

**ROAD RAGE – A PASTORAL PERSPECTIVE  
ON TRAUMA CAUSED TO THE NEXT OF KIN  
AND THE POLICE**

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## DEDICATION

This thesis is dedicated to my beautiful wife Pinkie Diana Mosese, the mother of my three sons. The woman who has changed me and made me a better person. She stood by me during trying times and encouraged me to serve God with all I have. She supported me when days became dark and friends few. She became an inspiration and supported me financially, morally and socially. I also dedicate this thesis to my sons, Mahlabe, Tshepo and Lehlohonolo, who gave me enough time to study and never complained that I give them little time because of my studies. They have been children up to this day and were never involved in activities that brought shame to the family. Keep it up boys! I will always be proud of you.

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## GLOSSARY

**Author** – will mean the writer or researcher and these words will be used interchangeably.

**Road** – will mean all the different types of roads to be found in the Southern Africa eg. High ways, Free ways, Ordinary Streets, Gravel roads, one way roads, two way roads.

**Rage** – will mean uncontrollable violent behaviour

**S.A.P.S** – will mean South African Police Service

**Minister** – will mean pastor or priest and these words will be used interchangeably .

**MRC** – will mean Medical Research Council

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**CHAPTER ONE**

**INTRODUCTION**

The author will analyze road rage as it occurs on the different roads of South Africa and define what it really means. Causes of road rage or factors that lead to road rage will also be examined. The author will further analyze deeply the trauma that is brought about by road rage firstly to the next of kin, the victim and then the police officers. The purpose of this research is to help the police officers to cope with trauma in the different incidents that they are exposed to. Many suffer from stress and cannot cope with their daily duties because of the trauma they are exposed to. Some policemen and women in the S.A.P.S are medically boarded because they can simply not cope. They are mentally affected and many of them retire even before time because of the stress and trauma that they cannot face.

Quite a number of them have committed suicide. They are irritable and frustrated. The S.A.P.S has never looked deeply into this problem and it affects the whole police service. On the other hand the death of a loved one in the family brings hardships and pain to the family, and may trigger rage to officers. The spouse is traumatized and in some cases the victim could be the only bread winner in the family. The family is left with nothing to put on the table the children feel lost and see the death of their father, in the case where the victim is their father, as an incident that has robbed them of their future. They will never ever have somebody like their father who will protect them. This circle starts another kind of rage, which someone can research later on. Pastoral care will then be robbed in order to try and deal with the trauma that the death has created in the lives of the police officers and the lives of the next of kin.

Hightower, editor of *Caring for People from Birth to Death* shares an insight which is worth to share about rage. He says:

- Hear what their feelings are. Recognize their feelings, reflect them back gently, and be ready to let the person concerned expresses and talk about their feelings. It is more destructive to bottle up the feelings than to express them.
- Reassure the person concerned that it is okay to have whatever feelings they have and that you will not reject or criticize them.
- Appropriate touch can be very important. It communicates that the person is not alone. It is something positive you can do as a response to what you have heard and despite helpless feelings to do anything.

There are four identifiable stages through which a grievances person moves:

1. Shock: Feelings too painful to face are cut off. Mrs Smith is clearly in this stage. The ability to make decisions, plan and organize is impaired. Someone is needed to support and make decisions, but without taking over.
2. Control: Feelings are controlled for the sake of other people. Many in our culture believe the bereaved ought to be strong and brave.
3. Regression: A lot of energy has been used up in holding oneself together and keep strong feelings in place. The bereaved may become selfcentred and introverted, and swamped by bad feelings from the past and fear for the future.
4. Adaptation: Bereaved people learn to adapt to the changed situation, beginning to re-own the part of themselves which has been 'invested' in the relationship with the person who died; and start to reinvest in other relationships both existing and new. (Hightower: 1999:64,65)

## **BACKGROUND**

When I grew up, it was very rare to hear about road rage. It was there but it occurred very seldom. The then apartheid government protected whites over the majority of blacks. Whites would stop a black man driving a motor vehicle and beat him up for no apparent reason, and got away with murder. Even if the perpetrator is arrested, he would be acquitted once he arrives at the police station. Black police officers could not do or say anything about this because a white man was above the law then. Any black police officer who could not be found to be on the side of the victim, would be fired without having his case heard. This way, many black police officers were scared to lose their jobs and preferred to keep quiet even if it was against their consciences. Their quietness would mean they could stay longer on their jobs and meant that they were obedient to their white fellow police officers. A senior black officer in the rank of a sergeant was not supposed to say anything to a junior white officer. The author wonders if this quietness created deep cruelty that produced rage later on. The junior white officer would give orders to a long serving black senior officer and cooperation was expected, even if the requirements were impossible. The life of a black person was nothing as compared to that of a white person. For example, if a black person killed a white person, the army and a strong police force would go out in search of a black person who has committed murder. This was a very rare incident but once it had happened, the family of that black person would also be harassed. The house where the black person stays would be ransacked and things turned up side down, and sometimes furniture would be broken in order to instill fear on family members so that they should tell where the perpetrator is. For example, during the 1976 riots in Soweto a white man was killed by students and the police and the army harassed many families of students and broke furniture and in some cases broke down the doors (Tsietsi Mashinini's home: Sowetan 1976) The police became very brutal to the family of the black man.



I became a teacher and taught for twenty years and after twenty years of teaching, I then decided to join the police service. I served South Africa Police Service for ten years. It was during these ten years of service in the SAPS that I realized what road rage does to the families of the victims and to the police officers.

I was allocated to drive a patrol car and to attend to complaints made by families. I was teamed up with a fellow police officer and we would attend to different types of complaints like house breaking, robbery, disturbance of peace, including road rage. By road-rage I mean barbaric uncontrollable behavior of motor vehicle drivers on the road that leads to hurting others or even killing them. Road rage is very prevalent these days and it is not only an issue of black and white, it also happens on black on black and white on white. The effects of road rage does not only traumatize the families of the victims but also traumatizes the police officers who attend to the scene. It could be that the victim is the sole bread winner of the family, and after his death the family is left with no one to take care of them. The children of the victims become orphans and ask themselves questions which cannot be answered by anyone. The children develop hate and anger that is deep centered and that cannot be easily removed. The wife of the victim together with the children will have to face a bleak future.

Ministers of religion or pastors who officiate at such funerals quote Job 1:21 “Naked I came from my mother’s womb, and naked I will depart. The Lord gave and the Lord has taken away, may the name of the Lord be praised”. The author is of the opinion that some Pastor are not sensitive in addressing this kind of trauma, hence their kind of scripture passages at this time. Many people question this quotation. They ask theological questions like why does the Lord allow such things to happen. They ask that if the Lord is loving, caring and protecting, why the Lord allows their father to die such a violent death.

The police who attend these scenes are also traumatized. Most of them suffer from stress, and other stress related deceases. They also need to be counseled after going through these incidents. Some are even hospitalized because of the trauma they have experienced. Others become depressed and lose their senses.

In South Africa and many other countries, there are many factors that causes road rage. The following are but a few out of many I have experienced and have decided to list. Racism, overtaking, tailgating, finger gesture, jealousy, lack of respect for other road users (reckless and negligent driving), and drunken driving. All these incidents when occurring, bring trauma to the families of the victim and the police officers. The question to ask is: Why this kind of rage, what is its source?

In the chapters that will follow, the researcher will closely examine these factors mentioned above so as to make readers understand how these bring trauma to the families of the victims and the police officers. What is the cause of road rage, one would ask let us examine the problem statement in order to further understand this problem

## **PROBLEM STATEMENT**

The researcher poses two questions as a way of researching this problem.

1. Why do people behave in a way that leads to rage on the road?
2. How does a Pastor deal with trauma as families deal with grief?

The author will examine ways which leads people to behave in an animal fashion as they treat their fellow human beings. The author will further analyze how best to come up with a solution towards this problem. The church is challenged by this act and ministry through preaching from the pulpit in order to try and help people to best behave and to treat and respect one another. The question of being

made in the image of God should also be stressed. Our African community has lost a way of living together. The spirit of Ubuntu is getting lost.

The second thing is to educate and to empower pastors to be able to deal with the problem of trauma on families of victims and on members of the SAPS. Workshops should be put in place to train police officers who attend scenes because counseling should start at the scene.

### **AIMS AND OBJECTIVES**

As we deal with this problem, the author will develop a model that will assist pastors and the families of victims on how to cope with trauma to empower police officers who will in turn work with families of the victims. This process will help arrest rage at an early stage.

### **RESEARCH GAP**

A lot has been written about road rage, but what struck me is that very little if not nothing, has been done about the counseling aspect of the trauma caused to three people in particular, and that is the families of victims, the police officers and the priest or pastor.

## **PRELIMINARY CONCLUSION**

In the research gap mention was made that very little or nothing was done about the counseling aspect of the trauma caused to the families of the victims, the police officers and the priest. In next chapter the author will analyze Ross methodology on bereavement as a way of helping family members and police officers who are traumatized by road rage. The author will also use Gerkin's methodology of shepherding in assisting the bereaved families, the police officers and the priest.

## **CHAPTER TWO**

### **METHODOLOGY**

The quantitative method will be followed where Kubler-Ross's book will be utilized and backed up by other authors like Gerkin, Edward Wimberly, D.D. Williams, two main sources that will help each other in pastoral care. This researcher and the selection literature to be used will be based on the idea of bereavement through personal observation in ministry, experience and reading materials in the context of research. The five stages of Kubler-Ross's process of bereavement will be engaged in order to facilitate Gerkin's model of pastoral care so as to help empower pastors to work with families that are affected. Kubler-Ross's five stages of bereavement are as follows denial, anger, depression, bargain and acceptance.

Edward Wimberly in his book, *Claiming God and Reclaiming Dignity*, analyzes lament as a pursuit of God and quotes (Job 23:3,4). He says privileging conversation with God proceeds on the basis of making one's conversation, in one's life narrative. He tells us that in the book of Job, there are several conversations, and each character in the unfolding drama is used to present different conversations about the inherited Jewish wisdom tradition as it relates to suffering. (Wimberly: 2003:113). The researcher will engage Wimberly at length in the next chapter.

Daniel Day Williams in his book, *The Minister and the care of soul*, states that Christ is present in the person in the obvious sense that the purpose of God, made known in Jesus Christ, is the fulfillment of God's kingdom in all life.

Christ is therefore present in every person as the ultimate meaning and reality which leads to the fulfillment of God's will for life. To see every person as a created life "in Christ" is the key meaning of Christians "realism" in dealing with person. Realism means knowing that each person has been created in God's

image and is capable of being open to the Grace of God and of beginning to love (Williams 1961:40-41)

The author will use some stages that Kubler-Ross speaks about in her book “On death and dying” to show the pain that the family goes through. Ross in her book On Death and Dying says when we look in time and study former cultures and people, we are impressed that death has always been distasteful to man and will probably always be. To a psychiatrist this is very understandable and can perhaps best be explained in terms of our understanding of the unconscious parts of the self; to the unconscious mind, death is never possible in regard to ourselves. It is inconceivable for our conscious to imagine an actual ending of our own life here on earth, and if this life of ours has to end, the ending is always attributed to a malicious intervention from the outside by someone else. In simple terms, in our unconscious mind we can only be killed; it is inconceivable to die a natural cause or of old age. Therefore death in itself is associated with bad act, a frightening happening, something that in itself calls for retribution and punishment.

Just as we, in our unconscious mind cannot differentiate between the wish to kill somebody in anger and the act of killing, so the young child is unable to distinguish between fantasy and realism. The child who angrily wishes his mother to drop death for not having gratified his needs will be traumatized greatly by her actual death – even if this event is not linked closely in time with his destructive wishes. He will always take part or all the blame for the loss of his mother. He will always say to himself – rarely to others – “I did it, I am responsible, I was bad, therefore Mommy left me”. It is well to remember that the child will react in the same manner if he loses a parent by divorce, separation, or desertion. Death is often seen by a child as impermanent, and therefore little distinct from a divorce, after which he may have an opportunity to see a parent again.

When we grow older and begin to realize that our omnipotence is not really so great, that our strongest wishes are not powerful enough to make the impossible possible, the fear that we have contributes to the death of a loved one diminishes – and with it the guilt. The fear remains diminished, however, only so long as it is not challenged too strongly. Its vestige can be seen daily in hospital corridors and in people associated with the bereaved. A husband and wife may have been fighting for years, but when the partner dies, the survivor will cry and be overwhelmed with regret, fear, and anguish, and will fear his own death more still believing in the law of talion – an eye for an eye, a tooth for a tooth-“I am responsible for her death, I will have to die a pitiful death in retribution”.

Maybe this knowledge will help us to understand many of the customs and rituals that endured over the centuries and whose purpose is to diminish the anger of the gods and society, as the case may be, thus decreasing the anticipated punishment. I think of the ashes, the torn clothes, the veil, the Klage Weiber of the old days – they are all means of asking others to take pity of them, the mourners, and are expressions of sorrow, grief, and shame. A person who grieves, beats his breast, tears his hair, or refuses to eat, is attempting self-punishment to avoid or reduce the anticipated external punishment for the blame he expects on the death of a loved one.

The grief, shame, and guilt are not very far removed from feelings of anger and rage. The process of grief always includes some elements of anger. Since none of us likes to admit anger at a deceased person, these emotions are often disguised or repressed, and prolong the period of grief, or show up in other ways. It is well to remember that it is not up to us to judge such feelings as bad or shameful but to understand their true meaning and origin as something very human. In order to illustrate this I will again use the example of the child – and the child in us all. The five-year –old who loses his mother is both blaming himself for her disappearance and expressing anger at her for having deserted him and for no longer gratifying his needs. The dead person then turns into

something the child love and want very much, but also hate with equal intensity for his severe deprivation. (Kubler-Ross 1973:2,3,4).

Ross further develops this argument by mentioning the stages towards bereavement. She states the stages as follows: denial and isolation, anger, bargaining, depression and acceptance.

## 1<sup>st</sup> STAGE

### DENIAL AND ISOLATION

According to Ross, denial functions as a buffer after unexpected shocking news allows the patient to collect himself and, with time, mobilize other, less radical defenses. Denial is usually a temporary defense and will soon be replaced by partial acceptance maintained, denial does not always bring increased distress if it holds out until the end, which is a rarity. A person's first reaction maybe a temporary state of shock from which the person recuperates gradually. When the initial feeling of numbness begins to disappear and the person can collect himself again, the usual response is "No, it cannot be me". Since in our unconscious mind we are all immortal, it is almost inconceivable for us to acknowledge that we too have to face death.

## 2<sup>nd</sup> STAGE

### ANGER

When the 1<sup>st</sup> stage of denial cannot be maintained any longer, it is replaced by feelings of anger, rage, envy, and resentment. The next question becomes "Why me?." In contrast to the stage of denial, this stage of anger is very difficult to cope with from the point of view of family and staff. The reason for this is the fact that this anger is displaced in all directions and projected onto the environment at times almost at random.

When ever the patient looks at this time, he will find grievances. He may put the television on only to find a group of young jolly people doing some of the modern



dances which irritates him when every move of his is painful or limited. He may see a movie western in which people are shot in cold blood with different onlookers continuing to drink their beer. He will compare them with his family or the attending staff.

The strategy is perhaps that we do not think of the reason for patient's anger and take it personally, when it has originally nothing or little to do with the people who become the target of the anger. As the staff or family react personally to this anger, however, they respond with increasing anger on their part, only feeding into the patients' hostile behavior. They may use avoidance and shorten the visits or the rounds or they may get into unnecessary argument by defending their stand, not knowing that the issue is often totally irrelevant.

### 3<sup>rd</sup> STAGE

#### BARGAINING

The third stage, the stage of bargaining, is less well known but equally helpful to the patient, though only for brief periods of time. If we have been unable to face the sad facts in the first period and have been angry at people and God in the second phase, maybe we can succeed in entering into some sort of an agreement which may postpone the inevitable happening: "If God has decided to take us from this earth and he did not respond to my angry pleas, he may be more favorable if I ask nicely." We are all familiar with this reaction when we observe our children first demanding, and then asking for a favor. They may not accept our "No" when they want to spend the night in a friend's house. They may be angry and stamp their foot. They may lock themselves in their bedrooms and temporarily express their anger by rejecting us. But they will also have second thoughts. They may consider another approach. They will come out eventually volunteer to do some task around the house, which under normal circumstances we never succeeded in getting them to do, and then tells us, "If I am very good all week and wash the dishes every evening, then will you let me

go?” There is a slight chance naturally that we will accept the bargain and the child will get what was previously denied.

Most bargain are made with God and are usually kept a secret or mentioned between the lines or in a chaplain’s private office. In our individual interviews without an audience we have been impressed by the number of patients who promise “a life dedicated to God” or “a life in the service of the church” in exchange for some additional time. Many of our patients also promised to give parts of or their whole body “to science” (if the doctor use their knowledge of science to extend their life)

#### 4<sup>th</sup> STAGE

##### DEPRESSION

When the terminally ill patient can no longer deny his illness, when he is forced to undergo more surgery or hospitalization, when he begins to have more symptoms or becomes weaker and thinner, he cannot smile it off anymore. His numbness or stoicism, his anger and rage will soon be replaced with a sense of great loss. This loss may have many facets; a woman with a breast cancer may react to the loss of her figure; a woman with a cancer of the uterus may feel that she is no longer a woman. Our opera singer responded to the required surgery of her face and removal of her teeth with shock, dismay, and the deepest depression. But this is only one of the many losses that such a patient has to endure.

