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DISSERTATION SUMMARY

INTERPRETATION OF PASTORAL PSYCHOLOGY METHODS IN PASTORAL CARE OF DYING PEOPLE AND THEIR RELATIVES

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Summary

Counselling incurable patients and their relatives is the subject of my dissertation. This specialization constitutes an important projection and challenge of the pastoral work, and also of theological education and vocational training, this is how I can explain my choice of the subject. Preparation for counselling presumes a profound theoretical knowledge and practical experience, but the counsellor's personality, attitude and his empathic behaviour are all determining.

Many people tried to dissuade me from this subject saying that it's too hard, and too mournful, and even in these days many are surprised when I mention the subject of my research.

These attitudes make clear for me, that I have to take up the subject, as the counselling of incurable patients and their relatives is the most difficult part of counsellor's work. Besides the above mentioned reasons, I had two personal experiences, which strengthen me in choosing this subject.

At the beginning of the 2000s I attended a hospice training with theoretical and practical courses that offered directly applicable experiences in counselling which affirmed my conviction that the topic must be studied. A chaplain during his pastoral service very often meets dying, death, burial, mourning and it is his own responsibility to be present competently next to his patients in these difficult situations. In the same period I met Alaine Polcz, she had a great influence on me, and she was who encouraged me to investigate the subject. The fact that I have met her, her comportment and aura determined me in my work. I have approached the subject as a hospital chaplain, theology teacher and tutor of vocational trainings for priests, according to the following three aspects: the work of a priest, the fields of pastoral psychology, and my own personal involvement.

In my dissertation I would like to create a well-structured, systematic theoretical foundation on a specific field of pastoral psychology: the counselling of dying persons and their relatives. The theoretical systematization is completed with case histories, and in the same time in the empirical chapter of my dissertation I present the results of a survey research in order to explore the different attitudes toward death.

I have a long-term goal, namely my dissertation could become the base of a handbook for priests and helping professionals, and a useful reading material for those who face life-situations when they have to uphold their own incurable relatives.

I am convinced that counsellors should be more experienced both theoretically and practically in this specialization of pastoral psychology, and they should be present more intensively in counselling dying persons and their relatives. As a result I have formulated another hypothesis. I think that among professionals we should pay more attention to the question of death, in order to demolish its taboo, and to become able to talk about it in those situations when the dying person and his relatives need it.

The structure of my thesis is based on the following five chapters:

I. The place of death in our life
II. Counselling of dying people and their relatives
III. Special problems
IV. Assistants (helpers) and counsellors
V. The research and conclusion

I. The place of death in our life

In the first chapter I focus on the changes of the attitudes toward death in diachronic approach. I review people's attitude toward death in the history based on Ariès' works . Using his relevant expression I follow „the history of death". Then I summarize the different systems of view of philosophy based on Pilling, specifying the images of death as results of the philosophical approach. The largest subsection of this chapter is the interpretation of death-conception of the Bible, analysing the passages related to death. Contemporary attitudes toward death are presented separately in another chapter, which is completed by questionnaires' processing in chapter V. of dissertation's empirical part.

Examining attitudes toward death (I.1. Attitudes toward death over time) we can distinguish four periods: the period of tamed death, death of ourselves, other's death, and the period of forbidden death.

The period of tamed death was characteristic mainly in the early middle age, but its influence continued until the 18th century. In this period people conceived death as a fact of life, they knew that they have to get ready for it, being aware of its signs. Burial places were located in

the churches or in their neighbourhood (until the 18th century), in the centre of settlements. In this way the dead „were present" in the living world. The living weren't afraid of the dead, and dead weren't respected particularly.

The expression of the death of ourselves was representative at the end of the middle age. Death became more personal, the concept of judgement and the testament (last will) appeared. Until now the main-point of the burial was the committal to the earth. In this period the burial was completed with the funeral procession and funeral mass and the laying out.

The other's death appears in a third period. This aspect is related to the modern era, and it is characterised by averting death. Cemeteries got far away from the living quarters, registered graves appeared, the cult of dead strengthened, and with all this together mourning became less bearable. Members of the family took care of the dying person, but he lost all his rights to initiative, the family and the doctor were aware of his real situation and it happened that the dying felt into the state of unconsciousness for months. Because of these facts of changing the dying person becomes secluded.

