1)**

3. THE DIAGNOSIS-THE PATIENT-THE PASTOR

a. Cancer diagnosis and patient's reaction

After hearing the cancer diagnosis, patients may cry a great deal. They are mourning the possibility of their own death and the loss of the feeling that they will live forever. They are mourning the loss of their health and their image of themselves as vital, powerful people. Grief is a normal response; the family must try to accept it. Holding in feelings and maintaining composure in the face of death does not define bravery. The single, most important thing the family can offer is the willingness to go through this experience with their loved one. Unless the patient asks to be alone, stay with him or her; provide lots of physical touching, hugs, and closeness. Share feelings without thinking you have to change them. **(20)**

The emotional impact of cancer and its treatment is enormous to the patient and to the family. The diagnosis of cancer brings immediate thoughts of death, usually lingering death, even though many cancers can now be cured and patients survive longer today with many cancers than they did a decade or two ago. For an older person with another life-threatening illness, such as heart disease, the diagnosis of cancer is a severe additional threat to life. For an otherwise healthy, young person, particularly for a child, cancer is a disaster and profoundly changes one's entire outlook on life. **(21)**

Jean B. Moen, Joan E. Roover, and Marion F. Stonberg enumerates the following diverse issues confronting the cancer patient:

1. Cancer is a disease where the communication about the illness is frequently not complete between the patient, family, and health care team because of fear, anxiety, threat of death, and the inability of everyone to face the outcome. General communication, unrelated to the illness, frequently suffers also.

2. The patient's attitude toward the diagnosis is affected by the fact that most people equate the diagnosis of cancer with death.

3. The patient feels helpless in the control of the disease. Some diseases are managed by diet, medication, or restricted activity, and the patient is able to have a sense of control through cooperation with the prescribed regimen. No matter how cooperative a cancer patient may be with treatment, the disease can progress.

4. The patient can never feel really secure and "cured" because of the nature of the disease. With each ache or pain or at each check-up examination, the patient fears a recurrence or a new primary.

5. An adjustment may be necessary to accept or live with an altered body image, either cosmetic or functional.

6. The inability to keep a job or a change in vocation may have to be faced.

7. Financial security may be threatened due to high hospital and treatment costs and inadequate insurance coverage.

8. The individual's family and societal relationships may be changed because of an inability to fulfill perilunes obligations. **(22)**

b. The priest facing the problems of cancer patient

Despite the very serious problems the priests are facing, if they are willing to confront openly and honestly the experience of dealing with the life-threatening disease of every patient, the experience may contribute to their own personal growth. The beginning focus in the discussion of the pastoral care of the cancer patients must be on us: on us as human beings, some of whom will grow old and die and some of whom will die before we know anything at all about the latter stages of the aging process. How can it be possible for us to be effective in our relationships with cancer patients as dying persons when the awareness of the reality of our own dying has not been adequately visualized by us, the emotions felt as much as we can, and these relatively well assimilated? How can we expect a dying person to become more realistic about her or his condition when we ourselves are effectively denying our own death? **(23)**

Since so much of what is involved in our ministry with cancer patients has to do with life's meaning, how are we going to be capable of being completely present to that person unless we ourselves are in the process of working out the meaning of our own personal lives within the context of the only absolute certainty of our lives, our own death, also for all of us, should we live so long, our understanding of ourselves as persons with numerous limitations, those who know pain, who suffer, who experience significant losses, who get ill ourselves, and whose inevitable death is a part of our own present being? **(24)**

The first absolutely critical issue, then, in terms of willingness and ability to work helpfully with cancer patients is who we are as persons. What kind of people can we tolerate? Which ones frighten us, anger us, lead us to feel depressed? These feelings of ours tend to make us very selective of the persons with whom we relate well, grequently, regularly, and effectively, and our behavior of attention or inattention, approach of withdrawal, has an important positive or negative impact upon these persons' lives, and in tern, back upon our own. The whole point I am in the process of trying to make here is that what the cancer patient needs with great urgency and

intensity is, on the whole, what we all need at all times. Those who work with the cancer patients, the elderly and the dying are in a position to use their genuine humanity, their warmth and sensitivity as persons, in the meeting of these needs. **(25)**

Recently, Arthur Dyck, professor of population ethics at the Harvard School of Public Health, contrast two contending policies regarding the value of life: one the "quality-of-life issue" and the other the "equality-of-life issue." In the end he supports the latter view by bringing back to the lesson of the Good Samaritan. We must administer to the care of the maimed, the dying, the bleeding, and the incompetent. His final words are, "the moral question for us is not whether the suffering and the dying are persons, but whether we are the kind of persons who will care for them without doubting their worth." **(26)**

In discussing the psychologic impact of cancer, one must consider the many variations of disease, prognosis, and forms of treatment with age and socioeconomic implications and describe their impact on the individual. Every patient is an individual with his own complex emotional configuration. **(27)**

c. The priest helping the cancer patient

The priest may assist the patient through the stressful period of diagnosis. Explanation of diagnostic procedures reduces fear of the unknown and allows the patient to be prepared for what is to be expected of him. It is often helpful to the patient for the pastor to be present when the physician discusses the diagnosis and the options for treatment. Knowledge of physical and emotional responses is necessary to deal with the variety of problems faced by the patient who has cancer. The pastor should understand and accept the patient's coping behavior. Often the pretreatment phase is extended because tests are needed to establish the stage of disease; this places an additional psychologic burden on the patient. The pastor should encourage and allow the patient to discuss fears and anxieties and be available to explain again procedures that have been discussed by the physician. **(28)**

Sometimes the patient must face surgical procedures that will alter their body image while also having to deal with a diagnosis of cancer. Stress can be alleviated somewhat by allowing the patient and family to express their feelings; by preparing them for the surgical procedure with careful explanations of equipment, techniques, and procedures to be used; and by describing postoperative care and the plan for rehabilitation. Because of the variety of surgical procedures performed, some type presenting its own problems of wound healing, rehabilitation, and return to the patient's normal lifestyle, patients treated surgically face many needs. Specifically, the pastor should determine what information the patient and family need in order to cope effectively. If radical surgery has been performed which results in an alteration of the patient's body image, it may be anticipated that the patient will go through some degree of depression, mourning for the lost body part, anger, and fear - all of which require time to be resolved. As a result of this depression, patients sometimes refuse to learn to care for themselves. Teaching should take into account that the patient has to adapt to the alteration in body concept and the care of the deficit. The patient's spouse or other emotionally significant person may need to be included in this teaching since the patient's social adjustment often depends on their acceptance. **(29)**

d. Cancre patient’s needs

We must pay attention to the importance of relationships patients may have established with their church and their religious counselor. The first meeting of the pastor with the patient is

the most propitious. In a case of cancer, the situation is more critical because the patient may have been studied previously and a tentative diagnosis made. For this reason, it is essential that sympathetic report be established by the collaboration of the doctor and the pastor. The patient is vulnerable. He expects the worst. Frightened and uneasy, he needs more than anything to be recognized as a human being, not as a disease. He wants the compassion and understanding that these two persons can provide. The clergy, being an important resource, both in and out of the hospital, must know the following fairly common needs of persons who have been affected from cancer:

Expression of feelings: Undoubtedly the place to begin is for the person to have the opportunity to express whatever feelings of fear, anger, guilt, sadness, loneliness, or other feelings that she or he may have. The need of the ill person is for someone who is willing to take the time to sit and listen, to encourage his expression, to struggle to understand, and who is capable of receiving the strong emotions which are involved. Those patients do best who have been encouraged to express their rage, to cry in preparatory grief, and to express their fears and fantasies to a pastor who can quietly sit and listen. **(30)**