There may be the added loss of a job due to many absence or the inability to function, mother and wives may have to become the breadwinners, thus depriving the children of the attention they previously had. When mothers are sick, the little ones may have to be boarded out, adding to the sadness and guilt of the patient. All these reasons for depressions are well known to everybody who deals with patients. What we often tend to forget, however, is the preparatory grief that the terminally ill patient has to undergo in order to prepare

himself for his final separation from this world. If I were to attempt to differentiate these two kinds of depression, I would regard the first one a reactive depression, the second one a preparatory depression. The first one is different in nature and should be dealt with quite differently from the latter.

An understanding person will have no difficulty in eliciting the cause of the depression and in alleviation some of the unrealistic guilt or shame which often accompanies depression. A woman who is worried about no longer being a woman can be complemented for some especially feminine features; she can be reassured that she is still as such a woman as she was before surgery.

## 5<sup>th</sup> STAGE

### ACCEPTANCE

Acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for “the final rest before the long journey” as one patient phrase it. This is also the time during which the family needs usually more help, understanding, and support than the patient himself. This is the time when the television is off. Our communication then becomes more nonverbal than verbal.

The following two interviews are examples of husband and wife attempting to reach the stage of acceptance. Dr. G., a dentist and father of a twenty-four-year-old son, was a deeply religious man. We have used his example in Chapter IV on anger, when the question is raised. “Why me?” and he remembered old George and wondered why that man’s life could not be taken instead of his. In spite of the picture of acceptance that he presented during the interview, he also demonstrates the aspect of hope. He was intellectually quite aware of the state of his malignancy and as a professional man realized the slim chances of continuing to work. Yet he was unwilling or unable to consider the closing of his office until briefly before his interview. He maintained an office girl to accept his calls and sustained the hope that the Lord might repeat an incident that

happened to him during the war years when he was shot at a close distance and missed “being shot from twenty feet away and the person misses you, you know that there is some other power than the fact that you are a god dodger or whatever.” (Kubler-Ross 1973:2,3,4,34,35,44,45,46,72,74,75,76,100,107).

The author is of the opinion that Ross encourages a Pastor to journey with the bereaved by assisting the bereaved to understand and to accept what has happened. Neither denial nor anger, nor depression can bring back the dead or reverse what has happened. The Pastor need to be there during the time of trauma experienced by the bereaved because this is the time when the Pastor is needed most. The bereaved will be able to understand the trauma easily when surrounded by people who worship with them. The Pastor must therefore organize a support group that will also journey with the bereaved in their pain and suffering.

Having shared the five stages of bereavement the reader realizes how Gerkin’s model of Pastoral care is, as a shepherd will help victims and police officers who are traumatized. In his book, Gerkin shares about shepherding as caring for the flock. Gerkin uses three classes of leaders in Pastoral care: the priest, a hereditary class that had particular responsibility for worship and ceremonial life; the prophet, who spoke for Yahweh in relation to moral issues, sometimes rebuking the community and its stated political leaders; and the wise men and women, who offered counsel of all sorts concerning issues of good life and personal conduct. Each in his or her own way was vitally concerned with the care and discipline of Yahweh’s people, both as a community and as individuals. For the prophet, that meant confronting the people with their deviation from the will of Yahweh. For the priest it meant faithful and reverent observance of worship and cultic practice. For the wise men or women it meant practical moral guidance in the affairs of living together as a community.

The long story of the care of God's people has been shaped not only by Wisdom, important as that has been. People have found the care of God and God's people communicated to them in the richness of ritual practice as well as in wise guidance. Likewise, God's care as from time to time been expressed in prophetic acts of leadership and confrontation with the implications of the will and purpose of God for the mutual care of the people, indeed for the care of all human affairs and for the earth itself. Care for the people of God involves care that confronts issues of justice and moral integrity in the life of the people. With the coming of Jesus, who, according to John's Gospel, identifies himself as "the good shepherd," the shepherding image takes its place as a primary grounding image for ministry. Applied to Jesus' ministry, the shepherding image incorporates not only the wisdom expressed in certain of the parables and the Sermon on the Mount, not only his priestly leadership in relationship to his followers, but also elements of prophecy such as are found in the story of Jesus' cleansing of the Temple and his confrontations with the Pharisees and Sadducees. (Gerkin: 1997:23, 24, 27).

Wimberly in his book, *Claiming God Reclaiming Dignity* brings a theological argument of rediscovering God through Job. The book of Job provides us with a challenging view of sanctification. Job's life teaches us that the process of becoming holy must take place in the midst of one's own suffering. In the midst of suffering, God encounters us and provides sustaining fellowship. But sometimes persons are so wounded that they cannot bear to encounter anyone or anything else. Often when a person makes a decision to seek counseling, that decision is a decisive act that begins the healing process. Normally wounded person defend themselves against the prospect of further hurt. They cover or disguise their hurt in an effort just to get by or to stop feeling the pain inside. Entering the counseling process is like the client offering a tentative invitation. It is then the job of the counselor to expose the wound so it can be shared and thus eventually healed. This task is a delicate operation and not something to be entered into without sufficient reflection, training, and supervision. Often pastoral

counselors make a way for God. Through empathic listening and informed feedback, the counselor can guide the client to a place where he or she can open up to God and begin to engage God in conversation. The very fact that a person can sustain fellowship with God or anyone else is a sign of growing health. The more a person can engage in a sustained fellowship with God, the more he or she can participate in God's redemptive activity in the world in a realistic way.

Thus the book of Job is for some about the learning that comes as one participates in the redemptive activity of God taking place at the cosmic level. As Job struggle with conversations he has with his friends, he revises his notion that holiness means the absence of suffering. The book of Job, rather, sets the stage for the later theological belief that holiness must become a reality in the mist of suffering. Suffering does not mean that one has been abandoned by God or that one has sinned, but it means that one has entered into God's process of redemption. Suffering is the necessary circumstance that one must confront as the result of accepting one's vocation in God's redemptive work. Our suffering means that we have entered into God's story at the deepest possible level. Thus suffering is a sure sign of God's presence rather than absence. As we suffer, we imitate Christ and thus we are sanctified in the eyes of God. (Wimberly 2003:69,70)

Wimberly teaches us that during worst scenarios of pain and suffering we should not think that we are alone. In the mist of pain and suffering during times of tribulations God is there with us. God will never forsake us. We should look at the story of Job who even during pain and suffering never blamed God but accepted what happened as a man of faith.

The other material that will be utilized, as I have stated is Anne Wimberly's book; *Nurturing Faith and Hope*. In this book, Anne looks at Faith and Hope as the centre of evocative nurture. She says that "faith is understood as our belief or trust in our relationship with God and God's relationship with us through Jesus Christ and the Holy Spirit. Hope is our expectation and endeavors to live

confidently and courageously in community after the model of Jesus in times of triumph and in the midst of hardship and tribulation. (Wimberly 2004: xviii) In her other book entitled *Soul Stories. African American Christian Education*, Anne says “Christian education that is relevant in and beyond the present era must help us to grapple with the realities of our everyday lives and to envision how we as Christians can go forward in liberating and hopeful ways. ( Wemberly 2005:1)

I will also use Ellen G. White’s book, *Steps to Christ* to try answer the question the victims offspring normally ask; “ why did god allow this happen?” in order to show that God does not enjoy. Ellen in his book says: “It is a mistake to entertain the thought that God is pleased to see His children suffer. All Heaven is interested namely in the happiness of man. Our heavenly Father does not close the devices of joy to any of His creatures. The divine requirements call upon us to shun those indulgences that would bring suffering and disappointment, that would close to us the door of happiness and heaven.”(White: *Steps to Christ* 39)

Dr T.L. Osborn’s book “*Healing the Sick*” will also be used. Dr. Osborn’s has this to say about suffering. Another scripture which is so often used is 1<sup>st</sup> Peter. But the God of all grace, who had called us to his eternal glory by Christ Jesus, after that you have suffered a while, will make you perfect, establish, strengthen, settle you. (1 Peter 5:10) He continues to explain this by saying this does not say: “After you have been sick and have suffered with disease for a while, God will make you perfect and stable.” However, it does not say: after that you have suffered a while.

This could be used in order to help the next of kin of the victim to cope with the suffering they are going through. (Osborn 1992:76) Gurney’s book, *The Face of Pain* is one literature that one could use to talk to the family of the deceased because death leaves a black hole in their hearts and souls. The story of Maria could be used to show how powerful are those who trust in the Lord. Gurney tells us that after religion was outlawed in 1976, individual and families known to

be faithful were marked. Maria was one of those. When the police invaded the privacy of her small, humble home because of her believe in Christ. They were searching for religious artifacts, icons, books, the Bible. The penalty for keeping such object could be up to seven years in prison.

Overturing everything they finally found a few items which they mistakenly assumed were what was kept (Gurney 1998:2) The author would also use information to be found on internet to describe what road rage is and further utilize the incidents that are mentioned to show the after effects of road rage in order to support the thesis. The incident of road rage that the author will use will range from tailgating, drunken driving, finger gestures, reckless driving, driving without drivers license, pointing of a firearm, negligent driving, shooting of other road users, overtaking on the wrong side, murder and other factors that shows no respect for the law. The author will deal with these incidents individually as they appear on the internet. The researcher will also show that most of these incidents were barbaric behaviour and some were deliberate as reported.

There are also studies and surveys conducted by other researcher including interviews on the same subject road rage. Reports were given with figures showing that road rage is the highest in South African roads.

## **PRELIMINARY CONCLUSION**

In this chapter the author was dealing with the methodology of Kubler-Ross's five stages of death as a way of helping the bereaved families and police officers to move on from one stage to the other. The methodology of Gerken's shepherding model was also used to complement Ross on the care of people as a flock would be cared for by the shepherd.

In the next chapter the author will define road rage in depth and states causes of road rage like violence and other attributes.



## **CHAPTER THREE**

### **ROAD RAGE**

What is road -rage?

Road rage is an issue that concern human beings, especially the loss of life. According to James and Nahl in their book Road rage and aggressive driving, road rage is serves an expression that was introduced into the public library by the popular media. Though there has been no agreed upon definition, people use the phrase in order to refer to an extreme stage of anger that often precipitates aggressive behaviour, sometimes restricted to words and gestures, sometimes as assaults and battery. They say that a variety of facts have been named to account for the increase in aggressiveness between drivers, such as traffic congestion, feeling endangered, being insulted, frustration, time pressure, fatigue, competitiveness, and lapses in attention. They further state that theoretically it is possible to restrict road rage to felonious or criminal acts of violence by one driver against another. They further indicate that even if people could agree on the usage, there is a similar problem with the term aggressive driving referring to reckless behaviour such as running red lights or giving someone a brake job, as well as to speeding, tailgating, and the lane hopping. To many, they say, these maneuvers are merely preferred style of driving that is assertive and competitive, not aggressive or hostile. They further state that word usage can almost never be legislated according to ideological preference, and society has then been using road rage and aggressive driving to designate many forms of both hostile and illegal driving ( James and Nahl 2000:22,23)

Larson in his book Road Rage to Road-Wise states that road rage incidents, where actual physical assaults take place, are only the tip of the ice berg. He says that lesser forms of assault, including ugly, threatening gestures verbal attacks, and using one's automobile to harass other drivers are endemic. "He says if looks could kill, there would be widespread slaughter."

He looks at the relationship between aggressive driving and road rage amongst the Americans. He says that Americans experience the urge to harm or kill while driving. He says such levels of anger would never occur between the same individuals were they had to meet on the street, even if one person inadequately bumped into the other. Larson states that this anger is a direct consequence of aggressive driving. He says that anger while driving and road rage would not occur without aggressive driving. He asks the question what exactly is aggressive driving and how does it result in anger and road rage? He defines an aggressive driver as a driver who in his/her determination to archive certain goals, engage in risky driving behaviour-speeding, competing, tailgating, cutting off, refusal to yield right of way, weaving, lane changing without signal, running through red lights, making illegal turns-and inconsiderate of other drivers and passengers (Larson:1999:26,27)

The author agrees with the definition of an aggressive driver as stated by Larson. This type of driver is irresponsible and negligent. This driver has no respect for human life and is selfish in that he /she regards him/herself as the only person allowed to use the road. This type of driver is easily annoyed and can be dangerous to himself/herself and to other road users.

The Anger and Stress Management Centre of S.A. says that South Africa has one of the highest figure accounting for 56% of road incidents. The centre states that road rage and aggressive driving go hand in hand.

The Centre lists the following as contributory factors or causes of road rage:

- ❖ Drive aggressive
- ❖ Be impatient and intolerant e.g. no one is to be in front of me.
- ❖ Have an “I can do what I want” attitude.
- ❖ Think they don’t need to obey the rules of the road.
- ❖ Be selfish e.g. not let anyone out.
- ❖ Overtake on the left

- ❖ See speed limits as the minimum speed one should exceed.
- ❖ See taxis as a major source of anger.

(<http://www.anger.co.za/Road/Rage/Road/rage.html>)

2007 report from internet.

Sakkie Smith submitted a paper on road rage on internet on Wednesday 2007-06-27 at 13:27 about Road rage in South Africa. Sakkie had this to say: Is road rage a new phenomenon (because of the stress of modern life), or it is a part of our human character? The author of this thesis believes that it is nothing new because when you open the news paper and see the sad result of what happens when people cannot control their temper on the road and then get involved in an argument with a pedestrian or another driver.

Sometimes it can also lead to physical violence. Jan Smit is most probably the earliest reported victim of such an incident in the new Dutch colony at the Southern tip of Africa. In 1696 Jan Smit and a certain Cloete got involved in an argument over the right of way or as stated in the way he handles his horse...’ One thing led to another, an argument ensued and they got into a brawl. Smit pulled a dagger and Cloete defended himself by using his, fists, clobbering Smit with a pieces of wood and then apparently stomped on his chest. After complaining for a few days about chest pain, Smit died.

So, road rage has been with us for a long time. The Medical Research Council regards Road rage as levels of aggressive road behaviour. It says: “Using ideas from the work of Shinar and Wells-Parker,” we measured aggressive road behaviour on a continuum of four levels, which include:

- ❖ Level 1: non-threatening expressions of annoyance such as complaining and /or yelling to one’s self and/or fellow passengers in response to another driver’s behaviour.

- ❖ Level 2: aggressive driving i.e. mild verbal or gestural expressions of anger, directed at the perceived offending motorist-includes the use of insensitive or obscene gestures and inappropriate and excessive use of the horn and lights.
- ❖ Level 3: road rage (mild), i.e. threatening and intimidating behaviour such as trying to cut another car off the road or following/ chasing another driver in anger.
- ❖ Level 4: road rage (extreme) i.e. direct confrontational behaviour such as arguing with or assaulting another motorist.
- ❖ 'Other high-risk' or 'other hazardous' behaviour refers to deliberate and dangerous driving but where there is no interaction (for example running red lights, weaving in traffic, driving above the speed or legal alcohol limit).
- ❖ By depicting aggressive road behaviour along a continuum, we suggest that all categories of these aggressive behaviours are related to road safety, public health and criminal justice.
- ❖ Whereas aggressive driving (characterized by instrumental aggression) is regarded as a traffic offence, road rage on the other hand, is characterized by hostile aggression and is regarded as criminal behaviour.

(<http://www.smitte.co.za/?q=node/2>)

(<http://www.smitte.co.za/?q=node/2>)

South African publications on driver aggression are limited mostly to magazines articles. Published journal articles include an editorial describing the association between road rage and psychiatric morbidity and article based on criminal justice issues around the Eadie road rage trial. The following story will share what road rage is all about:

### **THE EADIE CASE**

While driving home after spending an evening at his sport club, Graham Eadie was constantly harassed by another driver through tailgating, flashing of lights

and overtaking only to slow down in front. When the two vehicle stopped at a set of traffic lights, Eadie alighted from his vehicle and used a hockey stick to damage the victim's vehicle after which he fatally assaulted the victim using his fists and feet. My question is what actually happened to Eadie which caused such a rage? Is it tailgating or something deeper in his inner world. Eadie was later judged to possess criminal and cognitive capacity through out the incident and was found guilty of murder.

In South Africa in 2001, 27% of all injury related deaths were as a result of road traffic collisions. For the same year, the National Department of Transport indicated that South African road users had 512 000 crashes, which caused 7 900 deaths and 150 000 injuries. The cost of this carnage to the South African economy was estimated to be approximately R13.8 billion. However, for 2000, the South African National Burden of Disease study projected the country's traffic fatality burden to be in the region of 18 000 deaths per annum, in which case, the economic cost would also be much higher. The author is going to share eg in four of the provinces as a way of examining road rage and it impact on South Africa. In light of the disproportionately high National Traffic injury statistics and the increasing focus on road rage, and exploratory study was carried out among motorists in the Durban Metropolitan Area (DMA) (One of the cities in South Africa). In this study, we aim to:

- ❖ Establish a demographic and motoring profile of motorists in the DMA;
- ❖ Describe the nature and extent of aggressive and other hazardous' road behaviour in the DMA; and
- ❖ Establish predictors for aggressive road behaviour.

(E-mail:anesh.sukhai@mrc.ac.za)

On August 20, 2003 at 04:31 pm an article was found on internet stating that the increase in the carnage on South African roads in mainly due to road rage and aggressive driving. This was revealed in a report released after a study by the

Medical Research Council (MRC) in collaboration with the University of Natal Interdisciplinary Road Accident Research Centre in Durban. The study was conducted in four of the country's provinces with the highest road fatalities, which are KwaZulu-Natal, Gauteng, Western Cape and Eastern Cape.