The fourth period is the time of the 20th century, characterized by the forbidden death. In this case we can mention the presence and connection of two psychological elements: one of them is the further development of the tendency which had began in the 19th century and it manifested in the fact that the dying person renounced of everything for his family benefit, even of his right to keep under control his own death. *

After the philosophical examination of the attitudes toward death (I.2. Attitudes toward death in philosophy) based on the work of János Pilling we can pick out four different aspects: the rational-mathematical, the mechanical-physical, the cosmic-organic, the ethical-heroic image of death. The rational-mathematical approach tries to demonstrate logically that the fear of death is pointless, so there is no reason for the living to deal with the question of death. The mechanical-physical aspect emphasises the fact that death is the absolute end, there is no afterlife. The most ancient image of death is the cosmic-organic one, based on the harmony with nature, the Life Cycle, and the repetition of decay and emergence. According to the ethical-heroic approach – which is the most significant conception of modern people – death refers to somebody else. Day after day we meet other's death in the television, in the news, in films, but these deaths are far away from us, they are not about us, they don't affect us, they don't threaten us.

The Bible in line with the problem of death is preoccupied with two great issues: why has a human being die, and what will be his destiny after death (I.3. Death in the Bible). The basic notions for dying and death in the Bible are: the Hebraic mut (to die, to kill) and mavet (death), and the Greek thanatos (death) with all their diversified derivates.

The Bible contains human experiences, and religious questing of a few thousands years. Among the major problems of life death, mortality and the hope of eternal life always had a high priority. The metaphorical language of the Old Testament gives help even nowadays in counselling incurable patients, this is the form used by the patients to express and describe their condition. Mortality often is visualised by the images of nature's transience such as wilting flowers, shrivelling flowers. (Is. 4,6; Ps. 90,5)

Some of the biblical stories reveal such an idyllic picture of death, that we desire their materialization during the counselling of dying persons and their relatives. For example the story of Abraham who shared his fortune and died in peace: "Then Abraham gave up the ghost, and died in a good old age, an old man, and full of years; and was gathered to his people." (Gen. 25,8).

Interconnection of death and judgement in the Bible is realized in two ways: on the one hand God can smite the sinner with death, to protect the other members of the community, on the other hand the community can punishes the person (or the group), to protect community's chastity. The Bible uses different manners of speech related to death: it declares that death is the natural attendant of life, but in the same time it searches the origins of death, and it considers as a consequence of sin. In the context of human suffering death appears with its projection, and horror. Path of life and path of death become separated from each other on the pages of the Bible, mainly as alternatives, or two different options, symbolizing the gracious and vicious life. Prophets often used in their sentence prophecies the naturalistic visualization of the dead body as a deterrent. We can also find phrasings of the Bible in which death is described as a possibility of escape or way out from suffering and pain. Reviewing the place of dead we could observe the distance travelled by humanity from the early idea of Sheol to the height of the hope in life after death described in the New Testament (which we have treated also separately, taking into consideration the popular reality of the cult of death, documented also with archaeological finds, as well as the early evolution of the concept of resurrection).

In our days (I. 4. Approach to death in our days) we have to face the taboo of death, old age and illness. Klára Cselovszkyné Tarr says: „Modern age also has its dark side and nobody is willing to speak about it, we disguise it with euphemisms or we try not to talk about it and we simply avoid it. Don't think about great things/big deals, illness, old age and death is enough. The shady side of life became taboo in a world, where only the following categories are valid: strong, young, and beautiful."

Ignoring or excluding fear of death only deepens the taboo and the encryption of death. The taboo of death is demolished in the hospice movement and palliative care. In Europe great changes have happened in the 80's, when the hospice movement and the palliative care appeared, trying to assure a meaningful and decent human life until the last moment. Hospice nurses try to attenuate physical and mental pain, and they offer the opportunity of saying farewell, making the last will, arrangements of grievances and clarifying questions of faith and of conscience. Alaine Polcz said: „ The philosophy of hospice is: death is a natural part of life. There is a time to die, one should not accelerate or slow. Dying is one of the most precious stages in our life. The target of hospice is: to give back the dignity of death, to help the patient and his family, to be able to communicate freely about accepting death."

II. Counselling dying people and their relatives

This chapter is the longest part of my dissertation. I have systematized the pastoral psychological knowledge that should be adopted by all means in counselling incurable patients and their relatives.