No pastor can tell another how to conduct this stage of patient care. It is a very personal matter , varying from pastor to pastor and patient to patient, but it is essential for the pastor to listen, to understand, and to explain. Sometimes, he can do so in a few minutes; at other times, it takes much longer. In any event, at the end of this first meeting the patient must have a sense of trust and hope. **(31)**

Pastors, as all health professionals, have a great deal of difficulty, and probably feel the most insecure, in the area of dealing with the emotional aspects of cancer. It is inevitable that while talking with the pastor, patients may discuss their feelings, symptoms, fears, anxieties, family situations, or prognosis. The pastor should take cues, both verbal and nonverbal, from the patient and react according to these observations, remembering that all patients are not alike in their response to the same illness. A supportive relationship depends on a humane, sympathetic, and flexible attitude, encouragement, and a willingness to listen, discuss, and give information within the scope of the patient's knowledge of their disease and their desire for help as expressed by questions and conversation. **(32)**

The pastor should become well-aquainted with the patient's pain. Sometimes even a simple conversation with him about his pain can help the others deal with it better. Besides this, the patient often feels better in knowing that he is understood by others and especially by the pastor, and not forsaken. **(33)**

And the question is, as in a pastoral-psychological way, how do we help people? I think we help people not by telling them how they ought to feel. We don't know how pain is going to feel. **(34)** That's how we show how much we care, by understanding the people who we are with when they are in pain. **(35)** Whatever the patient and his family feel is okey. If we find ourselves trying to change how others feel, we must stop. It will lead to pain and blocked communication. Nothing can hurt a relationship more than for people to feel they cannot be themselves. **(36)**

Open and supportive communication requires sensitivity to what we hear and say. We do not have to find solutions for the patient's problems, to "rescue" the patient from depressing feelings. Simply let him express such feelings. We do not have to provide therapy, since our efforts will probably communicate lack of acceptance and the message that the feelings ought to be different from what they are. The best we have to offer is acceptance and acknowledgment of what the ill is feeling. Carl and Stephanie Simonton counsel us: "Ask yourself whether you are doing more talking than listening or whether you are finishing the patient's sentences. In either

case, consider whether your own anxieties are speaking and whether it might be more helpful to let the patient lead the conversation. If you talk less, you may encounter long periods of silence. There is a great deal of introspection necessarily going on during this time, so it perfectly natural that both you and the patient will be deep in thought at times; it does not mean a rejection of each other. The silence may even serve to encourage a normally withdrawn person to begin to share long pent-up feelings. Try to become comfortable with the silences." **(37)**

The Overcoming of Loneliness: We are saved, in some potent meaning of that word, if only one person, or hopefully a few people, will be willing to sit and listen and accept and understand and be for us, struggling to participate with us as much as they possibly can. Sick people, whether they are at home or in the hospital, need expressions of love, and this means love from a personal contact. When we hear such comments from the sick person: "Of what use am I to anyone ... " - this is a sign that the person feels alone, as though he was no longer of any value to anyone. This is fear and sorrow which arises from the person's sense of being forgotten. Expressions of love to the sick are signs that someone values them, that they are still important to others. The priest can play an important and helpful role in this matter. Very often the mere silent presence of the priest beside the sick person has great significance. This last message, "I'll be with you," is essential. All the fine words and phrases are of less help than our being with the patient, whatever the age. **(38)**

That One's Life Has Been Meaningful: A third need of every person, of a cancer patient, and much more urgently of a dying person, is the conviction that he has not lived in vain, that he has achieved some important things (within the family, in the community, in work), that his life has had a meaning and a purpose.

Sick people frequently give way to a feeling of aimlessness -they lose their sense of the meaning of life. They frequently pose the hard question: "Why did this happen to me?" Thus reaction is particularly common in the case of a tragic situation. The priest is the one who help an unfortunate person make peace with the fact of misfortune and find the meaning in life even in such a helpless state. The above reaction is understandable. When the whole structure which holds up a person's life is crumbling, when all plans come to to ruin, then indeed it is common to lose the meaning in life. This happens before serious operation, and it is so good when, at such a time, there beside the sick person stands an intimate, understanding friend, or a pastor. **(39)**

Sometimes it also happens that, at this time, patients show a sense of humor and even a sort of mischievousness. Psychologically speaking, this is a person's attempt to restore his self-identity, his state, his normal ego. In such a stage patients will frequently try to be helpful to someone, to serve someone's needs. This should not be hindered or dinied, for this is their attempt to manifest their humanity, their previous self-image. **(40)**

To Find Meaning in the Present Moment: Fourth, it is essential that the pastor be able to participate with the patient in their struggle to find meaning in the present process with its increasing debilitation and often pain and inevitable end. Our respect for other persons, our valuing of them, is fully expressed only if we can truly allow them, with our participation, to work out and express the meaning of their present experience in their own way, even if it is different from the meaning we might attribute to it. It also has to be recognized clearly that the way in which we might frame the gospel for ourselves and share it with another person, even when he is a person of faith, might not significantly touch the most important concrete issues of that person's life in the process of illness as he sees them. Our task and opportunity is to be the facilitator of a particular person's discovery in his particular set of experiences of the meaning that may be there for him. **(41)**

To Continue To Feel Useful**:** David Switzer has the complete statement of a student in a theological seminary, written several months before he died of cancer. Among the other struggles he referred to, he said: "The issue that bothered me most was the question of my worth as a human being. I wondered whether people had written me off as being among the dead. I longed for someone to tell me that I was still wanted and needed." Even when a dying person is no longer functional in the usual sense, or is in the process of losing functions and is beginning to feel useless, the responsive helping person may meet that person's need by reinforcing his affectional value, helping the person identify and affirm his symbolic value. A human being's sense of usefulness does not have to be lost. **(42)**

To Contact with the future**:** Patients speak more readily of their life to someone from a system outside their family, someone from the medical staff, or a priest, etc. It is very good when a pastor adapts to the patients' state and listens to them, for they are trying to preserve their picture of the life they have lived to keep their contact with the past. Now the patients need contact with the future as well, and they will find it more easily with the priest or some other person rather than with members of the family. The terminal patients speak about various failures and sins, sometimes even about petty things - they express penitence. **(43)**

To be Treated as a Responsible Person**:** It is essential the patient be treated as a responsible person, not an irresponsible child or a victim. The best approach is to be supportive without "babying." The treatment may very well be painful, so a babying response misleads and diminishes the patient. When either the patient, the spouse, or another family member is afraid, it is important that they communicate as one adult to another, realistically and openly acknowledging the potential risks and pain involved. **(44)**

A supportive rather than babying stance is equally important with children who are cancer patients. Just because a child is sick does not mean he wants or needs to be treated like a baby. In addition, children are often able to cope more effectively with their feelings than are adults, because their feelings are closer to the surface, and they are less likely to judge themselves for what they feel. But not babying children, you are communicating recognition of their own resources. **(45)**

When the patient has advanced cancer, palliative rehabilitation can be of assistance in maintaining comfort and increasing person independence. Encouraging the patient to assist in personal care to the extent of physical capabilities will enhance a feeling of worth and dignity and allow the patient to maintain control. It is important that each patient be considered as an individual, providing those measures of rehabilitation which are appropriate to reasonable expectations and desires. **(46)**

4. F A M I L Y S U P P O R T

a. The priest guiding the patient’s family

Spouses and family members frequently need as much support and guidance in coping with feelings as patients do. No experience is more certain to make you feel at times confused, inadequate, and lacking in compassion and understanding than watching someone you love go through a life-threatening disease. Yet this experience can also leave you feeling enriched and human in ways not normally experienced in everyday living. **(47)**

The pastor cannot help the terminally ill patient in a really meaningful way if he do not include his family. They play a significant role during the time of illness and their reactions will contribute a lot to the patient's response to his illness. If the pastor can help the patient and his family to get "in tune" to each other's needs and come to an acceptance of an unavoidable reality

together, he can help to avoid much unnecessary agony and suffering on the part of the dying and even more so on the part of the family that is left behind. **(48)**