Thokozani Nkomonde, one of the researchers, says more than 60% of tax drivers admitted they were impatient, disregarded speed limits and lacked driving skills. She says drivers recommended that there should be more educational campaigns, harsher sentenced for law breakers and an increase in the number of traffic officers. "It's on the increase. Drivers, they reported that they're always in a hurry. They want to get to their destination in the shortest period of time and they don't like it when something stops them, like a truck," says Nkomonde. (<http://www.kplctv.com/Global/story.asp?S=1408042&nav=OnqxHYvA>)

The sample study was taken from 250 drivers in each of the four provinces, Kwa Zulu Natal, Western Cape and Eastern Cape. The researcher agree it's a small percentage to gauge public opinion.

Thokozani Bhatha, of the University of natal Interdisciplinary Accident Research Centre, says: "Since we're not trying to make any conclusion, but only to give out an indication of how the road rage situation is out there. There is aggressive driving so with that sample we are able to get an indication of how the situation is out there. Researcher added that they were startled to find a high percentage of drivers didn't believe drinking and drinking caused accidents. The survey also showed that they lacked faith in government initiatives to stem the carnage on the country's roads. (<http://www.kplctv.com/Global/story.asp?S=1408042&nav=Onqx>)

Fingers – and guns – pointed in S.A. road rage

On august 21 2003 at 03:51 am an article was found on internet where Lynne Altenroxel had this to say: A study by the Medical Researcher Council has shown that 57 of 1006 drivers interviewed said they had been shot at or had a gun

pointed at them during incidents of “road rage.” Only three admitted to doing it themselves. Nearly 10 percent said they had been deliberately rammed or had their vehicle damaged and 20 percent confessed to thinking about physically hurting another driver. “Most motorists (58 percent) reported that they simply ignored or controlled their emotions when they encountered such behaviour,” said the report, which was released in Durban on Tuesday.

More specific (calming) measures included smoking (five percent), deep breathing-including sighing-(three percent) and prayer (two percent)” The study was exploratory research to determine whether impressions of increasing aggression on South African roads were correct. Researchers interviewed motorists at fuel stations in and around Durban to quantify the extent of the problem-and gave those interviewed a car air-freshener with an anti-road rage message for their time.

A quarter of those interviewed said they had experienced extreme forms of road rage over the past year. These included:

- ? A driver getting out of a car to argue (17,8 percent)
- ? A driver getting out of a car to hurt them (5,1 percent)
- ? A driver deliberately colliding with or damaging their car (9,2 percent)
- ? Being shot of at or having a gun pointed at their car (5,9 percent)

Unsurprisingly, far fewer people (9,8 percent) admitted perpetrating such extreme outburst than being a victim of them (24,1 percent)

Significantly, highly aggressive behaviour such as being tailgated, being cutting off, being blocked from a lane or being followed or chased were the most common forms of road rage experienced. This topped milder forms of aggression such as hooting or making obscene gestures. More than 80 percent of drivers confessed to some form of aggression. This main cause of their agitation, interviewees said, cutting in front of them and then driving slowly.

South African drivers have a much higher risk of experiencing aggressive road behaviour than other countries, according to the report.

### **GAUTENG CASES**

Some of these examples will show how road rage begins and its effects on other drivers;

March 2003: A road – rage incident caused three cars on a free way to collide, one of which killed a four year old boy. The drivers of a minibus taxi and a BMW – in which the boy was traveling – had an argument. The driver of the BMW stopped on the emergency lane and the two drivers stopped and started to argue. Meanwhile, a Mercedes-Benz collided with the back of the BMW and the child was killed.

August 2002: Owen Kruger, a 30 year old Gauteng man, was found guilty of shooting and killing motorcyclist Morare Matekane (38) of Soweto. He claimed Matekane had been urged by a slogan-shouting crowd to assault him and that he fired at him in self-defence.

This claim was rejected by the court. He was sentenced on 8 October 2003.

Article found here:

<http://www.iol.co.za/index.php?click id=13&artid=vn200308211035147155 C 269121 & set id=1>

These incidents are not only S.A bound. They occur in other countries for e.g:

#### Dad shot to death in freeway road rage

Brent Whiting

The Arizona Republic

Aug.23, 2003 12:00 Am



A motorist was shot to death on Friday in an apparent case of road rage, his 3-year old son strapped in the back seat as he and another driver dodged in and out of traffic on interstate 10. Mack Robert Rue, 23 of Apache Junction, apparently got embroiled in a dispute with people in other vehicle, but Phoenix police said they aren't sure what sparked it. Shot once in the left side of the chest, Rue called police just after 10 am, asking for help. He had been shot west of 75<sup>th</sup> Avenue, and his green Dodge Neon rolled to a stop near 79<sup>th</sup> Avenue as he called police for help on a cellphone. He was pronounced dead at a Phoenix hospital. His son, Mack Jr., was secured in a child seat and was not hurt.

Witness told police that the Dodge and a white car were seen from at least 51<sup>st</sup> Avenue, driving west, chasing each other and weaving in and out of traffic, police Detective Tony Morales said. "This is a tragic situation that apparently escalated from a road rage homicide," (Brent Whiting) said Morales, adding that there possibly were two assailants. It was the latest in at least a half a dozen cases this year in which Valley motorists have been killed in confrontations with other drivers. The rash of high way deaths has spurred a warning that motorists should exercise extreme caution when confronted by aggressive drivers.

"This can escalate into road rage, so don't make obscene hand gesture or mouth obscene words when provoked by another motorist," said Officer Steve Volden, a spokesman for the Arizona Department of Public Safety. "You don't know who you're dealing with"

Also, motorists should try to stay well behind aggressive drivers, giving them plenty of space, Volden said. "It's better to be behind them, so you can keep an eye on them, than to have them behind you," he said. "If worse comes to worse, pull over and stop."

Linda Rue, the victim's stepmother, said Mack, an employee for a lighting company, lived in Apache Junction but worked in the West Valley. Rue, a Chandler resident, believes Mack was on his way to work when he was killed. He

was going to drop his son off at the West Valley home of his sister, who took care of him while his father worked, Linda said.

Police have released the boy to the sister, Rue said. Rue said her stepson, a single parent, worked hard for a living and liked to go camping. "He was a very good kid, very loving, and a wonderful father," the stepmother said.

Other people who have died in Valley road-rage cases this year include:

- ❖ Andrew Delarosa, 18, and Tyler Corum, 19, both of Pretoria, who were killed in a June 30 roll over of Interstate 17 near Rose Garden Lane after a passenger in another car leaned out and bashed their vehicle with a baseball bat.
- ❖ Lemetri Reed, 36 of Good year, who was killed June 19 while driving east on Loop 101 in North Phoenix near 59<sup>th</sup> Avenue.

Her car was struck by another motorist who lost control while swerving to avoid a box that has been tossed at him by an angry motorists.

- ❖ Lynsey Chainhalt, 20, of Phoenix, who was killed June 14 after gunmen pulled alongside her car on Arizona 51 and started gesturing at her.

She was chased to a north Phoenix, driveway and gunned down.

- ❖ Jesus Martinez, 19, of Phoenix, who was fatally shot February 16 in the 2600 block of North 45<sup>th</sup> Avenue by another driver apparently angry over a traffic slight, police said.

Phoenix police have urged witnesses to Friday's shooting call investigators at (602) 262-6151.

Original Article found here:

(<http://www.azcentral.com/arizonarepublic/local/article/0823wvroadrage.html> )

The author would have to share another story in order to highlight the traumatic impact left to members of the family.

**By Don Plummer**

**The Atlanta Journal-Constitution**

Two men faces charges in an 1-75 road rage incident in which a pick-up truck crashed while trying to knock a car off the road, Marietta police said. A rear-end collision about 8:30 p.m Monday on 1-75 South bound near Chastain Road set off a running altercation, said officer Jeff King. It began when a red GMC 1500 pick-up truck rear-ended a silver Ford Taurus, King said. The driver of the Taurus then pulled up next to the truck, exchanging shouts and gestures with the occupants of the GMC truck for eight miles, according to witnesses.

When the Taurus exited the highway at North Marietta Parkway, the driver of the truck followed, King said.

The truck's driver lost control as he attempted to knock the Taurus off the road, running off the highway and flipping before hitting a tree, King said.

After the truck crashed, the driver of the Taurus fled the scene, King said.

"He was trying to get to a place where he could call 911," King said

"He left the scene and went back to his sister's house and ended up calling the police from there."

The truck's driver and three passengers were taken to Wellstar Kennestone Hospital. The driver improved to stable condition by Tuesday afternoon, King said.

All four men inside of the truck were intoxicated at the time of the accident, King said.

The truck's driver, Jaun Fernando-Romo Zarate, 21, of Marietta, faces charges of aggressive driving, driving under the influence, reckless driving and driving without a license. The owner of the pick-up truck, Macro Antonio-Cerillo

Ramerez, who was a passenger at the time of the wreck, faces charges of permitting someone to drive under the influence, King said.

The Taurus' driver, Puis Zachary of Marietta, will not face charges, King said.

**Original Article found here:**

(<http://www.ajc.com/metro/content/metro/cobb/0803/27roadrage.html>)

**PRELIMINARY CONCLUSION**

In all the incident mentioned above, the author has shown what causes road rage and the incidents also depicted the state of mind of the perpetrator. The author that gave the a definition of what road rage is, are right. I agree fully with them but would like to add that road rage is barbaric behaviour of frustrated drivers that take out their frustration on to other road users.

Road rage is caused by selfish people who do not think that other people also have a right to live. Most of these incidents are heart breaking because they live families without their beloved ones. Children grow without relating to their parents. They can only be shown photos of people they will never touch or speak to. There is that emptiness in their lives. Which may also cause them to react with anger. In the next chapter the author will be exploring ways of caring as a way of dealing with the bereaved families and the police officers. Care must seek to address the problem of coping with loss and emptiness. It must try to heal the wound that road rage has created.

## **CHAPTER FOUR**

In the previous chapter, the author wrote a list of incidents which pointed out clearly what road rage does and the trauma that it leaves behind. In other words, the consequences of road rage and the pain and suffering it brings on those left behind.

In this chapter, the researcher will deal with pastoral care as applied to bereaved people and will further show how pastoral care should be applied to address their pain and suffering.

Elizabeth Kubler-Ross in her book, *On Death and Dying*, lists the five stages in the Grief Process. In the first stage, Denial and Isolation, she had this to say about denial. She says that denial functions as a buffer after unexpected shocking news, and allows the patient / person to collect him or herself, and with time, mobilize other less radical defenses. Denial is usually a temporary defense and will soon be replaced by partial acceptance. Maintained, denial does not always bring increased distress if it holds out until the end, which I still consider a rarity. The patient's first reaction on rage may be a temporary state of shock from which he recuperates gradually.

When he/she initial feeling of numbness begins to disappear and he/she can collect himself / herself again, man's usual response is "No, it cannot be me." Since in our unconscious mind we are all immortal, it is almost inconceivable for us to acknowledge that we too have to face death.

(Kubler-Ross 1986:35-37).

Payne, Horn and Relf in their book: *Loss and bereavement say: We would argue that grief is not an illness or medical syndrome. It is a widely variable response which changes over time, probably not in a linear fashion, although this will be debated later in the book. Grief hurts. People describe feeling torn apart or as if they have lost part of themselves. It is often described as physically and emotionally painful. According to Bowlby (1980:7), "Loss of a loved person is one of the most intensely painful experiences any human being can suffer."* It is debatable whether there is a universal human

response to loss (Wortman and Silver 1989). The anthropological evidence shows that physical and psychological expressions vary and that there are no universal expressions of loss (Parkes et al. 1997)

People may experience an alarming array of physical problems in the aftermath of a bereavement. The following is a list of physical responses to loss and bereavement:

- ❖ Fatigue: This they describe as loss of energy.
- ❖ Sleep pattern changes, usually insomnia.
- ❖ Aches and pain – these can be very variable such as headaches, back pain, muscular aches, tightness in the chest or throat.
- ❖ Appetite changes – usually anorexia with resultant loss of weight.
- ❖ Gastro-intestinal changes – nausea, vomiting, indigestion, constipation, diarrhoea.
- ❖ Vulnerability to infection – increased incidence of minor infections such as cold .

There are many psychological response to loss and bereavement. According to Rosenblatt (1997) there are no universal emotional consequences of a death and all expressions of emotional and the meaning ascribed to them are culturally defined. Perhaps the most readily acknowledged consequence of loss in psychological distress. In fact, its absence in western society is regarded as pathological, although the culturally approved expression of distress is mediated by factors such as relationship to deceased, gender, social class and age (Walter 1996; field et al. 1997).

The following are a list of the range of psychological responses encountered after loss:

1. Emotional
  - ❖ Depressions – sadness, loss of pleasure response, low mood, intense distress.
  - ❖ Anxiety – fearfulness, separation anxiety.
  - ❖ Hyper-vigilance – inability to relax.

- ❖ Anger – may be expressed as hostility to friends, family, health care workers or God.
- ❖ Guilt – feeling of self-blame for some aspect of the deceased's death or care during dying.
- ❖ Loneliness – feeling of being alone even when with others.

## 2. Cognitive

- ❖ Lack of concentration and attention – memory loss for specific events or general problems in recalling information or attending to new information.
- ❖ Pre-occupation – repetitive thoughts especially about the deceased, sometimes needing to talk constantly about certain events like a traumatic loss.
- ❖ Helplessness/hopelessness – coping response which is characterized by pessimism about the future.
- ❖ Feeling of distance/detachment – experienced as sense of unreality.

## 3. Behavioural

- ❖ Irritability – expression of anger and hostility, suspiciousness, distrust.
- ❖ Restlessness – inability to settle to specific tasks or feel relaxed.
- ❖ Searching – pacing, looking for deceased.
- ❖ Crying – tears, signing.
- ❖ Social withdrawal – remaining isolated, rejecting social groups and friendship.

James E. Hightower Jr., editor of the book *Caring for People from Birth to Death*, agrees with Kubler-Ross. He looks at Denial and Isolation as a feeling. For example, “No, not me, it cannot be true.” Denial is used virtually by everyone. I believe it should be seen as a gift from God. It allows us to protect ourselves from tragic news until we can muster courage to hear it. A feeling of loneliness and isolation is also very prevalent during this stage. ( Hightower Jr. 1999:190)

The second stage that Kubler-Ross talks about is Anger. She says that when the first stage of denial cannot be maintained any longer, it is replaced by feelings of anger, rage, envy, and resentment. The logical next question becomes: “Why me?” Kubler-Ross goes further to say in contrast to the stage of denial, this stage of anger is very difficult to cope with from the point of view of family and staff. The reason for this is the fact that this anger is displaced in all directions and projected onto the environment at times almost at random. (Kubler-Ross: 1986:44)

Hightower says very often this stage is given to family members, employers, doctors, nurses and ministers. It is a way of saying: “I am not finished yet, you have to listen to me.” (Hightower Jr. 1999:190)

Prof. J. M. Masango in his journal HTS Theological Studies volume 60 No 3 had this to say in his abstract on anger: This article traces the roots of aggression, anger and violence in South Africa and the rest of the world. The paper is divided into four parts: Aggression, Anger, Catharsis and Violence. As a result of violence against other human beings, especially women and children, a profound respect for human dignity has been lost. People have become extremely aggressive.

The last few decades have created a culture of violence because of the suppression or oppression of feelings. The article argues that frustration yields anger that leads to violent acts. The root cause of violence is frustration, which finally (if not attended to) produces anger, anxiety, conflict and the eruption of violence. Suicide bombers in Palestine and other parts of the world demonstrate this type of aggression, anger and violence. Anger, on the one hand, is a good defense mechanism. It helps people cope with their frustration. Violence on the other hand, is used as a means of dominance, especially against women and children. In a political situation it is used as a means of changing social structures.

(Masango 2004:993)



The author agrees with Prof. Masango because anger blindfolds a person to see clearly. A person responds on impulse out of anger. Getting the news that your beloved one has been killed by a person you know or don't know. The respond is that you want to avenge the death of your beloved because of frustration. The reader is now aware that one is beginning to move through the stages that Ross explains in her book.

The third stage Kubler-Ross mentions is bargaining. She says the third stage is less well known but equally helpful, though only for brief periods of time. If we have been unable to face the sad facts in the first period and have been angry at people and God in the second phase, maybe we can succeed in entering into some sort of an agreement which may postpone the inevitable happening: "If God has decided to take us from this earth and he did not respond to my angry pleas, he may be more favorable if I ask nicely." We are all familiar with this reaction when we observe our children first demanding, and then asking for a favor. They may not accept our "No" when they want to spend a night in a friend's house. They may be angry and stamp their foot. They may lock themselves in their bedroom and temporarily express their anger by rejecting us. But they will also have second thoughts. They may consider another approach. Bargaining is healthy because it helps the person deal with the reality of death. You bargain because you are not sure how to deal with what you are facing.

At the end they will come out eventually, volunteer to do some tasks around the house, which under normal circumstances they never succeed in getting them to do, and then tell us, "If I am very good all week and wash dishes every evening, then will you let me go?"

There is a slight chance naturally that we will accept the bargain and the child will get what was previously denied.

Most bargains are made with God and are usually kept a secret or mentioned between the lines or in a chaplain's private office. In our individual interviews without an audience we have been impressed by the number of patient's who promise "a life dedicated to God" or "a life in the service of the church" in exchange for some additional time.

(Kubler-Ross 1986:72, 74)

Hightower sums bargaining beautifully when he says, if anger has not worked to take away our hurt, then perhaps asking politely will. We learn as children that asking nicely gets one further with parents than demanding.

In the bargaining stage we ask God politely, “God, if I become a preacher will you get me out of this mess?” or “God, I’ll never hit my wife again if you’ll make her come back to me.”

Bargaining is often filled with irrational fears and excessive guilt. In other words, bargaining is another way of saying you will never do it again, if situation goes back to the better.