It is useful to highlight the importance of communicating the diagnosis (II.1. Communicating the diagnosis) and the right way and time of the communication and the models of communication. The lack of communicating the diagnosis makes difficult the counselling of incurable patients. After a time most people aspire to know what is really happening with them, they would like to find out details about their disease, about the course and outcome of it. In most of the cases the patient's environment rejects this (for example not even the accurate diagnosis is told to the patient).

According to the experiences from Romania the medical staff is preoccupied with the question whether they have to tell the diagnosis to the patient or not, and if they have to, how will the patient receive the bad news.

To avoid this unpleasant situation they usually communicate the diagnosis to the relatives. Kübler-Ross explains the transference and the solution of the problem in the following way: „The question shouldn't be whether to tell the diagnosis or not, but rather how should I share this information with my patient."

In counselling dying persons it is very important to know those fears (II.2. The fears of a dying man) which beset the patient. The fear of death is the strongest fear of the man. Dying people generally are in dread of two things: the physical pain and loneliness. Besides we have to deal with the consciousness of illness of incurable patients. Death is a taboo. In the times we live in cancer (as a disease) has become also a taboo. Béla Buda says: „taboos exist in societies even if not a religion or an ideology prescribes what isn't allowed to talk about.

The public opinion itself, the general feeling can also generate hidden taboos. In such cases the protection of the ego widens into social dimensions, and it is proper not to talk about those things which could cause anxiety in ordinary people, it could intimidate them, because it would remember them that death may happen to them too."

During counselling a dying person we have to develop an emphatic relation with the patient, to be able to understand his state of mind, even if we are outsiders, and our behaviour must be authentic: we might not express our hopelessness, when he needs hope, but when the patient gives up, then the we mustn't insist, because if we aren't in harmony, we can't perceive the patient's state of mind (mood) and we can hold him back from preparing for death and taking farewell.

The counsellor has to know the separate and recognizable stages of the process of agony (II.3. The process of agony). Kübler Ross described this process after a long investigation of incurable patients. Five different periods of the process have been identified: rejection, anger, chaffering, depression, resignation. Knowing these five periods of the process assures a kind of standard, but we have to take in consideration that each patient is reacting different, and some of them can return from one stage to another. It is very important to know, that not every incurable patient reaches the state of resignation. During the process of dying the counsellor is supposed to be in complete harmony with the state of mind of the dying person, because this

is the only way to help, to be there and experience the unique coexistence evolved in the spiritual depth of process of dying. This togetherness cannot be planned in advance.

„If the priest makes a fixed programme and he is preplanning his own mental constitution, his relationship with the patient will become endangered. Therefore we have to emphasize that the above mentioned stages aren't a schedule for the counsellor, but the can be an essential guidance to a better understanding of his patient." reminds us Gábor Hézser. He also refers to the fact that the presence of the counsellor can be disturbed by borrowing the prejudices, or by conventional conversation guidance and by indoctrination.

The counsellor's aim is to build up a free relationship with the patient. It is very important to know the psychological needs of the dying person summarized by Twycross–Lack : safety, belonging somewhere, love (expressing feelings, human touch), comprehension (understanding the symptoms of the disease, the opportunity of speaking about death), acceptance, self-esteem (the opportunity to give and to accept), and participation (in decisions).

The most frequent question is what to say to the dying person? The patients don't expect advices. An important teaching of counselling is that the counsellor never can give advices. Dying persons don't even need advices, but hearing, attention, and understanding. Viorst says: „We have to be easily accessible and open to their needs. We have to let them use us as they want but we cannot teach any dying person how to die. If we are near them, if we pay attention to them, then they could teach us, and they really do it."

Working as a hospital chaplain, counselling dying people, I give importance to speaking about the travelled distance in life, emphasising the most beautiful parts of it. Based on my professional experience I can affirm that this conversation has a very good influence on the dying patient, because he can face his own life and realise that he had a lot of beautiful experiences. I was very glad when I have found some cross-references at Alaine Polcz : „Many patients make a life-overview mentioning repeatedly their own omissions, bitterness and disappointments. We have to listen to these enumerations, but then we have to try to get them to the joyful part of their life. In this way, emphasising the values of his personality and his positive behaviour, we can help the patient to accept himself, to be able to forgive, and to ask forgiveness at the final reckoning."

Counselling incurable children and their family is a very stressful task. In this chapter (II.4. The child and the death) I present the difference between the behaviour of children and adults.