Illness may cause major disruptions in family life and at times family members may need as much help as the patient. Communication skills need to be developed. There is a time to speak and a time to listen. Developing the art of listening can be the most meaningful act the pastor can do for the patient and family. When family members appear to need help, the pastor should arrange appropriate referrals to ministers, counselors, lawyers, social workers, physicians, psychiatrists, and other families who have struggled with similar problems. Such resources may provide enormous emotional support and practical guidance in those times of severe stress for patients with cancer and families. **(49)**

The family need not believe the patient *will* recover; they need only to believe that he *can* recover. Since the patient's positive belief in the effectiveness of the treatment and trust in the pastor play an important role in recovery, the family may need to reexamine their own expectancies and attempt to alter their beliefs so that they will be supportive. They are part of the patient's "support system," so it is important that they support health and recovery. Illness and the hospitalization of a family member offers an exceptional opportunity for the proper pastoral care of the entire family. Such personal care can be very beneficial. In the presence of illness and the threat of death, it is easier for people to confess all sorts of negative family feelings, and, thus, a certain state of health and harmony comes to the family. Therefore, the role of the priest in such a situation is very important, with far-reaching implications. **(50)**

b. The supportive role of the patient's family

Carl and Stephanie Simonton advice their cancer patients' families how to become supportive to their loved ones: "The object is to discover how you can respond most beneficially for yourself and the person you love. And the first step is to accept your feelings and those of the patient and to understand that these emotions are necessary and right in coming to grips with the possibility of death. Everyone is aware of the need to be understanding, tolerant, and accepting of the patient. Apply the same principle to yourself. Just as you can understand the fright, the terror, the hurt of your loved one, be aware of your own fright, terror, and hurt, and be understanding with yourself as well. No one ever faces the death of someone they love without also facing their own eventual death. Accept yourself and be gentle. But even if the emotions are painful, it is important during the first weeks following the diagnosis of cancer to establish a basis for honest, open communication. The patient needs to be allowed - and encouraged - to express feelings. You and all members of the family must be prepared to listen, even though there may be a large part of you that doesn't want to. If the patient is denied the opportunity to discuss what is most troubling - fear, pain, death - he will feel isolated. When what really matters to you is precisely what you cannot discuss, then you are very lonely indeed. One key to easing this time is to encourage open expression of feelings, listen without judging, and accept your feelings and the patient's as natural and necessary. Then try to interpret the real meaning of a request, and honor as much of patient's needs as you can without losing your own integrity or sacrificing other members of the family in the process. There is no doubt that this will require unusual amounts of patience, sensitivity, and understanding on the part of the entire family, but knowledge of what to expect and some advice on how you might cope can help get all of you through the experience." **(51)**

It is more meaningful for the patient and his family to see that the illness does not totally disrupt a household or completely deprive all members of any pleasurable activities; rather, the illness may allow for a gradual adjustment and change toward the kind of home it is going to be

when the patient is no longer around. Just as the terminal ill patient cannot face death all the time, family member cannot and should not exclude all other interactions for the sake of being with the patient exclusively. He too has a need to deny or avoid the sad realities at times in order to face them better when his presence is really needed. An understanding helper can contribute a lot toward helping them maintain a sound balance between serving the patient and respecting their own needs. **(52)**

The general principles of being available, being open and being supportive and traditional and very important components of patient care. Teaching patients and families what they can expect emotionally, just as they are taught what to expect physically, can be enormously supportive. During evaluation, it can be pointed out to patients that their life-style is a source of self-esteem and that illness and any resulting changes in life-style are injuries that will generate strong feelings. **(53)**

Just as the family needs to avoid trying to rescue the patient from the joys and pains of everyday family life, patients need to avoid trying to rescue their families from painful feelings. In the long run, everybody's psychological health is improved when feelings are openly dealt with and resolved. **(54)**

Nothing could be more destructive of the patient's need to take charge of his own health. The rescuer may bring the patient food or drinks, even though the patient is perfectly capable of getting these for himself. It is also damaging to try to protect the patient from other family problems, such as a child's difficulties in school. Taking the attitude that the patient "already has so many problems" isolates him from the family precisely at the time when it is most important for the patient to feel commited to and involved with life. **(55)**

5. R E C O V E R Y

a. Patient's participation in his or her recovery

In this chapter we will describe what a cancer patient can do in conjunction with medical treatment to gain the health he deserve. Understanding how much he can participate in his health or illness is a significant first step for everyone in getting well. There are no guarantees at this time that a positive expectation of recovery will be realized. But without hope the person has only hopelessness (a feeling that, is already too much a part of the cancer patient's life and personality). We do not deny the possibility of death; indeed, we must help the patients confront it as a possible outcome. We must also help them believe that they can influence their condition and that their mind, body, and emotions can work together to create health.

Individuals who begin to accept responsibility for influencing the state of their health deserve the greatest of congratulations. Not only are they willing to begin the process of exploring their own attitudes, emotions, and feelings - and the ways these contribute to their response to stressful situations - but they are also finding the courage to stand up to the cultural rules they were taught and to reject those that are not conducive to health.

The real point of a self-examination is to turn up clues on how you can participate in health through a process of recognizing and changing self-destructive beliefs. If the patient has participated in the onset of the disease, he also has the power to participate in his recovery. **(56)**

Mind, body, and emotions are a unitary system - affect one and you affect the others. As Dr. Barbara Brown, a pioneer in biofeedback research, states: "The mind can relieve illness as well as create them." **(57)**

As early as 1959, Dr. Eugene Pendergrass, former president of the American Cancer Society, emphasized the necessity of treating the whole patient, not just the physical manifestations

of cancer: "There is solid evidence that the course of the disease in general is affected by emotional distress ... . Within one's mind is a power capable of exerting forces which can either enhance or inhibit the progress of this disease." **(58)**

The importance of Dr. Pendergrass's view is not just that it underscores the role that psychological factors play in aggravating a disease, it also emphasizes the possibility that psychological factors, including the patient's beliefs, may be mobilized to move toward health. Not only can mental and emotional conditions originate or aggravate physical conditions, they can also contribute to health. Just as one can become psychosomatically ill, so one who is ill can move in the other direction and become psychosomatically healthy.

Simontons have observed four psychological steps that occur in the upward spiral of recovery:

"1. With the diagnosis of a life-threatening illness, the individual gains a new perspective on his problem.

2. The individual makes a decision to alter behavior, to be a different kind of person. The individual begins to see that it is within his power to solve or cope with problems. He also discovers that life did not end when old rules were broken and that changes in behavior did not result in loss of identity. Thus, there is more freedom to act and more resources with which to live. Based on these new experiences, the individual makes a decision to be a different kind of person; the disease serves as permission to change.

3. Physical processes in the body respond to the feelings of hope and the renewed desire to live, creating a reinforcing cycle with the new mental state. The renewed hope and desire to live initiate physical processes that result in improved health. Since mind, body, and emotions act as a system, changes in the psychological state result in changes in the physical state.