(Hightower Jr. 1999:190,191)

Kubler-Ross’s fourth stage, is called depression, she says that the numbness or stoicism, the anger and rage of a person will be replaced with a sense of great loss. This loss may have facets: a woman with a breast cancer may react to the loss of her figure or part of her body while a woman with a cancer of the uterus may feel that she is no longer a woman. Hence the depression.

There may be the added loss of a job due to many absences or the inability to function, and mothers and wives may have to become the breadwinners, thus depriving the children of the attention they previously had.

If I were to attempt to differentiate these two kinds of depressions, I would regard the first one a reactive depression, the second one a preparatory depression.

The first one is different in nature and should be dealt with quite differently from the latter. An understanding person will have no difficulty in eliciting the cause of the depression and in alleviating some of the unrealistic guilt or shame which often accompanies the depression. Social workers and chaplains can be of great help during this time in assisting in the reorganization of a household, especially when children or lonely old people are involved for whom eventual placement has to be considered.

The second type of depression is one which does not occur as a result of a past loss but is taking into account impending losses.

Our initial reaction to sad people is usually to try to cheer them up, to tell them not to look at things so grimly or so hopelessly. We encourage them to look at the bright side of life, at all the colorful, positive things around them. The pastor will be journey with the bereaved through their pain suffering until they can begin to understand and accept their loss.

This is often an expression of our own needs, our own inability to tolerate a long face over any extended period of time.

When depression can become a tool to prepare for the impending loss of all the love objects, in order to facilitate the state of acceptance, then encouragements and reassurances are not as meaningful. The pastor will journey with them in this stage and not rush them in order to avoid their slip back later on.

(Kubler-Ross 1986:75, 76, 77)

According to Gerkin in his book, *Crisis Experience in Modern Life*, he says the logic of our paradigmatic approach to the exploration of crisis experience suggests that our study of death and anguish be followed by an in-depth examination of the human experience of bereavement and loss. In a broad sense bereavement and loss may be seen as the counterpart of death and anguish. Because person, relationships, projects, and even cultures die, humans must constantly sustain the loss of something or someone valued as significant for their life. Time flows, and with it life cycle ends, relationships are broken, and bereavements are sustained.

There are, of course, many kinds and levels of bereavement which persons experience. Bereavement comes not only with death but with all varieties of separation. Persons grow up and away from those to whom they have been attached in the bonds of family. Persons leave places, and there is the loss of a sense of place as well as the loss experienced by those who have been left behind. Relationships tear asunder; marriages end in divorce and there is loss and bereavement. In fact, one can view the entire process of the human life cycle as made up of a series of attachment and losses.

Reflecting on this theme suggests that there is a double structure of bereavement and loss in human life. On the one hand, just as the narrowing boundaries of aging and death are built into human existence, so the bereavement that comes with narrowing boundaries, aging and death are structured into finite life. But intertwined with that existential structure of attachment and loss is another, humanly constructed structure of loss, that related to human choice and the inability of persons to sustain their attachments or alter them appropriately with the passage of time without sustaining bereavement and the loss or failure of relationship. At the experiential level, therefore, the structure of bereavement and loss contain a peculiar mixture of anxiety and fear having to do with coming to terms with lives inevitable, on the one hand, and guilt, hostility, and shame related to the imperfectability of human relationship, on the other. Loss not only threatens the ultimate meaningfulness of an existence that contains inevitable bereavement, it also threatens the sense of self as able to sustain changing relationships.

Bereavement and loss, when thus viewed structurally, contain in a much more profound sense than is acknowledged in most of the psychological literature about bereavement, the fundamental questions both of the ultimate meaningfulness of finite existence and of human freedom and desire. The crisis of bereavement and loss is therefore to be seen as encompassing fundamental religious questions and not simply natural processes that can adequately be dealt with in psychological terms.

In order that we may examine in some depth both of these theological dimensions of the experience of separation and loss, I have chosen to divide our consideration of this theme somewhat arbitrarily into two chapters. In the present chapter we will explore the dynamics of attachment and separation as they are built into the life cycle of the family in order to uncover the way in which bereavement and loss are structured into intergenerational relationships. In chapter 5 we will pursue further the crisis of bereavement precipitated by the loss of intimate relationships through death. The chapters belong together and pursue related aspects of the same theme of loss. Our intentions will be to examine first the ways that humanly constructed styles of forming attachment affects most dramatically the equality and degree of

conflict experienced in both the inevitable losses that occur as children leaves home and, in some cases, when traumatic death occurs. (Gerkin: 1979; 74, 75,110,111,112)

Hightower Jr. sums it up by saying that when the person realizes the great loss he or she has sustained, and then depression sets in. For the terminally ill person this depression may be in a form of preparatory grief where impending loss is prepared for. It is a tool used to prepare more easily for one to deal with death. Whether grief is due to a situational loss or a preparation to die, the person should be allowed to be depressed – to mourn the loss and beginning to deal with reality of loss.

(Hightower Jr. 1999:191)

Kubler-Ross says this about the fifth stage of acceptance that it is not a sleep of avoidance or a period of rest to get relief from pain, discomfort, or itching. It is a gradually increasing need to extend the hours of sleep very similar to that of the newborn child but in reverse order. Acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for “the final rest before the long journey” as one patient phrased it. This is also the time during which the family needs help, understanding and support. (Kubler-Ross 1986:99,100)

The author agrees with what Ross says because during the time of bereavement, the family needs guidance and support. It will be pleasing and comforting to be with their priest who would also offer counseling and care.

Hightower succinctly summarizes acceptance by saying:

“This is not a happy state; rather it is almost devoid of feeling. It is a signal that the struggle is over.” It is the woman who can say: “I lost a breast cancer.”

It is the man who can say: “After thirty-four years with the company, I lost my job.” (Hightower 1999:65)

Kubler-Ross did not say we go through these stages sequentially so that stage 1 leads to stage 2, and so forth.

Rather, a person can be in acceptance today (or this hour) and in denial the next day (or next hour). “Grief is a journey with crooked roads and many turn-back signs; it is not an interstate highway connecting two points at the shortest distance.” (Hightower 1999:191)

Persons grieve regardless of chronological age or developmental task. The preschool child who loses a pet grieves. The middle-age child who moves from one town to another grieves. The adolescent who loses a first “love” to another girl or boy grieves. The young adult who doesn’t get the job hoped for grieves. The adult whose child leaves home grieves. The older adult grieves failing health or loss of sight, hearing, or mobility. From birth to death we are grievers.

(Hightower Jr. 1999:191)

The author agrees with Hightower in that in everything that we lose, we grieve. We never want to part with those we love through death or any other form that will bring permanent separation between our beloved.

Looking at the five stages prescribed by Kubler-Ross, I fully agree that the period of grief is the most painful time in the life of anybody.

Some ministers go to an extent of telling the bereaved family not to cry as the Lord has taken their beloved. They forget that people are allowed to cry to show their pain. Crying over something brings healing and closure.

The author believes that when death strikes, people must be allowed to cry because by crying, the process of healing begins. Telling people not to cry because they are Christians is suppressing the feelings and emotions of people. Very often people who suppress feelings get sick afterwards. Fulton in the book *Dying, Death, and Bereavement*, says the image of death is anthropomorphic, and understandably so. It is the individual who takes ill, sickens, and dies. It is the individual who is killed, either intentionally or unintentionally. And it is the individual who ends his or her own life or died by misadventure.

But the fact of death confronts not only the individual; it is also the challenge for society. This challenge, moreover, is not merely one of dealing with replacement, is of taking measures to assure that there is a sufficient number

of human beings to carry out the duties and tasks of maintaining the social order; nor is it only one of meaning, rationale, or eschatology. The challenge for a society is far more critical, for death poses a threat to the very existence of society itself.

I have reference not to the mortal conflict that a society will engage in to defend the integrity of its soil or its people or to the threat poses by environmental disaster. If either of these phenomena is of sufficient magnitude, it can, of course, destroy a society. But these are usually perceived as external threats, and their occurrence elicits a conscious response. I have in mind, rather, the ontology, largely unreflected and unrecognized, that defines a society's essence, structures its institutions, and informs its relationships to the unknown.

In a modern society as the United State, where relationships with the unknown ("God" or "the impersonal forces of life") is at best ambiguous, if not ambivalent, the cultural myths and social traditions that have grown up around the phenomenon of death play a mostly unacknowledged but nonetheless significant role.

This significance has not gone entirely unnoticed, however. Anthropologists especially have long recognized the importance for society and the individual of death and its dramaturgy. Scholars such as Durkheim (1954) Van Gennep (1961), Radcliff-Brown (1952), Malinowski (1954), Hertz (1968), Evans-Pritchard (1965), Geertz (1957), Mandelbaum (1976), and others have emphasized the role of ritualized behavior in facilitating and preserving social life in the face of oblivion.

For Malinowski, death is a "centrifugal force" in a society, evidenced by fear, dismay, and demoralization. Funeral customs, he argues, powerfully counteract this destructive influence. The ritual drama of the funeral and other death-related ceremonies, as part of the sacralizing institution of religion, restores a society's weakened solidarity and reestablishes its shaken morale (Malinowski, 1954, pp. 52-53). Van Gennep, moreover, would assign great importance to mortuary customs, because he finds those penitential ceremonies that incorporate the dead into the next world to be characteristically the most elaborate (Van Gennep, 1961, pp. 146)

Sociologists, too, have noted how death affects the social fabric, though they have a different estimate of mortuary customs as they pertain to modern social life. Robert Blauner (1978), for example, in his influential essay, "Death and Social Structure," challenges Van Gennep's assessment of funerary rites. It is Blauner's contention that while many non-modern societies organize their social life around the ever-present reality of death, modern societies need not. Increased life expectancy and other demographic shifts in society, secularization, medical bureaucratization, along with the isolation of the ill and dying person from family and community, all. The change in social organization found in large, complex societies, Blauner would agree, has not only relocated the setting of death but has also changed its social meaning and psychological valence to the extent that heretofore integrating funerary rituals and practices, despite their diminished place in social life, can, in fact, introduce discord and controversy (Blauner, 1978, pp. 35-39).

The late Talcott Parsons would concur with Blauner's assessment of the situation regarding modern responses to death, but he would accord a greater role to the individual in the direction and character that these responses have taken. Believing in the scientific tradition, acceptance of one's mortality within an eschatology that promises an afterlife, personal privacy, and social fluidity combined with "apathy," explain, he argues, modern society's reaction to personal loss and the modern encounter with death (Parsons, 1963, pp. 61-65). But the sociological issue raised here transcends the pragmatic questions of how modern society confronts death or how and why an individual responds to loss. Death compels us to ask many other questions besides the quintessentially instrumental ones. For instance: Why and for what purpose do we human beings exist? To whom or to what are we responsible? Why does a particular society exist? How did it come into being? To whom or to what is it responsible? What must be done, or who or what must be served or placated in order that we order that we or it may continue? What errors of omission or commission may precipitate our or its demise? What is the nature of the relationship between the body politic and the incorporeal spirit? What is the cosmological and historical significance of a society, and on what ultimate principle does it rest?



In the modern, secular world, when questions of this nature are raised, they are typically asked on behalf of the individual. On the other, when society's survival is questioned, as we have seen with Parson and Blauner, the discussion is usually a functional one, secularly based and institutionally focused. (Corless: 1994; 61, 62, 63)

The author agrees with Fulton that death affects the human fabric tremendously and probes human kind to ask questions which cannot be answered. Death leaves pain and suffering in the hearts and minds of those who remain behind with memories.

Weizman et al. in their book *About Mourning* say the bereaved person has another special need which is necessary to the process of mourning. This is the repeat the story of the loss and the details surrounding it, whether it begins with the diagnosis of an illness or the circumstances surrounding the death itself. This compulsion to repeat is an attempt to understand and make the event real on a mental and emotional level. The repetition serves as a catharsis and also as a method for mastering the situation. Friends and relatives may tire of hearing the same stories again and again or you may tire of repeating them, saying "I've told you this before." Perhaps it will help to know that this retelling has value. The bereaved should be encouraged to relate these stories in an attempt to expand feelings and reach new depths of feeling. The effect and intensity will change over time. The twenty-fourth telling will be different from the first. Thus, repetition is an important aspect of the healing. Important components of the process are crying, talking, sharing, and having permission from yourself and others to engage in these releases. Unfortunately, a climate in which people may grieve openly is seldom provided after the initial ritualized period of mourning. After that, the bereaved may receive unspoken messages from friend and other family members that imply: "Don't cry in front of me"; "Don't tell me how it hurts." This attitude is not supportive of the mourning process. What is supportive is for those around to give permission to share feelings and tears and to acknowledge the suffering of the bereaved. It is supportive to say simply and sincerely: "I know you hurt deeply."

Mourning is an adaptive process. It is a time of transition in which the old reality which included your loved one is gradually let go, and the new reality in

which the absence of your loved one is felt and realized is gradually let in. In this intermediate period you make efforts to adjust and adapt to the new social reality. A great deal of energy is used to accommodate the new reality and incorporate this change. It is a slow process. As you assimilate the loss, it becomes a part of you. Mourning is the process of absorbing the reality of death, experiencing all the emotions, and then being able to let go by expressing your emotions in various ways. It is imperative to express your feeling through talking, crying, writing, physical means, and in any way that is comfortable or unique for you. You will each need to find your own creative avenue for expression.

### **Death: A Crisis Event**

The death of a loved one or the facing of your own imminent death after the diagnosis of a life-threatening disease is a crisis event. There is no adequate preparation for an event of this magnitude because there is no way to imagine the depth and extent of emotional pain. A crisis includes extreme feelings, fear, confusion, and a sense of being powerless. The usual coping mechanisms are not adequate, but decision and action are usually required. The death of a significant person is a crisis when people require help. At this time individuals are usually open to receiving help from others, whether it be from family, clergy, friends, or mental health professionals. Intervention during a crisis can help prevent future emotional problems. When someone is so dreadfully burdened and assaulted, there is willingness, in fact a need, to accept help from others.

The crisis of the death of a loved one presents both danger and opportunity. Death is a part of life and how we cope with it or try to hide from it will be a dominant factor in how we live the rest of our lives. With support, expression of feelings, and the inner resources of the aggrieved, mourning is able to run its natural course. The person who can verbalize and emotionalize about the loss will have a better chance of emerging from this crisis with a mature attitude about life's priorities.

### **Mourning Defined**

The psychological definition of mourning as it is used in this book refers to the mental and emotional "work" following the loss of a significant person through death. The normal process of mourning, with all its attendant feelings, will be

experienced at the time of any loss: a death, separation, divorce, chronic or terminal illness of self or significant other, loss of a limb, or of a bodily function, birth of a handicapped child, or the loss of a hope, a country, or a home.

There are differences in various losses. In the case of illness or handicap, we lose a function but can sometimes compensate for that. We still have the presence of loved ones who care about us. With the death of a significant person, we lose the relationship, the focus of our love, and the love returned by the other. There is a dimension to the death of a loved one that causes a different kind of pain and helplessness, a special finality.

The definition that follows, from Webster's New World Dictionary, Second College Edition, are for words that will be used frequently throughout the book. Grief is defined as "intense emotional suffering caused by loss, disaster, misfortune, etc.; acute sorrow; deep sadness." The word derives from a Latin verb meaning "to burden." Indeed you, do feel burdened. You are carrying a heavy load of feelings. Mourn is defined as "to feel or express sorrow." Mourning is the expression of grief. The word derives from a Gothic verb meaning "to be anxious," remember; to think of." Mourning involves remembering and thinking of the deceased and this makes you feel anxious or uncomfortable.

Bereave means "to live in a sad or lonely state, as by loss or death." In Old English, the word meant "to deprive or rob." One mother said after her daughter's death, "I feel as if I were robbed of my most precious possession." The bereaved are survivors of a recently deceased person and are those in mourning.

Support means to endure . . . to carry or bear the weight of, to keep from falling, slipping, or sinking; hold up; to give courage, faith or confidence; help or comfort; to give active aid or to approve and to sanction; to keep intact, prevent failure. Supporting mourners reduces the loneliness of the grief experience. Support also means coaching the bereaved to express themselves and to have faith in recovery. Modeling behavior for mourning is also supportive.

Reality means pragmatic, objective fact, not taken on faith. Mature means fully grown, fully developed as a person. It is developing at a deep level,

experiencing deeply. Process is a continuing development involving many changes . . . a number of steps.

The mourning process is the ongoing psychological experience and the expression of grief. It is the expression of sorrow, anger, emotional suffering, and the full range of feelings experienced. The mourning process is continuous and changing.

### **Grief Demands Expression**

The goal of the mourning process is to integrate the loss that is known to be true in outward reality in order to have it become an emotional reality. This can happen only if you are able to express the anger, pain, despair, and all the other emotions that assail you. Your feelings must be talked about; words and tears must be shared with other mourners and with family and friends.

Feelings need to be released rather than blocked. If freedom of expression is denied, pushed away, or ignored, the mourning process is inhibited. As with any natural process that is inhibited, halting the mourning process can cause problems. Inhibition of grief may present a picture of strength to the world, albeit false, but stuffing sorrow away is a temporary solution. It takes a lot of energy to ignore feelings and one day, if they have been ignored, they may boomerang with full force at an inappropriate time or in a disguised fashion. Sometimes the belated reaction may seem unrelated to the earlier crisis. It is healthier to deal with the feelings when they occur and are accessible.

Audrey's experience which follows illustrates this. Aubrey, fifty-one year old, was widowed at twenty-one and immediately returned to her parents' home with her infant daughter.

Although I cried a lot, alone and with others, there was little talk about my feelings. My parents encouraged me to start dating shortly after the death. At twenty-three I remarried and tucked away all memories of my first love and my pain at his death. Ten years later I suffered an emotional breakdown.