According to Ilona Mária Nagy we can distinguish three categories of children's conception about death: animistic (2-5 wears old), personifying (5-9), and real (from 9 years).

The counsellor must be aware, that these categories slowly cross each other, and sometimes they preserve the relics of the previous category. We have to also know that children communicate differently about death, depending on their age.

A symbolic drawing, fairy-tale or a game can be very expressive for children. Children also have their own consciousness and fear of death, and just like adults, they forefeel the closeness of their own death. This fact is affirmed by János Ribár too: „It is very hard to talk about death with children. Deep in their little heart they usually feel that they are in hardness, in a dangerous situation, and they won't live for a long time.

Very often the child can read the truth from the face of his parents and doctors. Sometimes they ask questions about the truth, „In this case, when the child asks, we have to be very cautious with our answer about the truth. Alaine Polcz says: „Beside knowing the way of communicating the counsellor has to know also the immediate cause of it. We have to know, why the child is asking, namely what would he like to hear practically." Because the patient (being a child or an adult) always asks, because he is waiting for tranquilization, he wants to hear the truth (what he already knows), or he would like to talk about his fears, he would like to ask questions, to find out details, which scare him.

In the case of incurable children the counsellor has to spend as much time with the child's parents, as with the child himself. The counsellor has to pay special attention to the parent who is nursing the child in the hospital. This parent because of the anticipated mourning often can feel the need to talk about his child, to show his pictures. This phenomenon is very similar to the analysis of the path of the life in case of the adult patients, which is a very important episode before the death happens. János Ribár says: „Beside the child, who is seriously ill we have to pay attention to his parents, because there are situation when it is hard to decide who needs more help, the child, or his parents."

The counsellor helps not only the incurable patient, but also his relatives (II.5. Helping relatives and the medical staff). He can ameliorate their anxiety, which can appear because of the forthcoming separation, and he can help them to communicate easier and deeper. Moreover the counsellor has to follow the medical staff, because their work is emotionally burdensome, and their anxiety is intensified by the fear of death.

During long medical treatments a close attachment can develop between the patient, his family and the medical staff. Another interesting problem is the fear of death of the medical staff, the subject being already investigated. According to a survey, which compared a hospice medical staff with a normal one, nurses who worked on the non-hospice field wanted to avoid death at any price, and they affirm that the good dying is quick and unexpected. Those nurses who worked in hospice movement said that it is very important for them to have time to prepare for death; they don't want to avoid death, as death is unavoidable. Those who didn't work in hospice can't accept the fact that one day they also have to die, they can be characterized by an intensive fear of death. Hospice medical staff can accept easier that death brings relief; their relation to death is more spiritual.

To be present beside a dying person can be very stressful both for the relatives and for the medical staff. Hospitals and the medical staff is organised for healing. Therefore it is a great problem to be together with the dying person or later to say farewell to him. This is the reason why in a few hospitals so called farewell rooms have been created.

Treatment of the dead body is regularized by bioethical addresses. In our times in hospitals the dead body is very accurately separated. „For example the nurses after the death was confirmed, immediately clean the body, and when they have finished, they wash their hands" - writes Alaine Polcz.

Each time we meet death we remember our own death, and if we can't face this fact, then the scene of dying will be a very stressful thing.

Those, who have experienced many times due to their vocation other's death, got nearer to death and will counsel differently. According to Alaine Polcz : „To remain alone with a dead (beloved or unknown) is a great stress both for believers and atheists, for laics and the medical staff. (Exceptions always exist)." János Pilling completes the affirmation: „Almost everybody had or will have dead relatives. Our common interest is to treat the body condignly."

III. Special issues

One of the special issues of this thesis is clinical death (III.1. Clinical death). When the death occurs, two different stages can be distinguished: the clinical death and the biological death. Alaine Polcz says: "Clinical death means that the functioning of the most important organs

has ceased: circulation and respiration stops, that is to say the state of death, according to the old consensus. The signs of life cease, but development of modern medical sciences allows the restarting of the functions of living. Everyday application of the restarting is spreading continuously: in cases of accidents or heart-attacks, for example. Some of the ambulances are equipped with resuscitation devices. So returning from the clinical death exists, and it is only a transition to biological death."

The central nervous system is a very vulnerable part of the human body, but it can endure the clinical death for a few minutes. Clinical death also has different stages which actually are the transition to the biological death. A very important question is what happens with the "self" in the state of clinical death. Near-death experiences reveal that meanwhile the body is lying at the location of the accident, or on the operating table, the patient can see from a certain distance everything what is happening with him, and he can hear what people are talking around him, and when he is "brought back" to life it turns out, that he can tell what had happened.