4. The recovered patient is 'weller than well.' Patients who have actively participated in recovery from cancer have a psychological strength, a positive self-concept, a sense of control over their lives that clearly represent an improved level of psychological development." **(59)**

Illness is an opportunity for the individual to achieve emotional growth. For many cancer patients, the body has become the enemy. It has betrayed them by getting sick and threatening their lives. They feel alienated from it and mistrust its ability to combat their disease. Learning to relax and influence the body, on the other hand, helps people accept their body once again and their ability to work with it toward health. Learning to relax physically helps them break the cycle of tension and fear. For a few minutes at least, while they are relaxing their bodies, cancer is not the overriding reality of their lives. Many patients report that they have a different perspective and renewed energy after using relaxation. **(60)**

b. Setting goals

On receiving a cancer diagnosis, there is a tendency to begin living life tentatively and conditionally. Frequently, people withdraw from relationships or refuse to make commitments. Not only does this establish the negative expectancy of death rather than recovery, this tentativeness can also significantly diminish the quality of life. Goals are important in maintaining a high quality of life. The will to live is certainly strengthened, even when life is threatened, if people ensure themselves of meaning and pleasure. **(61)**

Cancer patients often feel the need to be creative - they want to do something. Even a sick person wants to feel that he is making some contribution to life, to his fate, and surroundings. This is very important because it gives people a goal, a reason for existence, and thus for getting well. All the patients had very strong reasons for wanting to live, could elaborate their reasons in great

detail, and felt that this intense attachment to a goal in life was an explanation for their unusually positive progress.

By asking cancer patients to set goals, the pastor help them conceptualize and focus their reasons for living, reestablishing their connection with life. It is a way of saying that there are things you want out of life and will make an effort to achieve. It is a way to transform emotional, mental, and physical needs into life-affirming behavior, to reinvest yourself in life. The will to live is stronger when there is something to live for. Setting goals has many other significant benefits for the cancer patient: The patient is acting upon life rather than being acted upon by forces not under his control. Goals are simply tools for patient to focus his energy in positive directions. They can be changed as his priorities change, new ones added, and others dropped. A goal is no more than a statement of his present needs, as he perceive them. He is responsible for understanding his needs and setting reasonable goals to meet them. And as he takes action to achieve what matters to him,he is investing his own life with meaning -the single most important step toward moving in the direction of health. **(62)**

c. Steps toward recovery

The pathways by which feelings can be translated into physiological conditions conducive to cancer growth can also be used to restore health, that is how mind and body can interact to create health. The explanation starts again in the psychological realm. In the first chapter we explained the causes under which someone can get cancer. At this point we will show how cancer patients can participate in getting well again, following the Simontons' method, which is the following:

> "Psychological Intervention: The first step toward recovery is to assist cancer patients in strengthening their beliefs in the effectiveness of treatment and the potency of their bodies' defenses. Then they can be taught to cope more effectively with the stresses in their lives. It is particularly important that there be a change either in patients' perceptions of themselves - so they believe they can solve whatever life problems faced them before the onset of the cancer - or in their perception of their problems - so they believe they can cope with them more effectively.
> Hope, Anticipation: The results of patient's beliefs in their opportunities for recovery, coupled with their "redecision" about the problems they face, are an approach to life that includes hope and anticipation.
> Limbic System: Altered feelings of hope and anticipation are recorded in the limbic system, just as were the previous feelings of hopelessness and despair.
> Hypothalamic Activity: Once these feelings are recorded in the limbic system, messages are sent to the hypothalamus reflecting the altered emotional state - a state that includes an increased will to live. The hypothalamus then sends messages to the pituitary gland that reflect the altered emotional state.
> Immune System: The hypothalamus in turn reverses the suppression of the immune system, so that the body's defenses once again mobilize against abnormal cells.
> Pituitarity Activity / Endocrine System: The pituitary gland (which is part of the endocrine system), receiving messages from the hypothalamus, sends messages to the rest of the endocrine system, restoring the body's hormonal balance.
> Decrease in Abnormal Cells: With the hormonal balance restored, the body will discontinue producing large numbers of abnormal cells, leaving fewer such cells for either treatment or the body's revitalized defenses to cope with.

Cancer Regression: Normal functioning of the immune system and reduced production of abnormal cells create the optimal conditions for cancer regression. Remaining abnormal cells can be destroyed either by treatment or by the body's defenses." **(63)**

d. Medical treatment for cancer patient

There are also two other pathways to recovery: either an increase in immune activity or a decrease in abnormal cells. Of course, the optimal conditions would be for both events to occur simultaneously. The thrust of medical treatment has been primarily the reduction of abnormal cells through irradiation or chemotherapy. Surgery is also a direct effort to remove all abnormal cells from the body. Only immunotherapy, however, is aimed primarily at increasing immune activity. Immunotherapy focuses on stimulating the patient's existing immune system by introducing potentially stimulating substances, such as bacteria or altered cancer cells. As the immune system attacks the cancer cells. Although immunotherapy is still in a relatively unrefined stage, in the future it may prove to be the superior method of treatment because it reinforces the body's natural functioning. **(64)**

Recovery is more likely when we mobilize the whole person in the direction of health. It is this concept, that the whole person be mobilized, that creates - even demands - a role for the patient in overcoming cancer and other diseases. The limits of the patient's responsibility extend far beyond getting himself to a physician who will "fix him up." Each person can assume responsibility for examining, even altering, beliefs and feelings that do not support the treatment, that do not move in the direction of affirming life and health.

6. R E C U R R E N C E A N D D E A T H

a. The body’s feedback and the priest’s role

Being prepared for a recurrence is one of the best ways to reduce the fear surrounding it. Usually the news is followed with a period of confusion and emotional turmoil. If patients decide that the future is going to be as painful as the present, they may give up emotionally, which can further hasten their physical decline. During a recurrence, we ask them to remember that this is a frightening and painful but temporary period. The shock and confusion will pass. When it has, they can begin to make a calm evaluation of what has occurred and what the future holds. **(65)**

A priest can be very helpful in discovering what message a recurrence holds, but patients must actively explore their own minds to understand the meaning of the message. The recurrence of cancer can be a time for patients to reevaluate their efforts to regain their health and decide whether or not to change direction. When the pastor helps people realize the value of their life, then they die easily and peacefully. It is very valuable to dying people to realize that they have done something for their children and for their descendants in general. **(66)**

The most meaningful help that we can give any relative, child or adult, is to share his feelings before the event of death and to allow him to work through his feelings, whether they are rational or irrational. If we tolerate their anger, whether it is directed at us, at the deceased,or at God, we are helping them take a great step towards acceptance without guilt. If we blame them for daring to ventilate such socially poorly tolerated thoughts, we are blameworthy for prolonging their grief, shame, and guilt which often results in physical and emotional ill health. **(67)**

Understanding the dying persons, expressing condolences, sharing their pain offers them support that is truly meaningful. Yet one must never try to console the dying person with some sort of argumentation. A person who thoughtlessly strives to stop the expression of pain and tears

should be asked to leave. The patients must cry out their feelings, or else they may suffer grave illness. Most cancer patients are less afraid of the fact of death than of its quality. They fear a lingering death that will drain family and friends emotionally and financially. They dread the prospect of months in a hospital, away from loved ones, leading a lonely, painful, and empty life. Their families often try to avoid the subject of death entirely. **(68)**

The one patient on the service who wants most to be seen, examined, and talked to is the patient who is or may be dying. When people see that death is inescapable, and life has no more comfort for them, or that they are left alone and forgotten, they are filled with hopelessness, sorrow and even mortal despair. Dying people, who have become aware of the nearness of death, often express the wise that someone be beside them, for death is hardest when one is alone. It is very important to show concern for the patient. Even such expressions of concern as fixing their pillows, covering them or holding their hand, assures the dying that they are not forgotten, that someone cares and shows them love. One need not hold lengthy discussions over such a patient; the entire retinue should not crowd into the room, but a sympathetic visit on the part of the priest can be more beneficial than an extra dose of narcotics. Attention to the little details, such as food, drink, bowels, position in bed, and air in the room, brings big emotional dividends. Above all, touch the patient, shake hands, take the pulse, and gently palpate the areas of pain. **(69)**