I have never mentioned Marty's name. First my parents and then my husband colluded with me to block out what I felt and had lived through. I was restricted in mentioning Marty's name. Finally my psychologist told me I should talk about him like you would reminisce about any past event . . . .

Then I began to talk. Finally I realize how I needed that. I really did. I began to feel better.

This is an example of insufficient talking and insufficient expression of feelings. The denial took the form of focusing on the future and finding a replacement for the lost person rather than on experiencing the feelings at the time of her loss. Her feelings remained and lingered on as unfinished business, only to erupt at a later time.

When an attempt is made to block out some feelings, the whole range of feelings is affected. If you try to block out pain, sadness, and anger, you begin a process of blocking feelings. Therefore, all feelings are blocked and diminished. If you think of feelings as a continuum, pleasant feelings on one end and unpleasant feelings on the other, your ability to feel joy will be blocked, along with your ability to feel pain and sadness. You will end up immobilizing more than just the unpleasant feelings. You will freeze pleasant and joyful feelings as well. The process of holding back becomes ingrained and the ability to express yourself naturally and spontaneously is throttled. Turning the feelings inward may become your process. You become your capacity to laugh and to enjoy yourself as you give up your capacity to feel pain and sorrow. Too much elapsed time and too much denial make it difficult to get back in touch with those feelings which are essential for resolving and integrating a loss. A loss needs to be fully felt and expressed in order for healing and recovery to occur.

### **Phases and feelings of Grief**

The emotional suffering of grief encompasses many feelings that are sometimes confusing and often overwhelming. The process of mourning, that is the ongoing events and feelings, weaves a loosely into phases. The feelings in each phase demand expression.

In order to help understand the process, the following categories have been used to help clarify and organize the flow of feelings. The phases are characterized by a dominant feeling or process. They are: shock, undoing, anger, sadness, and integration. These phases and feelings will be explained in the following pages. Some illustrations of the emotions experienced during the mourning process are given in the explanation of each phase. The phase and feelings will become clearer as they are applied to examples of different losses and various life situations.

The idea of stages of grief was introduced and popularized by Elisabeth Kubler-Ross and has been interpreted more rigidly than intended. The use of the word “phase” is preferred here since it connotes the looseness of the process. The phases are used as a way of conceptualizing and understanding the emotional experience of mourning and are helpful in giving a framework to this process. These feelings are categorized to clarify this experience and are necessary since personal feelings are often disorganized and confusing. The phases are not time limited or sequential, nor are the feelings. Some feelings do not clearly belong in one phase or another but actually occur in several phases and are connected to other feelings. For example, feeling powerless recurs in almost every phase with some variation. Although a rough estimate of time is given for some phases, these are flexible guidelines and require interpretation and application to each individual and circumstance.

It is important to remember that the same feelings will return again and again and they often overlap. You may feel many feelings in one day and that can be overwhelming. You may believe you have dealt with a certain set of emotions and, lo and behold, they recur. As time passes, the emotions oscillating between sadness and hope change their pattern. The changes from emotional highs to emotional lows are less frequent and dramatic. The time between being weighted down becomes spread out and the sadness is of shorter duration. The feelings experienced in each stage constantly change and rearrange themselves. Be aware of feelings and phases as they change, overlap, retreat, and return until you achieve integration and balance. Allow yourself to flow with your own emotions.

During the early phases of mourning, and your feelings about the death, are prominent. They monopolize most of your thinking and emotional life. As time goes on and feelings are attended to and expressed, thoughts of the deceased become background and other things become foreground. In working towards the integration of the loss, the balance between foreground and background changes, you can once again attend to the tasks of daily living, and other things will begin to interest you. The deceased and your grief return to the foreground when a particular reminder, special date or holiday

comes around. The foreground and background continue to change and the balance between your grief and your relief also shifts.

### **The first phase: Shock**

The period of shock varies considerably depending on the circumstances of the death and the individual mourner. Although shock, disbelief, and denial are dominant in this phase, it does not mean that many other emotions are not experienced. It does not eliminate sadness, anger, guilt, and other feelings that may creep into awareness. These are neither lasting nor intense, and dealing in depth with these feelings is usually postponed to a later phase.

When you first hear the news of a loss, whether it is the diagnosis of an illness or the death of a loved one, you feel stunned for a moment. It does not seem to register. It feels totally shocking. Then follows a reaction of disbelief: “No, it can’t be true.”

Wilma said: “I can remember those minutes or two so well; it wasn’t right away. Not that I didn’t believe my friend. I believe her, but I didn’t want to believe what she was telling me. I remember the process of not wanting to believe he was dead, of taking and pushing it out, which is my usual process—pushing out all bad news for the first second or two before I take it in.”

When informed of her son’s death in an automobile accident, Margery was in total shock. “They said ‘He’s DEAD’ and it’s like somebody took a knife and cut out the part of me that had feelings. Talk about shock! I felt absolutely, positively nothing. Like I wasn’t there, numb. I knew what to do. I went through the motions of telling the children and notifying others. But it was just absolutely an unbelievable thing. I thought it really couldn’t happen. It might happen to somebody else but it really couldn’t be. Except I knew it was true.” The phrase “I still can’t believe it” crops up again and again, usually meaning “I don’t want to believe it. I wish it weren’t true.” Believing is also an adaptation to the reality that the death is true. It takes time for this to be believed emotionally. These feelings of disbelief fade in and out and intermingle with other feelings during the first year or sometimes even longer when the death is sudden or bizarre.

Some people are numb at first and there is no visible reaction, but others may begin to cry or become hysterical and talk and moan while crying. Crying is a

spontaneous response to death, and tears will emerge in men and women unless an attempt is made to block them or the person is in shock.

**Confusion and Bewilderment.** The initial impact may cause you to feel confused and bewildered, not really knowing what to do, whom to turn to, or how to express yourself. You may feel you need someone to guide you, to help you. When you do make contact with someone, you will find there are others willing to help.

The feeling of being dazed and confused may linger, especially if the death has been sudden. Many persons report an initial reaction of hysteria giving way to one or two weeks of confusion. Your sense of time becomes distorted, and it may become difficult to recall events occurring around the time of the trauma. After all, for you it is as if time had stopped.

**Denial.** The experience of assault upon the self calls forth some protective mechanisms. The process of denial is an attempt to shield oneself from the impact and pain. This temporary denial serves as a protection to the self for it would be unbearable to let in all the pain at once or allow the meaning of the loss to penetrate all at once. The reality is absorbed in small doses so that the meaning of death can be taken in little by little. This is a normal reaction and serves the purpose of self-protection.

If the denial continues beyond a reasonable time, it prevents you from dealing with the reality. Then it becomes harmful and is no longer a useful mechanism. If denial stands in the way of getting treatment for illness or precipitates inappropriate behavior, it becomes a problem and not healthy, functional defense.

Keeping busy is the way of supporting denial. Claire said, as if to her feelings: "Go away, I'm too busy." It takes time to attend to your feelings and it is necessary to take the time to feel and to allow them to emerge.

**Isolation and withdrawal.** The feelings of vulnerability and defenselessness are common in bereavement. It is not surprising that another way a mourner would seek protection is by withdrawal. During this phase you sometimes feel isolated with your grief. You may feel as if no one understands. You may withdraw, not because you do not want to be with other people, but as a way to protect yourself from further assault. It is another effort to protect the self from being hurt again. The feeling of isolation and the reaction of withdrawal



seem to go together. There is a strong need to be connected to others and taken care of by others, yet ironically the emotional experience is one of being separate and alone. The shock and the assault have the effect of disconnecting you from others. This is yet another confusion to the mourner and to those in the support system as well. Ruth explains her feelings: I wanted to be taken care of and protected, yet I felt completely alone. I couldn't reach out to anyone else for help at this time. If someone called on the phone or asked to be helpful, I couldn't admit my need or accept help. But if someone just came to the door without asking, I was able to accept and feel comforted by their presence and concern. I didn't understand my own feelings of isolation nor my behavior of not being able to accept kind offers. Mourners are very sensitive. It is hard to reach out and ask for help but offers are usually greatly appreciated. It is sometimes difficult for others to break the barrier, but it is extremely important to try and reach out, to be comforting to the bereaved. The withdrawal should not be mistaken for a desire or wish to be alone. This is an emotional experience of isolation. If others interpret this as a wish for privacy, it often does harm to the bereaved, because then the emotional experience and the social reality are the same and the bereaved will surely feel as if no one cares. If others understand that this feeling of isolation and behavior of withdrawal are emotional reactions, they can deal with them appropriately. Others should not interpret such behavior as a personal rejection but, on the contrary, should make every effort to bridge the gap, to stay in contact and in the presence of the mourner,

Sudden Death. The period of shock will vary depending on whether the death was sudden or occurred after a long illness. It takes much longer to recover from a sudden death that has occurred from a heart attack, accident, suicide, or sudden illness. It makes you feel you cannot trust anyone or count on anything. It upset the normal course of events. Expecting to see your loved one later on, you receive news of the death instead. It is totally contrary to the anticipation. As Wilma said: "The suddenness of his death, of course, had a special impact. There's no way to respond to something sudden. People prepare for certain things but sudden death is just plain shocking." (Weizman and Kamm: 1987; 38-45)

The author agrees with Weizman et al. that the bereaved have a special need necessary to the process of mourning. This is the need to repeat the story of the loss. The bereaved has to talk about the loss and not bottle it up because it creates pain and suffering. Talking about loss creates room for the process of healing to take place.

Dickenson and Johnson in their book *Death, Dying and Bereavement* say all four religions discourage too much weeping. Hindus say weeping creates a river which the soul has to cross. Sikh Gurus discourage too much grief, because the deceased has gone to God. The Hadith says that weeping is permitted for three days, but not beyond that, and wailing is forbidden, although it still occurs in villages on the Indian subcontinent, and the expression of grief is less inhibited than among native Britons. This can cause problems in hospitals, especially in large wards.

For Hindus in India the period of mourning last between ten to sixteen days. The family are regarded as extremely impure, and no other Hindu will receive food or drink from them. Furniture is removed from the living room, white sheets spread on the floor, and friends and neighbours drop in throughout the day to condole and listen to the readings from the Bhagavad Gita or other books, and to sing hymns. The family live austerely on simple food, without radio or television. On the tenth to twelfth days a series of rituals enable the soul (atman) to form a new 'celestial' body and join the ancestors. In Britain these rituals are usually done on the same day, and are considered by many Hindus to be the most important rituals they can do for the deceased. Gifts of money, food and clothing, which the deceased would normally need, are given to the Brahmin priests or to charity.

There are further rituals at one, three and six months. Widows used to be in mourning for at least a year, but here it is reduced to three months, after which they can go out and gradually resume normal life. In addition there is an annual ceremony, called *shaddha*, in which further offerings are made to the deceased relatives on the anniversary of the death and to all the ancestors during a period in the autumn called *pitr paksha*, maintaining a continuous link between the living and the dead. Gifts are made to Brahmins and to charity.

Sikhs follow a similar pattern in the home, without the severe restrictions of Hindus. It is the custom to read the holy book, the Guru eight to ten days (sadharaan path). This should normally begin after the funeral, but if there is a long delay because of an inquest, it may be started sooner. At the conclusion of the reading and prayers, if the deceased was head of the household, there is a pagri ceremony, followed by a feast in celebration of a long life if the deceased was elderly.

Islamic law required friends and relatives to feed mourners for three days. After this the family should return to normal, and no one should talk about death or the deceased, unless the family is grieving too much or brings the subject up. The only greeting given at this time is 'From God we come, to God we return'. Wailing is still very common, and one young woman who was reminded that it was forbidden pointed out that if she did not wail the rest of the community would criticize her for not having enough feeling. Unofficial mourning often continues until the fortieth day with Qur'anic readings. At the end of this period the family may call their relatives and friends and have further readings and a meal to signal the end of mourning. At the end of Ramadan, during the festival of Eid, graves are visited.

Among Sri Lankan Buddhists mourners may return to work in three or four days. There are no religious restrictions for widows, although they may withdraw from social life for a time. Chinese Vietnamese Buddhists call the monks again on the seventh day to give the spirit a 'send-off' when all the relatives and friends come, and money is given to the temple. Other Vietnamese have a series of rituals which enable the spirit of the deceased to join the realm of the ancestors, and they will be especially honoured during the anniversary of the death and the lunar new year. Mourning lasts for 100 days, during which time no one wears bright colours or flowers. The wives and children of a man must mourn for three years, but the immediate family only mourns for one year on the death of a woman (Pearson, 1982:480).

### **Finding meaning**

Hindus believe that after death most people are reborn in a better or worse state, depending on how they have fulfilled their dharma (cf. Firth, 'Approaches' above). A common explanation for premature or untimely death

is karma. The death of a child may be conceived of as either the parent's or child's karma, or both, as one Hindu explained:

The child has a certain period fixed with you. (Understanding this) helps the parents to come to terms with the death ... the only way you can explain to the mother is that this child was only going to live with you for five years, and you have to accept it, because now the child has gone for its betterment. Sikhs also accept the concept of karma and rebirth but believe these spiritual death-and those who are close to God will be united with God after death. Buddhists also believe in rebirth, although it is not the soul that is reborn, but a collection of five aggregates containing patterns created by karma. At popular level this may be seen as fate, so that if a person dies young it is seen as being ordained. Buddhist teaching emphasizes the ephemeral nature of life and provides the way to overcome the suffering inherent in it.

Muslims believe that everything that happens is the will of Allah (God). At death the soul awaits the Day of Judgement, when the righteous will be resurrected and go to heaven and the wicked and unbelievers will go to hell. The belief that everything is in the hands of God brings great comfort at the time of bereavement. A Muslim woman who lost a much-wanted baby boy prematurely said that she found great comfort from a visit to Mecca:

We have three days' strict mourning, when the neighbours and friends come to help with food, and you talk about the death, and read the Qur'an, and you remember that this is God's will, that everything that happens according to His will. He is gracious and merciful, and never sends you a trial that you can't handle, he always gives you the strength you need. And because I know it was God's will, I feel I can cope, I have made a good adjustment, even though I miss my son, because I know he and I are in God's hands. (Dickenson et al, 1993:257 – 259)

The author has a different opinion that is opposed to that of Hindus. The author believes that weeping is good as it brings healing. If the bereaved bottle up their pain inside, they will not heal easily, it will take time for them to heal.

Gerkin in his book *An Introduction to Pastoral Care*, states “More than any other image, we need to have written on our hearts the image most clearly and powerfully given to us Jesus, of the pastor as the shepherd of the flock of Christ.

Admittedly, this image originated in a time and place in which the shepherd was a commonplace figure, and we live in a social situation in which shepherding is a scarcely known, even marginalized vocation. Nevertheless, the New Testament depiction of Jesus as the good shepherd who knows his sheep and is known by his sheep (John 10:14) has painted a meaningful, normative portrait of the pastor of God’s people.

Reflection on the actions and words of Jesus as he related to people at all levels of social life gives us the model *sine qua non* for pastoral relationships with those immediately within our care and those strangers we meet along the way.”

“We need also to take with us our memory of those pastors of past eras who distorted the image of the pastor as Christ’s shepherd by assuming the authority to judge and direct God’s people – an authority that rightfully belongs only to Christ himself. Particularly in the time of the church’s rise to power during the Middle-Ages, but also in the time of Richard Baxter and his rationalist cohorts, the pastor tended to taken on authoritarian power over people in ways that corrupted the consciousness of the people – and all in the name of Christ! The better, more lively exemplars of the pastor as the shepherd of Christ’s flock have been those of our ancestors who exercised their shepherding authority to empower the people and offer care for those who were being neglected by their communities.

In important respects the monks of the desert and the St. Francis of our heritage were better models of the good shepherd than were the Gregory the Greats, who used their pastoral authority to control and direct. Here Seward Hiltner’s definition of proper shepherding as “care and solicitous concern” becomes an apt guideline for our efforts to embody the model of the shepherd in our pastoral work.”

(Girken: 1997:80, 81)

The author supports Gerkin because for us to follow and care for the flock of Christ we need to have written on our hearts the image given by Jesus Christ of the pastor as the shepherd of the flock. The author believes that for one to care for others, one must have true love to take care of others.

We should not be judgmental and want to be respected when we ourselves do not have respect for others. Do unto others as you would want them to do unto you. The author wants to expand this further by saying that we do not only have to care for those we see in our churches, but we should also care for those who are not members of our denominations. We need to be there for the people of God, especially the bereaved families.

We must not be authoritative, but we must humble ourselves and be reachable. We will sometimes be called when we are on our day offs. We must not say we are a day off, but we must be there for those families that are mourning.

Wuellner, in her book entitled *Feed my Shepherd*, says. Those two disciples on their way to Emmaus that early evening are walking through deep levels of shock, grief, disappointment. Memories that burn, disillusion, and bewilder are very much with them. Then the stranger joins them, walks with them, enters their sad conversation, and begins to unfold for them the meaning of what has happened. Though they do not recognize him until they all sit together at supper, even on that healing walk their hearts burn within them as he talks with them (Luke 24:32). I am sure this warming of their hearts comes not just from his words but also from his presence with them.

What God says to each of us in the healing of our pain differs widely, for each person's wounds are unique. Joining them became a therapeutic event that began healing them.

The bereaved who lost their loved one through road rage should also be assisted in their loss by assuring them of the love that God has for them even during their most painful moment. They need to be told about the healing ministry of Jesus Christ. The pastor must journey with the bereaved in a way of dealing with their pain in order that the healing process can begin to take place.

But the healing presence is the same for us all. Christ's presence is the source of healing power that sets our hearts on fire, a very different fire from the burning of unhealed memories.