Resuscitation is a great achievement of medicine, not only because many human lives are saved, but from the reports of the revived persons, for the first time in the history of humanity we can find out something about the experience of death. Religions always have been preoccupied with the experience of death, but the results weren't verifiable with the methods of the natural sciences.

People returned from the state of clinical death feel more secure and they confess that they have no more fears. We can interpret the phenomenon as we want, one thing is sure: these people had a great experience. Hennezel wrote: "People who return from the state of clinical death are calm and transformed; they got closer to themselves, and to the essence of things. They seem as they have suddenly understood what is important in life. This experience showed them that they can't identify themselves anymore with their body, which it is only a shell." This knowledge determines their further lives and their fear of death ceases.

Here we have to mention two important books. One of them is Raymond Moody's work, published in 1975 and re-published in 1987 (Life after life) in which we can read about 150 cases presenting how dying people lose their consciousness. The other one is a basic work by Johann Christoph Hampe (To die is something else) including the confessions of resuscitated patients after a long period of loss of consciousness.

People who return from the clinical death go through three phases: the exit of the Self, making-peace-with-oneself or in other words life-panorama, and the expansion of Self.

Those who once have experienced a form of the exit of the self affirm that they had such a peculiar experience, that they can't talk about it. Jung also has had a near-death experience and he declares: "What is happening after death it is so great, that our notions and emotions aren't enough to express an approximate term about it."

The phenomenon of life-panorama occurs so frequently that it can be considered a very important part of the dying experience. All experiences say that despite they can't estimate exactly the time of the phenomenon, they can confirm that the events of their life have glided in front of their sight in such a particular way that had never happened before and they were able to relive them.

The extension of the Self means an experience full of light and colour, often connected with voices and music, and weightless levitation. Hampe says about this experience: "The feeling of peace and happiness is inexpressible. All things which have ever beset me remained far-far away from me, and I couldn't even evoke them. Thoughts – I wonder if I still was in possession of my thinking. It was as though emotions had been dissolved in everything, in clear perception and everything seemed to be a sublime and glorified reality."

János Pilling summarizes the essence as follows: "The way of thinking of those who have returned from the clinical death changes significantly – first of all they will appreciate themselves and the values of life – and so their relationship with other people will also change. These changes can occur – not at the same degree – at everybody who gets in close proximity of dying. Changes in the relationship to death and religion appeared only at those persons, who had near-death experience during their clinical death." The fear of death decreases at the patients who had near-death experiences and their faith in the life afterlife increases (III.2. The other world (the world afterlife)).

There are two ways of Euthanasia (III.3. Euthanasia) for incurable patients: passive Euthanasia (discontinuation of the treatment) and active Euthanasia (inducing death intentionally). There are some cases when Euthanasia could really assure a solution, putting an end to the psychical and physical suffering of the patient, when his death is predictable, but in the same time through Euthanasia he could be deprived of the life-stage including his lead on. Palliative care

organised in the spirituality of hospice is a human method of helping the dying person. The patient has its own role in this process when he doesn't ask further treatment.
The concept of euthelia (III.4. Euthelia) was introduced by László Bitó. The euthelia should be a legal way of ending the struggle of the medical staff for the patient's life. "We both know that active euthanasia is in practise everywhere, even if it is considered to be passive, or simply it is dissembled. This fact is hardly acceptable for me, even if I find an empathetic doctor or nurse who helps me to die. Because euthelia – the good end – and its institutions and helpers, as I have drew in my book, it is only a dream."- says László Bitó.