Sometimes in the course of conversation dying people make vague references to something they have lived through a long time ago. They begin to speak about something and they suddenly fall silent. This is often an attempt to speak about something unpleasant or unfinished. Then, it is recommended to encourage the patient to get it out, or to confess it for the peace of his soul and conscience. However, this matter should be dealt with in an understanding manner, carefully and tactfully. The presence of the spiritual minister at the side of the dying person is very important, because the priest, the good pastor, is a person who is in touch with both worlds: the world of humanity and the world of the spirit. However, the priest stands beside the sick person as human, first of all, because it is from this sort of relationship that it is possible to develop relations of a purely spiritual nature. However, it is better not to seize upon the person and force him to dwell on religious subjects. A sincere, warm, loving approach to the sick will lead them to ask for religious ministry themselves. Then such ministry will have a completely different meaning. **(70)**

When a person is dying, the last and ultimate sense of control that he has seems to be taken away. The other person is the one who is dying; therefore, respect for such people as persons means respect for their denials and their defenses as they are seeking as best they can to deal with their condition and situation. We are to move at their pace, not ours, with the degree of openness they desire. Our primary influence is not in our crashing through their defenses as the brave bearers of the objective reality concerning their lives, but with our accurate communication of empathy, our willingness to accept their feelings and share their struggles, tenderly and tentatively responding to their own testing of what it might be like to lower their defenses. Then, with a certain type of toughness, we are called to stay with them if they invite us into the raw and intense emotion of their inner lives. **(71)**

b. **The family of dying person**

Actually, some of our most effective work with a dying person is our contribution to the family members. The first need of the family is to accept the reality of the situation. We can only be patiently with them as the struggle with their denial and the difficult process of the acceptance of the fact of their family member's dying. Second, we can assist in facilitating the family's own

anticipatory grief. We can help them understand their own personal reactions: their fear, anger, guilt, grief, conflicts, how they differ from one another, and how their reactions affect one another. They have a very difficult process to go through also. Third, we can help the family understand the dying person more fully: the rising and falling of that person's different feelings, the day by day unpredictability of the person's moods and behaviors and levels of energy, his irritability, wanting to be taken care of, the person's occasional insistence on special favors, the withdrawal. In such increased understanding this may begin to help them not take personally some of the things which the dying person says or does, although we and they always need to be open to the possibility that some of the behaviors are realistic reflections of the nature of the relationship. **(72)**

The most heart-breaking time, perhaps, for the family is the final phase, when the patient is slowly detaching himself from his world including his family. They do not understand that a dying man who has found peace and acceptance in his death will have to separate himself, step by step, from his environment, including his most loved ones. How could be ever be ready to die if he continued to hold onto the meaningful relationships of which a man has so many? I think we can be of greatest service to them if we help them understand that only patients who have worked through their dying are able to detach themselves slowly and peacefully in this manner. It should be a source of comfort and solace to them and not one of grief and resentment. It is during this time that the family needs the most support, the patient perhaps the least. I do not mean to imply by this that the patient should then be left alone. We should always be available, but a patient who has reached this stage of acceptance usually requires little in terms of interpersonal relationship. **(73)**

The dying person can be of great help to his relatives in helping them meet his death. He can do this in different ways. One of the ways is naturally to share some of his thoughts and feelings with the members of the family in order to help them do the same. If he is able to work through his own grief show his family by his example how one can die with equanimity, they will remember his strength and bear their own sorrow with more dignity. **(74)**

In the final extremity of dying, when these already discussed needs are reasonably well met, we must assist by our attitude and behavior the inclination that some number of dying persons have to let go of life. At this time, dying persons may need our help in feeling that this pulling away is all right, nothing to feel guilty about, as we leave them in peace. To do this requires that we ourselves be willing to accept their lessened need of us, their withdrawing from us, and we, then, must deal with our own feelings of the loss of that person. **(75)**

We must assure the patients that we will be as supportive and caring through their dying as through their struggle to regain their health. We should point out an important thing to the patients: Whether or not they recover from the cancer, they have succeeded in improving the quality of their living - or the quality of their dying - and have exercised great strength and courage. **(76)**

Once the patient dies, I find it cruel and impropriate to speak of the love of God. When we lose someone, especially when we have had little if any time to prepare ourselves, we are enraged, angry, in despair; we should be allowed to express these feelings. The family members are often left alone as soon as they have given their consent for autopsy. Bitter, angry, or just numb, they walk through the corridors of the hospital, unable often to face the brutal reality. The first few days may be filled with busy-work, with arrangements and visiting relatives. The void and emptiness is felt after the funeral, after the departure of the relatives. It is at this time that family members feel most grateful to have someone to talk to, especially if it is someone who had recent contact with the deceased and who can share anecdotes of some good moments towards the end of

the deceased life. This helps the relative over the shock and the initial grief and prepares him for a gradual acceptance. Elisabeth Kubler-Ross provides helpful information for those in ministry: "Let the relative talk, cry, or scream if necessary. Let them share and ventilate, but be available. The relative has a long time of mourning ahead of him, when the problems for the dead are solved. He needs help and assistance from the confirmation of a so-called bad diagnosis until months after the death of a member of the family." **(77)**

7. EPILOQUE OF HOPE AND FAITH

If a patient stops expressing hope, it is usually a sign of imminent death. We should not "give up" on any patient, terminal or not terminal. It is the one who is beyond medical help who needs as much if not more care than the one who can look forward to another discharge. If we give up on such a patient, he may give up himself and further medical help may be forthcoming too late because he lacks the readiness and spirit to "make it once more." It is far more important to say, "To my knowledge I have done everything I can to help you. I will continue, however, to keep you as confortable as possible." Such a patient will keep his glimpse of hope and continue to regard his physician as a friend who will stick it out to the end. It is this glimpse of hope which maintains then through days, weeks, or months of suffering. It is the feeling that all this must have some meaning, will pay off eventually if they can only endure it for a little while longer. It is the hope that occasionally sneaks in, that all this is just like a nightmare and not true; that they will wake up one morning to be told that the doctors are ready to try out a new drug which seems promising, that they will use it on him and that they may be the chosen, special patient, just as the first heart transplant patient must have felt that he was chosen to play a very special role in life. It gives the terminally ill a sense of a special mission in life which helps them maintain their spirits, will enable them to endure more tests when everything becomes such a strain. **(78)**

For a religious person who believes that God is in control, the development of cancer and subsequent plea of "Why me?" often causes great hostility toward the God. It is difficult to maintain faith and to feel cared about or important under such circumstances. Thus, the burden of cancer affects almost every element of a patient's emotional life and requires profound readjustment in life-style.

One of the relationships that often gets changed or challenged by the situation of being a patient, of being ill, is the relationship with God. On the spiritual level there's often a sense of having been abandoned by God - of being far away from God. Many patients have said, "I can't pray anymore. I pray, but I don't feel like God is here. I can't feel God's nearness." And these are people who could before. In terms of spiritual life, not feeling the presence of God or experiencing Him - feeling abandoned by God - is a great threat, a great challenge. Peter Poulos, a Hospital Chaplain, in his article: "The Unity of Body, Mind and Soul: Pastoral - Psychological Perspective", notes underlines the followings: "The theological dimension of being ill is that we are faced with our limits. We are faced with the fact that we are human beings - that we're not God. They see that they too want to be God - or want to be able to control God. They see that they too can become frightened and at times angry with their limitations - the limitations of being human. A big part of what we are dealing with on a daily basis is learning to live with our humanness, learning to live within the limits and trying to become more comfortable with the fact that we are not all powerful - that we are not God." **(79)**

In this stage of the acceptance of death and the final preparation for it, a major role is played by faith and hope in God. It is in this stage that the truth of faith is tested, or it may also happen that a person's faith fails. Whatever the state of a person's faith as the person approaches

this phase, this is the stage in which he will die - it is best not to trouble them about it any longer. In the worst cases people may pass through this stage in a spirit of utter resignation. Such a death is not pleasant. One should note here that everyone dies in their own way: as they have lived, so do they die, for every manner of life is a preparation for one's own death. **(80)**

People facing death need to be allowed to complain against God Himself - do not rush to bring them to their senses. It is better to understand them and not wonder at them. we should know that the Lord understands the person beaten down by sorrow better than do we. He understands their feelings and sufferings and does not count their pain as sin. Terminal illness is a most critical state. Therefore we must understand the person and be conscious that this state will quickly pass.