For many of us, the walk to Emmaus has become a radiant scriptural metaphor for our transitional times, for our unfolding and growing in the life of Christ. The Bible story holds so many meanings. (Wuellner 1998:97)

For the author, the walk to Emmaus also reflects our walk with the risen Christ to whatever has hurt us, and still has a strangling infecting hold on us. The author

aligns himself with what Flora is saying. During the period of grief, one needs the presence of a minister who is responsible in the bereaved's congregation. Seeing a minister during this period, gives one hope and assurance that a person you worship with, or one's spiritual father is with you during a difficult time. I have heard one person telling me that seeing a minister during this difficult time, begins the healing process for some or most of the people. (If the minister is a good shepherd working with people.)

It is very important to note that the mere presence of the minister says a lot. It shows that the pastor is sharing in the pain that the family is going through.

Oates in his book *New Dimension in Pastoral Care*, defines pastoral care as "The Christian pastor's combined fortification and confrontation of persons as persons in times of both emergency crisis and developmental crisis." (Oates 1970:2)

He further says that the Christian pastor is one dedicated to the care of souls in the name of the Master, who came to serve and save every suffering sinner on the face of the earth.

Fortification is the modern-day meaning of the King James word comfort. It means to strengthen, encourage, support, put heart into sustain.

Confrontation means to bring persons face-to-face with themselves, with one another, and with the issues of justice, mercy, and peace, integrity, truth, and understanding. Times means the propitious moment, the *kairos*, when eternity breaks into time and life-and-death issues are posed for the human soul.

Emergency crisis refers to a critical moment essentially unpredictable, which is characterized by surprise shock and chaos.

Wayne is in line with what other authors say about pastoral care. It should be applied especially to people in pain and suffering, to ease their pain, and to be able to face the situation.

(Oates 1970:3, 4)

Landrum in her book *Acquainted with Grief* says people in grief should share their compassion, support groups can also share their knowledge on how they have coped with the changes their loss forced upon them. She says as you share your compassion and knowledge with them, you find that you, too, are strengthened.

(Landrum 2006:105)

Keeping quiet about something that eats you, makes one to be bottled. You need to meet others and begin to talk about your pain. The minister can organize such people or support group and guide them to vent out their frustration, pain and suffering.

Nouwen wrote a book entitled *The Wounded Healer* and say: "The compassionate man stands in the midst of his people but does not get caught in the conformist forces of the peer group, because through his compassion he is able to avoid the distance of pity as well as the exclusiveness of sympathy.

Compassion is born when we discover in the center of our own existence not only that God is God and man is man, but also that our neighbor is really our fellow man."

(Nouwen 2005:41)

If pastoral care is not administered properly or not administered at all, people loose interest in the church they grew up in and go to other churches with the hope of finding solace. Poling clearly shares this idea in her book entitled *Victim to Survivor*. Nancy tells of a story of a girl who was abused at age



fourteen by her biological father. She lost her mother and thereafter the abuse increased. She had a crisis in faith. She never told anybody about the abuse except God. The question to ask is does God listen?

Angry with God about Manca's death, she no longer wanted to be part of a religion that would allow children to struggle alone. She quit going to church. (Poling 1999:23)

This is what will happen when pastoral care is not administered.

According to Jones, in her book *Helping Hands*, under the topic help for the bereaved, she says: In our contemporary society, which has largely dispensed with the formal rites of mourning, confrontation with the bereaved is uncomfortable, delicate and awkward for onlookers. Overt grief is poorly managed, agonies are supposed to be suffered in private and insufficient time is acknowledged for the slow healing process.

Death arrives in many guises, each leaving its trial of personal pain and anguish, whether it is the conclusion of protracted illness or the blow of unexpected loss, a senseless end by suicide or an accident. Each death, occurring in its unique set of circumstances, inflicts varied emotional and practical difficulties. The scars heal – sometimes, somehow.

Yet it must not be overlooked that the vulnerable bereaved person can also become the victim, falling prey to all manner of physical and psychological disorders. For, with good cause, death of a spouse or close relative features high on the list of stressful life events.

With 70% of urban deaths occurring in hospital and many home deaths in the care of community staff, nurses quickly find their own ways of coping. How can they best assist grieving relatives at this time of sadness, shock and utter bewilderment? Perhaps they could offer more than a bag of belongings and a death certificate. Several interesting projects in bereavement care and support groups suggest that these are welcome developments, probably vital in a fragmented, secular society, increasingly short of family and spiritual fellowship.

She further says in the next topic *Living After Loss*, within a split second my contented, stable family life was shattered by misery and confusion. The policeman standing nervously at my front door was the obvious bearer of bad

news. I felt the blood drain from my veins. Trevor, something dreadful had happened to my husband – instinctively, I knew.

Details were unclear. Trevor had collapsed at the railway station and been rushed to hospital by ambulance. The constable kindly drove me to our local accident department and the receiving nurse ushered me into a corner of the busy reception area. I couldn't see my husband. They suspected a heart attack and the team were doing their utmost to save him, although sister quietly warned me that his condition was critical.

Sitting alone among the motley crowd of casualties with comparatively minor injuries, my ears buzzed with the din around me. My wait seemed interminable and I could only surmise that the flurry of commotion in the emergency room was directed at my husband. Poor Trevor, if only there was some way I could help.

Considering the severity of the situation, my mind flowed with many trivial, often nonsensical, thoughts – who will feed the dog? What about the restaurant reservation for that evening? Our holiday plans next month? Had Trevor's boss been informed? Of greater importance, I worried about what I would have to tell my teenage children, both currently away on a school trip.

My thoughts were broken as a junior nurse brought me a welcome cup of tea, which I took thankfully, despite feeling wretchedly queasy. I searched for an encouraging sign but nothing was forthcoming, and I sensed the young girl's embarrassment as she hurriedly withdrew to her pressing duties.

The receptionist had offered to contact my close friends, Nina, who rushed to be with me. I was relieved to have her support, especially when the doctor finally took us aside to explain that Trevor had, despite all efforts, finally died. Unable to cry, I sat numb, still failing to absorb that fact.

Sister gave me the option of seeing Trevor, so I summoned up the courage to look at him in the emergency room. Such a terrible waste. Fifty years of age, in the prime of life, a fit man – or so we had believed – anticipating an enjoyable retirement after dedicated work at the bank.

Tears flowed and I suddenly became shaky, so the sympathetic sister took us to a side room, to allow myself and Nina a few moments of quiet. Sister explained about collecting the property and necessary forms, details which, thankfully, she wrote down, because I was too dazed to comprehend. I was

especially distressed by the idea of post-mortem. It seemed a final, cruel assault on my beloved husband but I was assured it was a legal necessity in the event of sudden death.

I was glad to leave the accident department, for it had little to offer me in my grief and I could see others had priority over the nurse's time. Nina drove me home and comforted me as I telephoned to break the awful news to the children. They traveled home immediately for a tearful, agonized reunion. I also needed to contact Trevor's elderly, frail parents, who were naturally distraught to learn of the death of their only son. They visited to stay over for the funeral and, for several weeks, I maintained a façade of strength to support everyone else's grief.

On reflection, I can't imagine how I survived the harrowing events surrounding Trevor's death, particularly our last farewell in the chapel. I lived in a haze. With no previous experience of close death, I'd never realized there were so many arrangements, formalities, legal and financial ramifications. It struck me as ironic that the greatest demands for so many vital decisions come at a time when we are least able to cope.

The funeral directors helped enormously, guiding me through the plans for cremation, the service, flowers, cars and catering. Beside having to take over the regular household accounts, with which I was totally unfamiliar, other important matters needed arranging and I'd no idea where to start: the will and probate, the mortgage, insurance claims, death grant, widow's benefit and pension, and finances for the children's future security.

I drifted around this minefield of officialdom and, in desperation, telephoned the Citizens' Advice Bureau. They named a local solicitor who could sort out Trevor's immediate affairs and also suggested that I contact the National Association of Widows. The NAW proved to be absolutely marvelous, giving all manner of advice and practical assistance. I've rung them numerous times, even months after the death, and they've never failed to come up with an answer.

In many respects, that busy period of sorting out the practicalities of Trevor's death kept the emotional reality at bay. It surfaced and hit me hardest as I sorted through his personal effects and began to dispose of his clothing. That sense of finality stirred feelings of anger at his leaving us abruptly. It was as

an illogical feeling but so strong that I was overwhelmed with guilt and hid my thought away. I'd often thought that a long-drawn-out illness, although traumatic in its own right, might somehow have prepared us more adequately for our loss.

I found it difficult to talk to the children. John was reacting badly and becoming hostile, while Sarah became silent and withdrawn for months, thereby compounding my worry and grief. Trying to pick up the pieces of our family life, I was being forced to adopt a new role and take new responsibilities in the home, although my heart was not in it. However, I'd been warned not to contemplate moving or making any major changes or decisions for at least a year had elapsed. Neighbours and friends, who had given their initial condolences and sincere offers of help, now never mentioned Trevor, as if fearful of unleashing my grief and tears. Yet it was a time when I would have dearly liked to talk.

Continued sleepless nights were making me tired and irritable. The GP reluctantly prescribed a mild sleeping tablet, just to tide me over that difficult period, and was concerned that my old ulcer problem might flare up again due to stress.

A few days later, I had a surprise call from the health visitor. She was most understanding and I found myself speaking openly to her about Trevor and my feelings of loss. The health visitor suggested that I might benefit from bereavement counseling and directed me to the local branch of CRUSE, which gives help to any person who is bereaved.

Though doubtful at first and still feeling very raw, I wrote a brief letter. The supportive reply was accompanied by several inspiring leaflets, which showed a great understanding of the need of bereaved people. I agreed to meet one of the counselors, knowing that she would have had experience and training in this special type of care. Several private interviews were very comforting and assisted me to help the children in their grief.

Eventually, I felt able to meet other members of the group and found I was not alone in my distress. I came to appreciate that the grieving process is normal and necessary and I was deeply moved by the experience of the mother whose child has died of leukaemia and the heart-rending agony of the man widowed by the careless action of a drunken driver.

Our first year was definitely the worst. Poignant grief emerged at each family celebration, marred by Trevor's absence at birthdays, our wedding anniversary of the death and relived every moment of that terrible day. My counselor kindly offered a home visit to help me through. I wept healing tears and surfaced ready to survive.

Reading in my local paper, I see the accident department now have a designated liaison nurse to guide relatives through the ordeal of unexpected loss. This seems to be a particularly valuable service to alleviate suffering at that crucial time and introduce them to subsequent helping services.

Through the CRUSE contact list, I have struck up a good friendship with another widow, so life is beginning to look up for me. My journey of recovery through grief was helped by people with special understanding of my difficulties and feelings each step of the way. They 'allowed' me to be happy again and gave me confidence to seek new dimension within myself, without thinking it disrespectful to my late husband. While retaining deep and loving memories of Trevor, I have been able to find a renewed purpose for my future, for there has to be a life after death. (Jones,1989:55-60).

The author agrees with Jones that even after the death of a family member, life must go on. Those left behind must be able to find their feet and strength in order to go on with life. For this to happen they will need support and guidance so as to move on. The best way of dealing with this loss is to talk about it so that healing can begin to take place.

Williams in his book *The Minister and The Care of Souls* says "The healing miracles in the New Testament appear often as signs of the Kingdom of God. Jesus' power to heal manifests the divine power, which restores all of life. Thus the natural desire to be relieved of mortal suffering is transmitted into the question about the meaning of life, and the search for a right relationship to God. It is because of his complex and mysterious relationship between part and whole, natural need and ultimate fulfillment, that Christian theology requires a clear view of the nature of man, and his creature-needs in relation to his destiny under God". (Williams1961: 15,16)

The pastor must take the model of Jesus Christ to heal people in order to bring them into the Kingdom of God. The minister must rely not in his power but the power that can transform the power of the Holy Spirit.

“Martin Ritsi a minister who spent three years in ministry in Africa was transferred to Albania. Martin and his wife Renee first met Tatiana in Albania. Tatiana came from an Orthodox family but her father had been imprisoned and tortured until he lost his faith.

His father asked how could there be God? How could God let all his fingernails be pulled out one by one whilst in prison? Although Tatiana spoke of Bible as children’s stories, and inspite of her indoctrination, she discovered within herself the desire to understand but the inability to believe. One day in conversation she said that the problem is that she has a black hole in her soul. She said that the problem is that she is empty and needed that hole be filled. This is from, *The face of Pain and hope* by Gurney”. (Gurney1998: 3) The story of Tatiana confirms what all authors have said. If Pastoral Care is not administered, people will have black hole in their souls.

They will loose their faith and move from one denomination to the other. Pastors need to be there in order to reach out to people.

Streaty Wimberly in her book *Soul Stories*, tells us of an activity where one, a pastor should describe the Liberating wisdom, Liberating Mind-Set, and Vocational Strategy.

“The liberating wisdom, liberation mind-set and vocational strategy are explored in *Grandmother’s Massage About Identity*. She says this is done first by considering how Psalm 139 is reflected in the story, given the social context in which it is cast.

Persons often respond to this invitation by saying that the story lets us know as African Americans that in spite of the social context in which they feel enslaved, devalued or denigrated, they are God’s creation.”(Wimberly 2005: 54)

It is during this time of distress where people need solace and comfort. In victim to survivor a small boy who suffered from polio relates the anger he had towards God and the church.

He tells us that “after the death of his mother everything went wrong. His abusive father drank everyday and life became misery. His father lost his job and could no longer take care of them. He says that community knew about

their plight but did very little to support them. He had to quit his church and stopped worshipping God thinking that God allowed them to suffer.”(Fortune et al 1999: 23)

Ann E. Streaty Wimberly in her book *Nurturing Faith and Hope* says “Eric Lincoln said the church should bring comfort and the security of God’s love and redemption into the hopelessness of object dereliction” (Wimberly: 2004:60)

The author further believes that the church has a huge task to play. The community within the church ought to stand up and own problems of their fellow members. In the creed we usually pronounce that “we believe in the communion of saints.”

This, the author believes should not be verbally said only, but action must be done that goes along with what we say and believe in.

Edward Wimberly in his book *Claiming God and Reclaiming Dignity* says that as pastoral counselors and caregivers, our task is to assist persons to form sacred identities. He says we partner with what God is doing and with what our faith communities are doing to promote sacred identity formation. He further says that our goal is to find the most appropriate intervention methods. (Wimberly 2003:122)

This support and care should also be given to people who lost their loved ones through road rage. What the author has shared above teaches us that even those affected by road rage can be placed under the same process.

The author agrees with Ed in this regard. The pastoral care-givers and counselors together with the church community must partner together to give support and to help to promote this sacred identity.

McGee in his book *Crisis Counseling*, describes four conditions essential for effective crisis intervention.

1. Location – He says persons doing it must be located in a specific community of people in crisis.
2. Availability – Individuals in crisis should be able quickly to achieve contact with those who can help.

3. Mobility – Those who help in crisis must be able to go to the scene of a crisis, roll up their sleeves, and do what is needed.
4. Flexibility of procedure – Crisis intervention requires a variety of means and methods, such as walk-in clinics, telephone calls, home visits, fifteen minute supportive sessions, and as many resources and support as possible. (Stone 1993:87)

McGee is right because during a crisis, you become better consoled when you see the person who leads you or even people you worship with giving you moral support.

Oates had this to say in his book *The Christian Pastor*, “Not only is the minister’s presence a spiritual fortification to his people, but his capacity to listen to their grief affords a catharsis of the spirit for them.” (Oats: 1980, 167)

I align myself with Oats in this since presence means a lot for the grieving family. This, to them goes with support during pain.

Howard Clinebell in his book *Growth Counseling* says “when people come for help with major life crises they often feel near despair.” (Clinebell 1992:48)

Clinebell is right. People lose hope during a crisis. We need to rekindle this hope. We need to become hope awakeners. The New Testament significantly links hope with faith and love (1 Cor. 13:13) as crucial factors in relationships that are constructive.

Howe in his book, *The image of God*, says that “in both Jewish and Christian theology, the starting point for understanding what it is to be human is the affirmation that human beings are created in the image of God.”

(Howe 1995:27)

For pastors to help people, I think it is important to understand that they are created in the image of God and that treatment should be the same. No one person should get better treatment because of material riches.



Hightower in the book he edited, *Caring for People from Birth to Death*, says that we need as pastors to respond to feelings by accepting how the bereaved feel and help them to express their feelings. He says we must be ready to share our own feelings. He further says that feelings of guilt and anger are often present alongside feelings of sorrow and despair. He says it may be helpful to give reassurance that it is alright to have these feelings and to express them even to God. (Hightower 1999:66)

Hightower has a point that I agree with that when a person has phased on, we must not suppress feelings and that we need to talk about the deceased as we remember him / her. We also should talk about the good and the bad he did.

This way, I believe, the bereaved will see that the deceased is remembered.

Gerkin in his book, *Crisis experience in modern life* says that we know that the dying and the bereaved experience many emotions running the gamut from anxiety to anger, from fear to guilt.

He says that some of these emotional experiences have an aura of psychopathology about them. He further says that we know, for example, how feelings of dependence and helplessness can become distorted in the agony of death. But deep within the experience at its core, the experience of death is existential. It is a boundary experience. He says if we are to minister to persons on this boundary, we must understand what that boundary experience contains.

(Gerkin 1979:74:75)

I fully support Gerkin in the above stated paragraph that we need to understand the boundary experience and what it contains.

A person going through the pain of loss of a beloved one may have mixed feelings and it is the duty of a pastor to first understand what the person is going through in order to try and help. We need to have time and to avail ourselves in order to journey with the family.