IV. Assistants (helpers) and counsellors

In the course of time theology and psychology have found their common language with difficulty (IV.1. Development of counselling).
Freud's ideas and the theologians' reaction had anyhow an important role in the problematic relation between the two disciplines. The works of Jung have helped the overture of theology and psychology and due to a flexible vision the common language could be developed. In the 1920-s a great distance existed between the counselling and the psychotherapy, everybody professed his own truth, without trying to develop a common language usable for both sides.
Appearance of Thurneysen , a protestant theologian was very important, he was who wrote: "C.G Jung, the Swiss psychiatrist has broken through the ideological orthodoxy of Freud, and involving all knowledge gained through psychoanalysis he laid psychology on a new, much freer and larger soil. His investigation is the most important step toward setting the entire psychology on new basis." Thurneysen emphasises that psychology is an essential auxiliary science for a theologian. On the field of psychology the opening arrived from America, with the works of Rogers. His view about humans and his therapeutic "method" is very similar to the theological concept, and he had a great influence on pastoral psychology and counselling practice. Pastoral psychology doesn't commit itself to none of the psychological tendencies, because its aim is to become a mediator between psychology, medicine and theology.
Practical benefit of the pastoral psychology is expressed in counselling. It is obvious by now that a counsellor needs to have basic psychological knowledge in. This doesn't mean that the

clinical counsellor has to become a psychologist, but he has to know those psychological processes without which he could cause serious damages to the patient.

Károly István Debrecenyi summarized the essence of the clinical counselling in ten keywords: human-centred character, non-directivity, empathy, discretion, a view about humans, spirituality, professional responsibility, creative ecumenism, interdisciplinarity, continuous professional control and support.

Points of contact and differences between psychotherapeutic and mental hygienic supporting relationship are: the occupations, attitudes towards healing, emotional contact, the frame, the method, and the target population. The counsellor must be aware that patients have different attitudes toward a counsellor and a psychotherapist. Patients consider that the counsellor is a supporter who lives in connection with God; they expect something else from a counsellor than from a psychotherapist.

A well-known training and professional developing for counsellors (IV.3. Qualification of the counsellor) is the Clinical Counsellor Training, which is indispensable not only for a hospital chaplain but for all who work in counselling.

Counsellor's personality and behaviour influences the counselling. This is why we can say that theoretical knowledge and professional experiences aren't enough, counsellor must have a very good self knowledge and a continuous development of their personality.

Endre Gyökössy says: "C.G. Jung in 1932 in a presentation in Strasbourg not by chance declared to the counsellors from Alsace, that in their activity not the method, but the counsellor's personality is important, the counsellor has to be an intuitive partner of the troubled person, and has to observe his wriggling fellow-creature being in need, and he has to hurry to his aid. Theology would say: counsellor's personality, his spiritual and psychological charge actually ensures the specificity of counselling."

The danger of existence of burn-out syndrome (IV.5. The risks of burnout) is mostly rejected by helpers, because they consider it the sign of their weakness, that they aren't able to cope with overstress and they can crash under the burden, they can go smash, it is hard to confess our weakness in a profession where the basic standards are the performance and the altruistic self-sacrifice. Maybe this is why another expression will be used, namely the professional deformation, which has a more neutral connotation and makes supporting easier.

The most important task of the counselling is organising trainings and supervision, and clarifying the different models of the counsellor (IV.6. The tasks of counselling: relevant questions, challenges).

Modern clinical counselling (IV.7. The counsellor in the hospital) began in the USA in 1920. Ecumenical case study groups for doctors and priests are organised and managed by Anton Theophilus Boisen.

They were searching a way to work together more efficiently for the patients. Boisen wanted to put the basis of counselling on psychology of religion, creating the harmony of the practice which has combined the methods of empirical theology, sciences and spiritual sciences.

Hans Christopher Piper and Heije Faber were two pioneers in initiating the American clinical counsellor's training based on Rogers's ideology. Heije Faber and Ebel van der Schoot wrote a book together: The psychology of the counselling conversation, this book became the basic work of the Hungarian counselling literature. Clinical counselling can't be organised patterned according to congregational counselling, because the clinical counsellor needs other methods, other knowledge and experiences. According to Timea Tésenyi : "The preconditions of the professional clinical counselling are: self-knowledge and insight into human nature, empathy, methods of the supporting conversation with no directive basis, consideration of the aspects of non-verbal communication, methods of the crisis intervention, worthy treatment for the symbols and rituals of the Christian tradition, and taking into account the specific institutional circumstances."