The hope that we won't die as a result of our present illness is not the same as Christian hope. Christian hope is rooted in faith in the gracious God who is with us and for us now and always. This hope operates whether we die or don't die at this time, whether we hope for a cure or reprieve or do not. "Whether we live, we live to the Lord, or whether we die, we die to the Lord. So then, whether we live or whether we die, we are the Lord's".**(81)** It is the hope that answers the question, "Who can separate us from the love of Christ?" There is "tribulation" and "distress" and "peril." There are unbelievable "powers" that disrupt and threaten our lives. But hope, anticipation of the future in God's hands, is the outcome of present faith, that nothing "will be able to separate us from the love of God in Christ Jesus our Lord." **(82)**

The real Christian triumph and victory is when we can transform death into an act of life. And I would submit that that is what we must preach to ourselves and to others. Because Christ has come and is crusified and is raised. That very act, miracle of miracles, can be transformed not into an act of separation, dissolution, corruption and victim of the devil and death, that it can become, itself, an act of a victory. I would claim that faith is the power of transforming death into an act of life. It's the power of transforming the ultimate separation into the act of ultimate communion. It's the trick, like the Church Fathers like to say, of taking the greatest victory of the devil and transforming it into a victory. And we know about them, as John Chrysostom says in the pastoral homily that we read in all our churches on Easter night, "Christ has risen and life is. Life reigns." **(83)** Our ministry should be incarnational. We are witness to the presence of God, to the presence of Christ in all of life. We are to represent Christ, to make Christ present again. **(84)**

8. E N D N O T E S

(1) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), p. 10.

(2) A. A. Amkraut, From the symbolic stimulus to the pathophysiological response: Immune mechanisms. *International Journal of Psychiatry in Medicine*, 1975, vol. 4, p. 541.

(3) C. B. Bahnson - M. B. Bahnson, Cancer as an alternative to phychosis: A theoretical model of somatic and phychologic regression. In D. M. Kissen - L. L. LeShan (Eds.), *Phychosomatic aspects of neoplastic disease* . Philadelphia: J. B. Lippincott Company, 1964, p. 42.

(4) B. Cady - H. N. Simpson - G. Farrish - J. W. Turner, History Taking for Cancer Detection. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Society, 1978), p. 12.

(5) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978) pp. 32-33, 35-36.

(6) G. Booth, General and organic specific object relationships in cancer. *Annals of the New York Academy of Sciences* . (New York: 1969, vol. 164), p. 568.

(7) E. M. Blumberg - P. M. West - F. W. Ellis, A possible relationship between psychological factors and human cancer. *Psychosomatic Medicine*, 1954, vol. 16, p. 276.

(8) E. M. Blumberg, Rsults of psychological testing of cancer patients. In J. A. Gengerelli - F. J. Kirkner (Eds.),*Phychological Variables in Human Cancer* . (Berkeley and Los Angeles: University of California Press, 1954), p. 30.

(9) T. H. Holmes - M. Masuda, *Life change and illness susceptibility* . Paper presented as part of Symposium on Separation and Depression: Clinical and Research Aspects, Chicago, December 1970, p. 22.
(10) H. Selye, *The stress of life* . (New York: McGraw - Hill, 1956), p. 11.
(11) G. F. Solomon, Emotions, Stress, the central nervous system, and immunity. *Annals of the New York Academy of Sciences*, 1969, Vol. 164, p. 335.
(12) E. Evans, *A Psychological Study of Cancer* . (New York: Dodd, Mead & Company, 1926), p. 19.
(13) L. L. LeShan, *You Can Fight for Your Life : Emotional Factors in the Causation of Cancer* . (New York: M. Evans & Company, 1977), p. 23.
(14) A. H. Schmale - H. Iker, Hopelessness as a predictor of cervical cancer. *Social Science and Medicine* , 1971, Vol. 5, p. 95.
(15) E. M. Blumberg, MMPI findings in human cancer. *Basic Reading on the MMPI in Psychology and Medicine* . (Minneapolis: Minnesota University Press, 1956), p. 452.
(16) B. Klopfer, Psychological variables in human cancer. *Journal of Prodective Techniques* , 1957, Vol. 21, p. 340.
(17) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), p. 70.
(18) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), p. 88.
(19) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), pp. 88-89.
(20) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978) p. 89.
(21) C. C. Gates, Psychosocial Issues in Cancer. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Soceity, 1978), p. 80.
(22) J. B. Moen - J. E. Roover - M. F. Stonberg, Resources and Rehabilitation. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Soceity, 1978), p. 331.
(23) D. K. Switzer, *Pastoral Care Emergencies - Ministering to People in Crisis* . (New Jersey: Integration Books-Paulist Press, 1989), p. 85.
(24) D. K. Switzer, *Pastoral Care Emergencies - Ministering to People in Crisis* . (New Jersey: Integration Books-Paulist Press, 1989), p. 86.
(25) D. K. Switzer, *Pastoral Care Emergencies - Ministering to People in Crisis* . (New Jersey: Integration Books-Paulist Press, 1989), pp. 87-88, 91.
(26) A. Dyck,*The value of life: two contending policies.*(Harvard ,1976,p. 30.
(27) C. C. Gates, Psychosocial Issues in Cancer. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Soceity, 1978), p. 80.
(28) C. A. Gribbons - V. Dunn - J. B. Moen, Cancer Nursing, *Cancer: A Manual for Partitioners* . (Boston: American Cancer Society, 1978), p. 325.
(29) C. A. Gribbons - V. Dunn - J. B. Moen, Cancer Nursing. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Society, 1978), p. 326.
(30) R. D. Abrams, *Not Alone With Cancer* . (Springfield: Charles C. Thomas, 1974), p. 32.
(31) J. E. Dunphy, Annual Discourse: On Caring For The Patient With Cancer. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Society, 1978), 340.
(32) J. J. Dawson, *The Cancer Patient* . (Minnesota: Ed. G. W. Davidson, 1978), p. 69.
(33) Stephan - Andrew Jarmus, *On The Issues Of Aging, Sickness And Dying* . (Canada: Ecclesia Publishing Co, 1989), p. 31.
(34) E. Grollman, Death and Dying: Pastoral - Psychological Perspective, in *Coping with Death and Dying; An Interdisciplinary Approach*, p. 51.
(35) E. Grollman, Death and Dying: Pastoral - Psychological Perspective, in *Coping with Death and Dying; An Interdisciplinary Approach*, p. 56.
(36) J. C. Zinker & S. L. Fink, The possibility for psychological growth in a dying person . *Journal of General Psychology* , 1966, vol. 74, p. 190.
(37) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), p. 237.
(38) *L. Feigenberg, Terminal Care - Friendship Contracts with Dying Cancer Patients* . (New York: Brunner/Mazel, Publishers, 1980), 67.
(39) G. O. Brim - Jr. Freeman - H. E. Levine - N. A. Scotch, *The Dying Patient* . (New York: Russell Sage Foundation, 1970), p. 390.
(40) Stephan - Andrew Jarmus, *On The Issues Of Aging, Sickness And Dying* . (Canada: Ecclesia Publishing Co, 1989), p. 31.
(41) A. L. Baider, Family Structure and the Process of Dying: A Study of Cancer Patients and Their Family Interaction . (Boston: Dissertation, 1973), p. 51.