Capps in his book *Life Cycle Theory and Pastoral Care* says, “Suffering is a major cause of disorientation in the world. He says that it can be caused by physical, psychological or social factors. But whatever its source, suffering affects the total person and causes us to perceive the world as an inhospitable, if not downright hostile, place to be.” All above is true in that during suffering a person is disorientated.

You may speak to a person undergoing suffering and the person could not be making sense of what you are saying. A person becomes helpless and life becomes meaningless to him / her. (Capps 1983:81).

Mc Affee in his book *Religion and violence* says “The structures of society in which we participate produce an inordinate and intolerable amount of suffering, destruction, and violation of human personality.” (Mc Affee 1920:36)

Mc Affee is right. We live in a world that has no respect for human life. We forget that we are all made in the image of God. We inflict suffering on the lives of others as if we have created them. We need to shift our mindset and go back to the principle of (Ubuntu) humanity for this nation to survive. We forget that everybody has the democratic right to life.

Means in his book *Trauma and Evil* says, “Grief and Trauma are like different sides of the same coin. They are different, yet they go together and where you find one, you find the other. The felt loss that leads to bereavement and grief is a form of trauma.” (Means 2000:141)

I want to agree with Means because suffering and grief brings trauma to people who least expected death to occur. Loss of a life or lives traumatizes people.

From the notes of Prof Yolanda Dreyer, *Theology of Suffering*, she quotes Paul Tillich in *The Courage to be* where he says: “Some suffering is so profound that the only response to it is silence, weeping or prayer. Silence emphasizes the mystery of suffering and conveys respect to the sufferer. Crying and prayer indicate dependence of God. Prayer is the language of the wounded.”

(Dreyer 2007:23)

As a believer, I agree that for a believer, prayer is the language that can be used in times of sorrow and suffering. But I am a bit worried about the non-believers. What language would they understand or use?

As believers we know that God is in our suffering and will journey with us through our tribulations.

There are a few things that pastors need to do in order to begin to heal the wound of the bereaved families, which Kubler-Ross highlights.

1. Ministers must be physically present during the time the family grieves.  
This presence will be remembered even long after the burial.
2. The Minister must listen  
We must listen to a person in both content and feelings.
3. Minister must help mobilize a support system for the grieving.  
The church can be utilized here, to support the grieving family.
4. Pastors must be genuine when dealing with grief. There are ministers who cannot stand grieving people. Ask for help. If a minister has this fear, seek help in order to outgrow the fear.

These are recommendations that can help pastors to deal with the pain of bereaved people.

The other group people that can be helped as well are the police. Seeing incidents of killings and road rage traumatizes them. The S.A.P.S. should organize workshops and arrange with counselors to give the police attention.

In the next chapter, the author will conclude by looking at Gerkin's model of Caring and also look at Kubler-Ross's model of grief.

### **PRELIMINARY CONCLUSION**

In this chapter the author was dealing with pastoral care and how it should be applied to the bereaved families and to the police. In the next chapter the author will highlight key issues that will help the priest and counselors to journey with traumatized people.

## **CHAPTER FIVE**

In this chapter the author will highlight issues that are key to pastoral care and how they should be applied by priests and other care givers.

In conclusion Gerkin states that before Christianity pastoral care was a significant aspect of the Israelite community's life and its tradition, out of which the Old Testament of Jewish Scriptures emerged. He further states that there is an understanding that pastoral care always involves a response to human experience and that this is central to the tradition of care.

Gerkin tells us of four models for pastoral care which originate from the Bible. He elaborates that turning first to the source, we learn that the care of the community of people who worshiped the one God, Yahweh, required the assignment of leadership roles to certain individuals. He says that our earliest pastoral ancestors are to be found among the leaders of the ancient people of Israel.

He speaks of recorded biblical history where custom was established to designate three classes of leaders: the priests, a hereditary class that had particular responsibility for worship and ceremonial life, the prophets, who spoke for Yahweh in relation to moral issues, sometimes rebuking the community and its stated political leaders and the wise men and women, who offered counsel of all sorts concerning issues of the good life and personal conduct.

(Gerkin 1997:21-23)

Gerkin's model of caring shows caring in its entirety, but I think Kübler-Rose's model of caring goes even deeper because she shows the stages of grief a person goes through so that caring can be administered in a better way, understanding where a person comes from and being able to see the particular area in which a person can be helped.

She lists the five stages of grief in her book on death and dying as denial and isolation, anger, bargaining, depression and acceptance.

Denial and Isolation

She regards this stage as a feeling that is experienced by everyone and says it should be seen as a gift from God. She says it allows us to protect ourselves from tragic news until we can muster courage to hear it. She says a feeling of loneliness and isolation is also prevalent during this stage.

### Anger

The anger question always focuses around the question why me? The denial stage is replaced by feelings of rage, resentment and anger. This feeling is often given to those who want to help, for example family members, doctors, nurses, and ministers.

### Bargaining

Ross says if anger has not worked to take away our hurt, then perhaps asking politely will. In this stage we ask God politely. If I do this God will you do something for me. Bargaining is often filled with irrational fears and excessive guilt.

### Depression

When a person realizes the great loss he or she has sustained, then depression sets in. this is a tool used to prepare more easily. Whether grief is due to a situational loss or a preparation to die, the person should be allowed to be depressed, in order to mourn the loss.

### Acceptance

This is not a happy state, rather it is almost devoid of feeling. It is a signal that the struggle is over.

Kübler-Ross did not say that we go through these stages sequentially. So that stage 1 leads to stage 2 and so on. A person can be in the acceptance stage today and the next day be in denial.

Grief is a journey with crooked roads and many turn-back signs, it is not an interstate highway connecting two points at the shortest distance.

Persons grief regardless of chronological age or developmental task.

She also states that from birth to death we are grievers. Ministers have a task to perform. Firstly they must be there physically for the grieving.

Secondly they must listen to the pain and anger of the grieving.

Thirdly they must mobilize a support system for the griever.

Lastly, they must be genuine. If a minister is uncomfortable at a place of grieving, he/she must say so and find someone who can help. (Kübler-Ross: 1986:34-37)

I believe that the model set by Kübler-Ross is a method that can be utilized by all. It deals with what ministers see in their daily lives. This method can also be applied to the S.A.P.S members. The S.A.P.S hierarchy should organize workshops where police officers could be given proper training and counseling lessons in order to deal with trauma cases. This will help alleviate the problem that the police officers face on a daily bases  
They are also people who grieve and need counseling.

The spirit of 'ubuntu' humanity is often shown during grief and it is my wish that all ministers involved in pastoral care can view this very seriously and follow the advise of Kübler-Ross and Gerkin's model of caring as they deal with grief in their respective perishes and communities. The spirit of Ubuntu manifests it self in people by the good works they do to others. The author believes that caring for others during their atrocities clearly shows the spirit of caring, the spirit of "Ubuntu".

Let us all care for our people and not choose to care for the rich and neglect the have nots of our communities.

According to Joubert in her thesis, counseling the bereaved and the dying, therapy starts with determining where the person has stopped in the grief process. The person is encouraged to talk about events leading up to the death itself and its aftermath. Attention is paid to what elicits emotional reactions and what the person avoids discussing. This indicates areas of conflict.

Therapy provokes strong emotional reactions and explores each emotion until it is exhausted. The therapist uses objects such as photographs, clothes, music, letters, places etc., to elicit painful memories which the person has been avoiding.

By using objects with emotional links with the deceased the person is lead to concentrate on the deceased and face the fact that s/he is gone. Emotions

aroused in therapy are explored until exhausted by discussing objects or events in ascending order of pain or by doing therapy in a setting, such as a hospital room or bedroom, which has painful associations for the bereaved. Therapy is a breaching of emotions, an exposure of conflicts caused by guilt, anger and unfinished business (resentments, things said or left unsaid etc.) between the deceased and the bereaved. To do this Hodgkinson (1984) uses the empty chair technique to establish dialogue between bereaved and deceased. The bereaved can question the deceased, explain his own actions and ask forgiveness. This dialogue should conclude with a form of symbolic leave-taking.

In spite of this description of therapy as an intense, orchestrated emotional experience, Hodgkinson (1984) maintains that therapy is short term and intensive, 2 or 3 times a week for a couple of months. This approach is not a first choice for therapy in the early stages of bereavement but rather for unresolved grief after the first year of bereavement (Hodgkinson, 1984).

Training volunteer counselors

Another contribution from the goal oriented therapist is Proulx and Baker's (1981) proposed use of Lazarus' BASIC ID as a basis for training volunteers to work with the dying or the bereaved. The advantages of teaching the principles of BASIC are that it uses concepts which are easy to understand and apply.

Using BASIC a volunteer counselor has the tools to evaluate a case thoroughly. Having identified and explored any problem areas in all modalities the counselor can plan and provide appropriate support or refer the person for professional help as required.

## **CONCLUSION**

The principles of hospice-encouraging home care, humanizing the hospital setting, open communication between staff, patient and family, and providing support for those in need should form the basis of care for the terminally ill. For a comprehensive support and counseling service hospice as a separate entity have drawbacks. Hospice reaches referred patients and families, terminal patients in a general hospital and families of sudden death victims rarely come into contact with hospice.

A comprehensive hospice service (home care, in-patients, day care and grief counseling) integrated into a hospital would reach more terminal patients, their families and the families of sudden death victims. Medical staff could identify and easily refer people who need help. Counsellors would then be available in the wider hospital setting to overcome problems which staff members experience with terminal patients (Kubler-Ross, 1970).

Such an integrated service works at Tygerberg hospital where counselors are an integral part of the hospital (Van Heerden, 1981). A counselor is present when patients are informed that their condition is terminal and when they are told that active treatment of their condition is being discontinued. Counselors are on standby when serious casualties are expected, they offer help to shocked relatives and the patient, if he is conscious. (Joubert, 1993:114-115) The author agrees with Joubert that for therapy to take place the bereaved must talk about the grief and that therapy provokes strong emotions.

Therapy should breach emotions.

According to Goldberg, Pastoral Bereavement Counseling is a series of eight conversations between a bereaved person and the one who wishes to help him. The words that are spoken are usually heavily freighted with emotion, pain, and hope. The helper's reactions are never random or thoughtless, they are always directed towards reaching a definable therapeutic goal.

Much more than conversation takes place. There is a sharing of feeling as the counselor witnesses the mourner struggling to heal. There is the sharing of feeling as the mourner witnesses the counselor's sincerity and empathy.

The counselor feels the course of his empathy throughout the entire course of the counseling. He is aware of his own pervasive struggle-mental and emotional-to choose the most effective approach. At every moment of the sessions the counselor is weighing alternative strategies-through words, attitude, suggestions, silences, and combinations thereof-to try to select the best course.

A Different Posture towards Helping Mourners

A Pastoral Bereavement Counseling session is not an ordinary conversation. It is unusually intense and palpably significant. It is both therapy and prayer,



and equally so for both mourner and counselor. For both principals it is a process of yearning and learning.

For the mourner it is a life experience that aims to assuage-in some significant measure-his sense of bottomless tragedy. For the counselor it is a potential fulfillment-in the most genuine manner possible-of a deeply felt wish to help a fellow mortal with more than platitudes.

The eight conversations are imbued with the perception, on the part of both the counselor and counselee, that they are together engaged in a significant journey that must inevitably affect both of them.

The bereaved are seeking a specific answer for their particular pain at this juncture in their lives. The counselor has an opportunity to genuinely serve both God and man, and to creatively confront his own sense of mystery about life and death. Both need to open themselves to whatever thoughts and feelings may arise in their consciousness during the 8-week exercise. Both need to open themselves to the possibility of an experience, a turning of a corner, that will have immediate as well as lifelong consequences. Both are serving God by grappling with life's problems with vigor and intensity, each at a particular juncture in their lives.

Both together have become partners with God during this activity-infinitesimal partners, but filling roles that are not utterly insignificant. True, the quantity of our mortal presence in this aspect of the God-man relationship is very tiny. But the quality of our presence, the question of how human existence relates to God's overall purpose, may be highly significant.

There's reason to believe that God does need us-otherwise, He would heal mourners entirely without us. What He seems to be saying to us is, "I'm sorry, but the only way to heal a mourner's pain is to let him struggle with it. If you struggle with the mourner through that journey of pain, you're helping him and Me".

This sense of engaging in an activity that is clearly in the "here and now" and yet also touches the mystery of eternity can insert a palpable religious dimension into a conversation or a therapeutic session. This infusion of a transcendental quality into a practical program makes this activity appropriate as part of a pastoral ministry. Pastoral Bereavement Counseling is a vehicle

through which a shepherd responds to God's command to serve both the Master and the flock.

We recognize that there may be others besides clergy, who are mental health parishioners or in allied fields, who might feel themselves called to be shepherds or pastors to mourners. While our principal intention is to recruit bereavement counselors from the ranks of the clergy, we can now envision that others also will feel impelled to participate with us. We hope that everyone who joins will find deep satisfaction in their work. We hope they will come to see themselves as blessed instruments of God's healing.

Pastoral Bereavement Counselors will be asked to dedicate their mental, emotional, and spiritual skills for one hour each week to the service of healing mourner. We ask them to make this contribution as a freewill offering to help a human being who is in pain. At the same time they will be performing a religious deed, an act that we believe is commanded by God, and that we believe is pleasing to Him.

We ask the to do this for the other without fee or compensation. For the sacrifice of their time and sadness that will singe their lives as a consequence of their freely sharing the other's pain, we hope they will be rewarded with emotional and spiritual satisfaction. We pray that they will often succeed and many times attain a peak sense of genuine fulfillment.

#### SEVEN ATTITUDES THAT MAKE IT POSSIBLE

A Pastoral Bereavement Counselor will need to develop a new inner orientation to the process of preparing for his mission. His effectiveness will depend on whether he adopts a different framework of postures and attitudes in relating to others than he may have previously employed.

The following are new attitudinal requirements to do counseling:

1. Be clear about your motives.
2. Understand and subscribe to the ethos of our program's overall design and structure.
3. Intensify your initial surface empathy to allow your feelings to resonate deeply with the mourner's actual pain.
4. Understand the dynamics of the recommended counseling skills, and seek to apply them competently and consistently.

5. Increase the efficacy of your empathy and counseling skills by consciously connecting them to a specific and attainable goal, and by never losing sight of that connection.
6. Understand that goal-directed empathy requires patience, tolerance, acceptance, and love.
7. Look forward to the possibility of bereavement counseling becoming-at certain times and under certain circumstances-a deep religious experience for yourself and for the mourner.(Goldberg, 1984:50-53)

The author agrees that for counseling to take place the seven attitudes prescribed by Goldberg should be followed closely and monitored seriously.

Cook and Oltjenbruns suggest that for people to understand Dying and Grieving, a lifespan and family perspectives must be studied. The following table shows the stages of the family life cycle:

Table 3.1

#### STAGES OF THE FAMILY LIFE CYCLE

Family life cycle stage	Emotional Process of Transition:Key Principles	Second-Order Changes in Family Status Required to Proceed Developmentally
<ol style="list-style-type: none"> <li>1. Between Families:</li> <li>2. The Unattached</li> <li>3. Young Adult</li> </ol>	<p>Accepting parent: Offspring separation</p>	<ol style="list-style-type: none"> <li>a. Differentiation of self in relation to family of origin.</li> <li>b. Developing of intimate peer relationships.</li> <li>c. Establishment of self in works</li> </ol>
<ol style="list-style-type: none"> <li>2. The Joining of Families through Marriage. The Newly Married Couple.</li> </ol>	<p>Commitment to new system</p>	<ol style="list-style-type: none"> <li>a. Formation of marital system to make space for child(ren)</li> <li>b. Realignment of relationships with</li> </ol>

		extended families and friends to include spouse.
3. The Family with Young Children	Accepting new members into the system	(a) Adjusting marital system to make space for child (ren). (b) Taking on parenting roles. © Realignment of relationships with extended family to include parenting and grand parenting roles.
4. The Family with Adolescents	Increasing flexibility of family boundaries to include children's independence	(a) Shifting of parent-child relationships to permit adolescent to move in and out of system (b) Refocus on mid-life marital and career issues. © Realignment of relationships to include in-laws and grandchildren.
5. Launching Children and Moving On	Accepting a multitude of exits from and entries into the family system	(a) Renegotiation of marital system as a dyad (b) Development of adult-to-adult relationships between

		<p>grown children and their parents</p> <p>© Realignment of relationships to include in-laws and grandchildren</p> <p>(d) Dealing with disabilities and death of parents (grandparents)</p>
6. The Family in Later Life	Accepting the shifting of generational roles	<p>(a) Maintaining own and/or couple functioning and interests in face of physiological decline; exploration of new familial and social role options.</p> <p>(b) Support for a more central role for middle generation.</p>

The experience of loss due to the death of a family member constitutes not only an individual crisis but a family crisis as well. A change in the composition of the family by even a single member has an impact on the dynamics of family interaction (Broderick & Smith, 1979). Additionally, even though individuals must cope with their own grief, they, “must do it within the context of adjustment of all people who are affected by the death” (Weinstein, 1979, p. 25).

#### Family System Theory

In the 1940s, Ludwig von Bertalanffy, a biologist, first proposed general system theory to describe all living things. During the past several decades, theorists and practitioners have used the system framework to understand the family. System theory includes several basic concepts: (1) First of all, a system

consisting of interacting parts, is characterized by wholeness or unity. (2) Second, systems are governed by rules. (3) Third, system can be described by some degree of openness. Following is a brief discussion of each of these concepts.

1. A system, while consisting of interacting parts, is characterized by wholeness or unity. In order to understand the whole, one must understand the parts, the interactions among the parts, and the relationship between the parts and the environment. Therefore, in order to understand the family as a system, one must look at individual members of the family, their relationships to each other, and their interactions with others outside the family. Families are composed of smaller units referred to as subsystems. It is useful to understand the subsystems of a family when attempting to understand the family as a functional unit.

Systems are entwined by boundaries which are abstract dividers between or among subsystem that define participation in them. Distinct boundaries can serve to define, protect, and enhance the integrity of individuals, subsystems, and families. Boundaries can change over time and with various situations. The extent of this change will be affected by characteristics of the boundaries (rigid, flexible, diffuse) in each family.

Theoretically, each individual can be thought of as a subsystem. Also, most families have marital subsystems, and parent-child subsystem, sibling subsystems. Other subsystem can be formed by generation, sex, function, or by variety of other factors. In addition, each family has its own particular set of different subsystems. Often referred to as alliances or coalitions, these subsystem are define by particularly close bonds between family certain members. Members of these subsystems are likely to feel closer to each other, do more activities together, be especially loyal and protective of each other, share opinions and see things the same way in the family, and support one another when disagreements within the family arise (Karpel & Strauss, 1983)

The death of a family member can have a unique impact on the members of subsystems of which that individual was a part. All family members may have lost the same person, but not the same relationship. Because subsystems within the family have been altered, the family as a whole will be out of balance and will need to reorganize.

2. Systems are governed by rules. Both overt and covert rules (shared norms and values that governed repetitive pattern of family functioning) help the system to maintain a steady state of dynamic equilibrium or balance, referred to as homeostasis. This homeostasis makes the system and the relationships of interacting persons within the system predictable. Schatz (1986) notes that the well-known family therapist Virginia Satir used a mobile to illustrate the concept of balance in a family system. When one element of the mobile is removed, the entire system is in a state of imbalance. In order for a system to change (that is, for a change in homeostasis to occur), rules must be modified so that a new balance can be achieved. A death result in disequilibrium in the family system and requires a readjustment among surviving family members. Thus, rules must oftentimes be changed following a death to allow the system to meet the needs of the individuals involved and the system as a whole (Golden-berg & Goldenberg, 1980).

In a family, rules govern the roles (expected behavior of family member), division of labor, power structure, and pattern of interactions. Some rules are overtly discussed and agreed upon. Other family rules are not openly discussed but are tacitly acknowledged and followed by family members, For example, it may be an unstated family rule that it is not okay to discuss the impending death of a family member or to show unrestrained

3. A property of all system is openness. The term “open system” and “closed system” refer to the extent to which a family is open and closed to new information and, thus, susceptible to

Open and closed family system react differently in response to a death. According to Bowen (1978), the open family is more likely to recognize the full meaning of the loss; thus its members may suffer intense emotional responses. After going through a period of disorganization, the family re-organizes in new and effective ways to meet the needs of the individual family members. This result is due, in part, to the fact that family members not only react to the news of the death, but also respond to each other's needs by offering nurturance and support. Additionally, they are willing to accept help from others outside of their own system. In an extremely closed system, the family is more likely to deny the loss, since acceptance necessitates change. Family members are locked into rigid ways of responding to each other, unable to respond appropriately to their current situation. Not only will the family have difficulty responding to the demands of the environment, but it may also be unable to respond to the needs of individual family members. Thus, they may be isolated in their grief. When families fail to respond openly to their loss, individual adaptation may be inhibited. The more closed a family system, the more likely that a death will be met in ways which are maladaptive for the family unit and consequently that it will have negative impacts on family members (Stephenson, 1985)

#### Developmental Stages of Families

As with individuals, families move through predictable developmental stages. While different theorists have proposed slightly different models of family development, Carter and McGoldrick (1980) have identified six stages in the family life cycle



and the particular developmental tasks and changes associated with each stage(see Table 3.1). Family roles change significantly upon entry to each new family stage. The resources, needs, and tasks of the family also vary in each stage of development.

Healthy families proceed through each stage relatively smoothly, completing appropriate developmental tasks and modifying patterns of interaction accordingly. Unhealthy families have difficulty and are often unable to complete the developmental tasks associated with particular stages. Consequently, they may get “stuck” in a stage, performing tasks and maintaining patterns of interactions appropriate to that stage but inappropriate for later stages.

The timing of a death in the life cycle of the family is often an important variable in the adjustment of the family and of its individual members (Rolland, 1987). For example, a family that experiences the death of one of its adult members may expect an older adolescent to become a surrogate parent for younger siblings and a companion for the remaining parent, thus truncating the normal process of separation during this age stage.

Ross gives a message of hope. This is what she says:

find her not.

My house is small and what once has gone from it can never be regained.

But infinite is thy mansion, my lord, and seeking her I have come to thy door.

I stand under the golden canopy of thin evening sky and I lift my eager eyes to thy face.

I have come to the brink of eternity from which nothing can vanish-n hope, no happiness, and no vision of a face seen through tears.

Oh, dip my emptied life into that ocean, plunge it into the deepest fullness. Let me for once feel that lost sweet touch in the allness of the universe. Tagore, from Gitanjali, LXXXVII.

We have discussed so far the different stages that people go through when they are faced with tragic news-defense mechanisms in psychiatric terms, coping mechanisms to deal with extremely difficult situations. These means will last for different periods of time and will replace each other or exist at times side by side. The one thing that usually persists through all these stages is hope. Just as children in Barracks L318 and L417 in the concentration camp of Terezin maintained their hope years ago, although out of a total of about 15,000 children under fifteen years of age only around 100 came out of it alive.

The sun has made a veil of gold  
So lovely, that my body aches  
Above, the heavens shriek with blue  
Convinced I have smiled by some mistake.  
The world's abloom and seems to smile.  
I want to fly but where, ho high?  
If in barbed wire, things can bloom  
Why couldn't I? I will not die!

1944, Anonymous

“On a Sunny Evening”

In listening to our terminally ill patients we were always impressed that even the most accepting, the most realistic patients left the possibility open for some cure, for the discovery of a new drug or the “last-minute success in a research project”, as Mr J. expressed it (his interview follows in this chapter). It is this glimpse of hope which maintains them 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 he 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 role in life which helps them maintain their spirits, will enable them to endure more tests when everything becomes such a strain-in a sense it is a rationalization for their suffering at times, for others it remains a form of temporary but needed denial.

No matter what we call it, we found that all our patients maintained a little bit of it and were nourished by it in especially difficult times. They showed the greatest confidence in the doctors who allowed for such hope-realistic or not-and appreciated it when hope was offered in spite of bad news. This does not mean that doctors have to tell them the hope that something unforeseen may happen, that they may have a remission, that they will live longer than is expected. If a patient stops expressing hope, it is usually a sign of imminent death. They may say, "Doctor, I think I have had it" or "I guess this is it" or they may put it like the patient who always believed in a miracle, who one day greeted us with the words, "I think this is the miracle-I am ready now and not even afraid maintained hope with the, we did not reinforce hope when they finally gave it up, not with despair but in a stage of final acceptance.

The conflicts we have seen in regard to hope arose from two main sources. The first and most painful one was the conveyance of hopelessness either on part of the staff or family when the patient still needed hope. The second source of anguish came from the family's inability to accept a patient's final stage; they desperately clung to hope when the patient himself was ready to die and sensed the family's inability to accept this fact (as illustrated in the cases of Mrs W. and Mr H.).

What happens with the "pseudo-terminal syndrome" patient who has been given up by his physician and then-after being given adequate treatment-makes a comeback? Implicitly or explicitly these patients have been "written off" They may have been told that "there is nothing else we can do for you" or they may just have been sent home in unexpressed anticipation of their

imminent death. When these patients are treated with all available therapy, they will be able to regard their comeback as “a miracle,” “a new lease on life,” or “some extra time did not ask for,” depending on previous management and communications. The relevant message that Dr. Bell\* communicates is to give each patient a chance for the most effective possible treatment and not to regard each seriously ill patient as terminal, thus giving up on them. I would add that 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 comfortable 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. He will not feel deserted or abandoned the moment the doctor regards him as beyond the possibility of a cure.

The majority of our patients made a comeback, in some way or another Many of them had given up hope of ever relating their concerns to anyone. Many of them felt isolated and deserted, more of them felt cheated out of the opportunity of being considered in important decisions. Approximately half of our patients were discharged to go home or to a nursing home, to be readmitted later on. They all expressed their appreciation of sharing with us their concern about the seriousness of their illness and their hopes. They did not regard their discussion of death and dying as either premature or contraindicated in view of their “comeback”. Many of our patients related the ease and comfort of their return home, after having settled their concerns prior to their discharge. Several of them asked to meet with their families in

our presence before going home, in order to drop the façade and enjoy the last few weeks together fully.

It might be helpful if more people would talk about death and dying as an intrinsic part of life just as they do not hesitate to mention when someone is expecting a new baby. If this were done more often, we would not have to ask ourselves if we ought to bring this topic up with a patient, or if we should wait for the last admission. Since we are not infallible and can never be sure which the last admission, it may just be another rationalization which allows us to avoid the issue.

We have seen several patients who were depressed and morbidly uncommunicative until we spoke with them about the terminal stage of their illness. Their spirits were lightened, they began to eat again, and a few of them were discharge once more, much to the surprise of their families and the medical staff. I am convinced that we do more harm by avoiding the issue than by using time and timing to sit, listen, and share.

I mention timing because patients are no different from the rest of us in that we have our moments when we feel like talking about what burden us and times when we wish to think about more cheerful things, no matter how real or unrealistic they are. As long as the patient knows that we will take the extra time when he feels like talking, when we are able to perceive his cues, we will witness that the majority of patient wish to share their concern with another human being and react with relief and more hope to such dialogues.

If this book serves no other purpose but to sensitize family members of terminally ill patients and hospital personnel to the implicit communications of dying patients, then it has fulfilled its task. If we, as members of the helping professions, 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 we 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.

The following interview with Mr. J. represent an example of the stage of anger and demonstrates-at times in a disguised way-the phenomenon of ever-present hope.

Mr. J. was a fifty-three-year-old Negro man who was hospitalized with mycosis fungoides, a malignant skin disorder which he describes in details in the following interview. This illness necessitated his resorting to disability insurance and is characterized by state of relapses and remissions.

When I visited him the day before our seminar session, the patient felt lonely and in a talking mood. He related very quickly in a dramatic and colorful fashion the many aspect of this unpleasant illness. He made it difficult for me to leave and held me back on several occasions. Much in contrast to that unplanned meeting, he expressed more annoyance, at times even anger, during the session behind the one-way mirror. The day before the seminar session he had initiated the discussion of death and dying, whereas during the session he said, "I don't think about dying, I think about living."

I mention this since it is relevant to our care of terminally ill patients, that they have days, hours, or minutes when they wish to talk about such matters. They may, like Mr. J. the day before, volunteer their philosophy of life and death and we may consider them ideal patients for such a teaching session. We tend to ignore the fact that the same patient may wish to talk only about the pleasant aspect of life the next day; we should respect his wishes. We did not do this during the interview, as we attempted to regain some of the meaningful materials he presented the day before.

I should say that this is a danger mainly when an interview is part of a teaching program. Forcing question and answers for the benefits of students should never occur during such an interview. The person should always come first and the patient's wishes

should always be respected even if it means having a classroom of fifty students and no patient to interview.

DOCTOR: Mr J., just for the introduction, how long have you been in the hospital?

PATIENT: This time I've been in since April the 4<sup>th</sup> of this year.

DOCTOR: How old are you?

PATIENT: I'm fifty-three years old.

DOCTOR: You have heard what we are doing in this seminar?

PATIENT: I have. Will you lead me with questions?

DOCTOR: Yes.

PATIENT: All right, you just go right ahead, whenever you are ready.

DOCTOR: I'd be curious to get a better picture of you because I know very little about you.

PATIENT: I see.

DOCTOR: You have been a healthy man, married, working, ah-

PATIENT: That's right, three children.

DOCTOR: Three children. When did you get sick?"

PATIENT: Well, I went on disability in 1963. I think I first came in contact with this disease around 1948. I first stated out with small rashes on my left chest, and under my right shoulder blade. And first it was no more than what anybody gets in the course of a lifetime. And I used the usual ointments, calamine lotion, vaseline, and different things that you buy in the drug store. Didn't bother me too much. But gradually by, I'd say by 1955, the lower part of my body was involved, not to any great extent. There was a dryness, a scalyiness had settle in, and I'd use a lot of greasy ointments and things like that to keep myself moist and as comfortable as possible. I still kept on working. In fact, certain periods through there I had two jobs because my daughter was going to college and I wanted to make sure that she finished. So I'd say by 1957 it had reached a point where I had started going to different doctors. I went to Dr. X for a period of about three months and he didn't make any improvement. The visits were

cheap enough, but the prescriptions were about fifteen to eighteen dollars a week. When you are raising a family of three children on a workman's salary, even if you are working two jobs, you can't handle a situation like that. And I didn't go through the clinic and they made a casual examination which didn't satisfy me. I didn't bother to go back to them. And I just knocked around, feeling, I guess, more and more miserable all the time until in 1962 Dr. Y had me admitted to the P. Hospital. I was in there about five weeks and really nothing happened and I came out of there and finally went back to the first clinic. Finally in March of 1963 they admitted me on disability.

DOCTOR: This was in '63?

PATIENT: In '63.

DOCTOR: Did you have any idea what kind of illness you had by then?

PATIENT: I knew it was mycosis fungoides and everybody else knew it.

DOCTOR: So, how long did you know the name of your illness?

PATIENT: Well, I was suspicious of it for some time, but then it was confirmed by a biopsy.

DOCTOR: A long time ago?

PATIENT: Not a long time ago, just a few months before the actual diagnosis was made. But you get one of these conditions and you read everything, and you learn the names of the different diseases. And from what I read, mycosis fungoides fit right into the picture and finally it was confirmed, and by then I was just about shot. My ankle had started to swell up on me I was in a constant state of perspiration, I was thoroughly miserable.

DOCTOR: Is that what you mean by "by then I was thoroughly shot? That you felt so miserable? Is that what you mean?

PATIENT: Sure. I was just miserable-itching, scaling, perspiring, ankle hurting, just a completely, thoroughly, utterly miserable human being. Now, of course, these kind of times you get a little resentful. I guess you wonder, why does this happen to me. And



then you come to your senses, and you say, “Well, you are no better than anybody else, why not you?” That way you can sort of reconcile yourself because then everybody you see you start looking at their skin. You look if they have any blemishes, any signs of dermatitis since your whole sole interest in life is to see if they have any blemishes and who else is suffering from something similar, you know. And I guess, too, people are looking at you because you’re much different-looking from them-

DOCTOR: Because this is a visible kind of illness.

PATIENT: It is a visible kind of an ailment.

DOCTOR: What does this illness means to you? What is this mycosis fungoides to you?

PATIENT: It means to me that to now they haven’t cured anybody. They have had remission for certain period of time, they have had remission for indefinite period of time. It means to me that somewhere, someone is going to do research. There are a lot of good brains working on this condition. They might discover a cure while in the process of working on something else. And it means to me that I grit my teeth and go on from day to day and hope that some morning I’ll sit up on the side of the bed and the doctor will be there and he will say, “I want to give you this shot,’ and it will be something like a vaccine or something, and in a few days it will clear up.

DOCTOR: Something that works!

PATIENT: I will be able to go back to work. I like my job because I did work myself into a supervisory capacity.

DOCTOR: What did you do?

PATIENT: Actually, I was active general foreman in the main post office down here. I had worked myself to the point where I was in charge of the foremen. I had seven or eight foremen who accounted to me every night. Rather than dealing with just the help, I dealt with more or less operations. I had good prospect for advancement because I knew and enjoyed my work. I didn’t begrudge any time that I spent on the job. I was always helping

my wife when the kids were getting up. We hoped they would be out of the way and maybe we could enjoy some of the things that we had read about and heard about.

DOCTOR: Like what?

PATIENT: Traveling a little, I mean we never had a vacation. Our first child was premature baby and it was touch and go for a long time. She was sixty-one days old before she came home. I still have a sack of receipt from the hospital at home now. I paid her bill out at two dollars a week and in those days I was only making about seventeen dollars a week. I used to get off the train and rush two bottle of my wife's breast milk to the hospital, pick up two empty bottles, come back to the station, and go on to my job in the city. I would then work all day and bring those two empty bottles home at night. And she had enough milk for, I guess, for all the premature kids in the nursery over there. We kept them pretty well supplied and this meant to me that we got over the hump with everything. I would soon be in a salary bracket where you don't have to pitch every nickel. It just meant for me that we would maybe sometime look forward to a planned vacation instead of, well, we can't go anywhere, this kid has to have some dental work, or something like that. That's all it meant to me. It meant a few good years of more or less relaxed living.

DOCTOR: After a long, hard life of trouble.

PATIENT: Well, most people put in a longer and harder struggle than I do. I never considered it much of a struggle. I worked in that foundry and we did piece work. I could work like a demon. I had fellows that came to my house and told my wife that I worked too hard. Well, she jumped all over me about that, and I would tell her it was a matter of jealousy when you work around men with muscle, they don't want you to have more muscle than they have and I definitely did, because when ever I went to work, I worked. And when ever there was any advancement, I made it, whatever advancement there was to be made. In fact, they called me into the office over where I was working and they told me when we

make a colored foreman, you will be it. I was elated for a moment but when I went out-they said when-that could be anywhere from now to the year two thousand. So it deflated me to an extent that I had to work under those conditions. But still nothing was hard for me in those days. I had plenty of strength, I had my youth, and just believed I could do anything. (Ross: 1981;122-131)

The author agrees with Ross that hope persist through all stages of grief. Hope maintains the bereaved through days, weeks or months of suffering. For the bereaved to go through the process of healing, they must have hope.

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