(42) D. K. Switzer, *Pastoral Care Emergencies - Ministering to People in Crisis* . (New Jersey: Integration Books-Paulist Press, 1989), pp. 94-95.
(43) A. Tounbee, *Man's Concern with Death* . (London: Hodder & Stoughton, 1968), p. 280.
(44) C. M. Saunders, The Mamagement of Terminal Disease (The Management of Malignant Disease Series). (London: Edward Arnold, 1978), p. 210.
(45) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), pp. 239-240.
(46) J. B. Moen - J. E. Roover - M. F. Stonberg, Resources and Rehabilitation. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Soceity, 1978), p. 335.
(47) C. M. Worby & R. Babineau, The family interview: Helping patient and family cope with metastatic disease. *Geriatrics* , 1974, Vol. 29, pp. 83-94.
(48) E. Kubler-Ross, *On Death And Dying: What the dying have to teach doctors, nurses, clergy and their own families* . (New York: Macmillan Publishing Company, 1969), pp. 142, 157.
(49) A. Sheldon - C. P. Ryser - M. J. Krant, An intergrated family orientated cancer care program: The report of a pilot project in the sociomotional management of chronic disease. *Journal of Chronic Disease* . 1970, Vol. 22, p. 748.
(50) D. Maddison & B. Raphael, The family of the dying patient. In: B. Schoenberg - A. C. Carr - D. Pereitz - A. H. Kutscher (Eds.), *Phychosocial Aspects of Terminal Care*. New York: Columbia University Press,1972,p. 189.
(51) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), pp. 230-231.
(52) E. Kubler-Ross, *On Death And Dying: What the dying have to teach doctors, nurses, clergy and their own families* . (New York: Macmillan Publishing Company, 1969), p. 159.
(53) C. C. Gates, Psychosocial Issues in Cancer. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Society, 1978), 89.
(54) C. M. Parkes, *Evaluation of family care in terminal illness* . (New York: Columbia University, 1975), p.21.
(55) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), p. 241.
(56) C. Weinstock, Psychosocial rehabilitation of cancer patients: A pilot study. *Int. Ment. Health Res. News* . Fall, 1974, p. 12.
(57) B. Brown, *New mind, new body* . (New York: Harper & Row, 1975), p. 34.
(58) E. Pendergrass, Host resistance and other intangibles in the treatment of cancer. American journal of Roentgenology , 1961, vol. 85, p. 895.
(59) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), p. 71-73.
(60) H. Benson, *The Relaxation Response* . (New York: William Morrow & Company, 1975), p. 9.
(61) J. S. Mitchell, *Psychosomatic cancer research from the viewpoint of the general cancer field* . (Philadelphia: J. B. Lippincott Company, 1964), p. 211.
(62) G. Booth, The Cancer Epidemic: Shadow of the Conquest of Nature . (New York: The Edwin Mellen Press, 1979), p. 203.
(63) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), pp. 89, 91. Simontons mention the following intresting example of a cancer patient, named Bob, who recovered from the disease: "Bob heard about our program and attended one of our patient sessions in Fort Worth. Prior to the meeting he was sent some materials describing our work as well as a tape recording that taught him the mental imagery process. Although his initial stay was only for a few days, the first session gave him renewed hope. In Bob's words: "When I got off the plane in Charlotte, my wife said, 'You look different.' And I was different. I had hope. I had returned home full of enthusiasm and new direction." Bob's chemotherapy was discontinued and his local oncologist evaluated him monthly. Bob found the discipline of practicing mental imagery regularly to be difficult but he kept it up. He also began to exercise regularly and soon was able to play twenty minutes of light racquetball. He began to build up slowly, regaining some of his weight. But the spectre of cancer still hung on. As he reported: 'No medical differences showed up for two, three, even four weeks. But I kept holding on to the belief that this system would work. After six weeks, I was examined by my doctor in Charlotte. My doctor turned to me in amazement and said with a very tender expression, 'It is considerably smaller. As a matter of fact, I would say that it's shrunk 75 percent in mass size.' We rejoiced together, but cautiously. Two weeks later - which was only two months after I had met the Simontons - I was given a gallium scan and various other tests and examinations. There was absolutely no disease present, only a residual scar nodule about the size of a small marble. Within two months of beginning relaxation and imagery, I was cancer-free! My doctors in Charlotte didn't believe it.' Over the next few months Bob's energy and vitality continued to increase, until he felt his energy and vitality were a great as or greater than they had been before his diagnosis. Bob still had a good deal of

work to do. He began to resolve many of the personal problems that had caused him to be emotionally "down" before the onset of the cancer. He also worked hard on changing behaviors taht were interfering with his relationships. [O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), pp. 19-20.]

(64) W. R. Smith, *Emotional history and pathogenesis of cancer* . (New York: McGraw-Hill, 1976). p. 31.

(65) E. Green, *Biofeedback for mind-body self-regulation: Healing and creativity* . (California: Cupertino, 1971), p. 19.

(66) Stephan - Andrew Jarmus, *On The Issues Of Aging, Sickness And Dying*. (Canada: Ecclesia Publishing Co, 1989), p. 28.

(67) E. Kubler-Ross, *On Death And Dying: What the dying have to teach doctors, nurses, clergy and their own families* . (New York: Macmillan Publishing Company, 1969), p.180.

(68) O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* (Boston: J. P. Tarcher, INC., 1978), p. 219.

(69) J. E. Dunphy, Annual discourse: On Caring For The Patient With Cancer. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Soceity, 1978), pp. 343-344.

(70) W. E. Oates, *Patoral Care and Counceling in Grief and Separation* . (Philadelphia: Fortress Press, 1976), p. 61.

(71) D. K. Switzer, *Pastoral Care Emergencies - Ministering to People in Crisis* . (New Jersey: Integration Books-Paulist Press, 1989), p. 96.

(72) D. Maddison & B. Raphael, The family of the dying patient. In: B. Schoenberg - A. C. Carr - D. Pereitz - A. H. Kutscher (Eds.), *Phychosocial Aspects of Terminal Care* .New York: Columbia University Press,1972, p.197.

(73) A. Sheldon - C. P. Ryser - M. J. Krant, An intergrated family orientated cancer care program: The report of a pilot project in the sociomotional management of chronic disease. *Journal of Chronic Disease* . 1970, Vol. 22, p. 750.

(74) S. E. Waxenberg, The importance of the communications of feelings about cancer. *Annals of the New York Accademy of Sciences* , 1966, Vol. 124, p. 1000.

(75) D. K. Switzer, *Pastoral Care Emergencies - Ministering to People in Crisis* . (New Jersey: Integration Books-Paulist Press, 1989), p. 98.

(76) T. H. Holmes - M. Masuda, *Life change and illness susceptibility* . Paper presented as part of Symposium on Separation and Depression: Clinical and Research Aspects, Chicago, December 1970, p. 32.

(77) E. Kubler-Ross, *On Death And Dying: What the dying have to teach doctors, nurses, clergy and their own families* . (New York: Macmillan Publishing Company, 1969), p.179.

(78) E. Kubler-Ross, *On Death And Dying: What the dying have to teach doctors, nurses, clergy and their own families* . (New York: Macmillan Publishing Company, 1969), pp. 139-141.

(79) P. Poulos, The Unity of Body, Mind and Soul: Pastoral - Psychological Perspective, in *Coping with Death and Dying; An Interdisciplinary Approach*, p. 93.

(80) Stephan - Andrew Jarmus, *On The Issues Of Aging, Sickness And Dying* . (Canada: Ecclesia Publishing Co, 1989), p. 29.

(81) Rom 14:8.

(82) Rom 8:33-39.

(83) T. Hopko, Death and Dying: Theological Perspectives, in *Coping with Death and Dying; An Interdisciplinary Approach*, p. 75.

(84) P. Poulos, The Unity of Body, Mind and Soul: Pastoral - Psychological Perspective, in *Coping with Death and Dying; An Interdisciplinary Approach* , p. 97.

9. BIBLIOGRAPHY

R. D. Abrams, *Not Alone With Cancer* . Springfield: Charles C. Thomas, 1974.

A. A. Amkraut, From the symbolic stimulus to the pathophysiological response: Immune mechanisms. *International Journal of Psychiatry in Medicine*, 1975, 5(4), 541-563.

C. B. Bahnson - M. B. Bahnson, Cancer as an alternative to phychosis: A theoretical model of somatic and phychologic regression. In D. M. Kissen - L. L. LeShan (Eds.), *Phychosomatic aspects of neoplastic disease* . Philadelphia: J. B. Lippincott Company, 1964) p. 42-62.

A. L. Baider, *Family Structure and the Process of Dying: A Study of Cancer Patients and Their Family Interaction* . Boston: Dissertation, 1973.

H. Benson, *The Relaxation Response* . New York: William Morrow & Company, 1975.

E. M. Blumberg - P. M. West - F. W. Ellis, A possible relationship between psychological factors and human cancer. *Psychosomatic Medicine*, 1954, 16 (4), 276-286.

E. M. Blumberg, Results of psychological testing of cancer patients. In J. A. Gengerelli - F. J. Kirkner (Eds.),*Phychological Variables in Human Cancer* . (Berkeley and Los Angeles: University of California Press, 1954), 30-61.

E. M. Blumberg, MMPI findings in human cancer. *Basic Reading on the MMPI in Psychology and Medicine* . (Minneapolis: Minnesota University Press, 1956), pp. 452-460.

G. Booth, General and organic specific object relationships in cancer. *Annals of the New York Academy of Sciences* . (New York: 1969, vol. 164), pp. 568-577.

G. Booth, *The Cancer Epidemic: Shadow of the Conquest of Nature* . New York: The Edwin Mellen Press, 1979.

G. O. Brim - Jr. Freeman - H. E. Levine - N. A. Scotch, *The Dying Patient*. New York: Russell Sage Foundation, 1970.

B. Brown, *New mind, new body* . New York: Harper & Row, 1975.

B. Cady - H. N. Simpson - G. Farrish - J. W. Turner, History Taking for Cancer Detection. *Cancer: A Manual for Partitioners* . (Boston: American Cancer Society, 1978), pp. 1-12.

J. J. Dawson, *The Cancer Patient* . Minnesota: Ed. G. W. Davidson, 1978.

J. E. Dunphy, Annual Discourse: On Caring For The Patient With Cancer. *Cancer: A Manual for Partitioners* . Boston: American Cancer Society, 1978.

A. Dyck, *The value of life: two contending policies.* Harvard , 1976.

E. Evans, *A Psychological Study of Cancer* . New York: Dodd, Mead & Company, 1926.

L. Feigenberg, Terminal Care - Friendship Contracts with Dying Cancer Patients . New York: Brunner/Mazel, Publishers, 1980.

C. C. Gates, Psychosocial Issues in Cancer. *Cancer: A Manual for Partitioners* . Boston: American Cancer Soceity, 1978.

E. Green, *Biofeedback for mind-body self-regulation: Healing and creativity* . California: Cupertino, 1971.

C. A. Gribbons - V. Dunn - J. B. Moen, Cancer Nursing, *Cancer: A Manual for Partitioners* . Boston: American Cancer Society, 1978.

E. Grollman, Death and Dying: Pastoral - Psychological Perspective, in *Coping with Death and Dying; An Interdisciplinary Approach* . New York: University Press of America, 1985.

T. H. Holmes - M. Masuda, *Life change and illness susceptibility* . Paper presented as part of Symposium on Separation and Depression: Clinical and Research Aspects, Chicago, December 1970.

T. Hopko, Death and Dying: Theological Perspectives, in *Coping with Death and Dying; An Interdisciplinary Approach* . New York: University Press of America, 1985.

Stephan - Andrew Jarmus, *On The Issues Of Aging, Sickness And Dying*. Canada: Ecclesia Publishing Co, 1989.

B. Klopfer, Psychological variables in human cancer. *Journal of Prodective Techniques* , 1957, Vol. 21, 331-340.

E. Kubler-Ross, *On Death And Dying: What the dying have to teach doctors, nurses, clergy and their own families* . New York: Macmillan Publishing Company, 1969.

L. L. LeShan, *You Can Fight for Your Life : Emotional Factors in the Causation of Cancer* . New York: M. Evans & Company, 1977.

D. Maddison & B. Raphael, The family of the dying patient. In: B. Schoenberg - A. C. Carr - D. Pereitz - A. H. Kutscher (Eds.), *Phychosocial Aspects of Terminal Care* . New York: Columbia University Press, 1972.

J. S. Mitchell, *Psychosomatic cancer research from the viewpoint of the general cancer field* . Philadelphia: J. B. Lippincott Company, 1964.

J. B. Moen - J. E. Roover - M. F. Stonberg, Resources and Rehabilitation. *Cancer: A Manual for Partitioners* . Boston: American Cancer Soceity, 1978.

W. E. Oates, *Pastoral Care and Counceling in Grief and Separation* . Philadelphia: Fortress Press, 1976.

C. M. Parkes, *Evaluation of family care in terminal illness* . New York: Columbia University, 1975.

E. Pendergrass, Host resistance and other intangibles in the treatment of cancer. American journal of Roentgenology , 1961, vol. 85, pp. 891-896.

P. Poulos, The Unity of Body, Mind and Soul: Pastoral - Psychological Perspective, in *Coping with Death and Dying; An Interdisciplinary Approach* . New York: University Press of America, 1985.

C. M. Saunders, The Management of Terminal Disease. *The Management of Malignant Disease Series*. London: Edward Arnold, 1978.

A. H. Schmale - H. Iker, Hopelessness as a predictor of cervical cancer. *Social Science and Medicine* , 1971, Vol. 5, pp. 95-100.

H. Selye, *The stress of life* . New York: McGraw - Hill, 1956.

A. Sheldon - C. P. Ryser - M. J. Krant, An intergrated family orientated cancer care program: The report of a pilot project in the sociomotional management of chronic disease. *Journal of Chronic Disease* . 1970, Vol. 22, pp. 743-755.

O. C. Simonton - S. M. Simonton - J. Creighton, *Getting Well Again* . Boston: J. P. Tarcher, INC., 1978.

W. R. Smith, *Emotional history and pathogenesis of cancer* . New York: McGraw-Hill, 1976.

G. F. Solomon, Emotions, Stress, the central nervous system, and immunity. *Annals of the New York Academy of Sciences*, 1969, Vol. 164, pp. 335-343.

D. K. Switzer, *Pastoral Care Emergencies - Ministering to People in Crisis* . New Jersey: Integration Books-Paulist Press, 1989.

A. Tounbee, *Man's Concern with Death* . London: Hodder & Stoughton, 1968.

S. E. Waxenberg, The importance of the communications of feelings about cancer. *Annals of the New York Accademy of Sciences* , 1966, Vol. 124, pp. 1000-1005.

C. Weinstock, Psychosocial rehabilitation of cancer patients: A pilot study. *Int. Ment. Health Res. News* . Fall, 1974.

C. M. Worby & R. Babineau, The family interview: Helping patient and family cope with metastatic disease. *Geriatrics* , 1974, Vol. 29, pp. 83-94.

J. C. Zinker & S. L. Fink, The possibility for psychological growth in a dying person . *Journal of General Psychology* , 1966, vol. 74, pp. 185-199.