Possibilities and tasks of the clinical counselling are determined by the structural and organizational conditions of the hospital. Hospital's aim is to shorten the time spent on patients' nursing, and the personality of the patient is much neglected. In our days there are a lot of surveys that justify that those patients who were visited by the counsellor recovered faster, spending a shorter time in the hospital (American insurance companies made the surveys), and in the same time the counsellor often mediates in the relation between doctor and patient. Creating a counsellor's job in a hospital is a profit-earning investment. The counsellor has an important role in the prevention of the burn-out syndrome of the medical staff. Investigation had been made about the effect of prayers and spiritual conversations on the process of recovery, the results were promising. According to the recognitions of the

investigations made by Larry Van De Creek , spirituality and prayers have a very important role in maintaining or getting back our health.
Counselling, conversations, visiting have a very good effect on the patient's state of mind.
Sára Bodó says: "Visiting the patient is one of the less spectacular forms of the assistance. The patient is lying on his bed; his time is spending in pain and vulnerability, in hope and fear. And somebody comes to him, maybe he knows him, maybe not, and this man brings nothing else but only himself. He brings a lot of things inside his heart, but these things will be revealed only in confidential conversations. He is the patient's visitor."

V. Research and conclusions

This chapter, as its title shows, presents the findings of the research (V.1. The questionnaire) conducted in 2012 and 2013. The method used was a survey by questionnaire. I asked 100 adult Unitarians (20 years and above) about some important questions regarding death.
When and how did you meet death for the first time? Have you already seen a dead man? How often do you deal with the question of death? What are you most afraid of referring to death? How can religious faith help you when in fear of death? What is the most difficult thing to bear when losing our beloveds? Who can help in time of mourning? Is it a taboo to talk about death? In what form would it be helpful to talk more about death? What happens to us after we die?
A detailed presentation of the findings of the survey, completed with tables and figures, can be found in my dissertation. Here I would like to point out some major questions and the answers given to them.
Q7. When and how did you meet death for the first time?
In this case, 2 answered never having encountered death, while 98 people had already had an experience of death. It is surprising and relevant for the counsellor that 54 of the 98 positive answers told to have met with death already as a child. This is important for us from two points of view: we tend to think that people begin to confront with the problem of death much later. On the other hand, as we know it from our background in pastoral psychology, children put their questions about death already at a very small age (4–5 years). From the perspective of the counsellor this is important because later they will recall these answers, related to their fear of death. We also know that parents tend to avoid giving an answer or they fabricate strange

explanations. This is the very first moment when the child faces with the fear of death of the parent, expressed by his confusion or even by his untruthful explanations.

Another momentous question:

Q9. How often do you deal with the question of death?

Here we had four possible answers: never, rarely, quite often, almost all the time.

11 answered with "never", 64 with "rarely", 19 with "quite often", and 6 with "almost all the time". We can see from the above answers that 64% of the asked deals rarely with the idea of death, and even there are some (11 %), who do not think at it at all.

The next question – Q10: What are you most afraid of referring to death? – is relevant because I have dealt a lot in my dissertation with the fact that, in counselling dying people, as they approach to the final, there are several types of fears that appear beside the fear of death. In the questionnaire we had four possible answers: no fear at all, fear of agony, fear of extinction, fear of loneliness. I thought that we would get with the survey a helpful answer to the question: are church-goers afraid of death, and if yes, what are they fearing more precisely?

57 people told they had no fear of death. This is a high ratio and it can be explained by the fact that the faith of church-goers (faith in eternal life) is probably much stronger. Those who are afraid of something are distributed as follows: 25 fearing extinction, 11 fearing agony, 6 fearing loneliness, and 1 who fears ghosts. This result is for me a completely realistic, because my dying patients, who tell me about their fears, are most often afraid of extinction: what will happen when all comes to an end? Or what will happen after that? These are their most frequent questions. The other fear is related to agony, its hardness, its duration, and its pain.

Question Q12: What is the most difficult thing to bear when losing our beloveds? It is relevant above all for the counsellor, since it brings forward the pains and fears of relatives, and it can serve as a reference in counselling for grieving people. 60% of the answers consider absence as the most painful after the loss of the beloved person.

Another very significant question was Q14: Do you think it is a taboo to talk about death? It had the most surprising result, because 74 people answered that talking about death isn't a taboo. However, literature is still presuming (as I mentioned in the theoretical part) that death is a taboo. The great number responses could be explained partly with the fact that, as I said, our subjects were church-goers, who hear probably more often about death. 20 people considered death as a taboo subject.

As a hospital counsellor and a professor at the college of theology, I think that we should talk more often about death, because there is too much eschewal and tabooization, and it is very difficult to counsel in these conditions, in order to create a communication between the dying person and his family. Thus, the next question is also very important for me: Q15. In what form would it be helpful to talk more about death? There were four possible answers: conversations, readings, books, or no form at all. In this case, the answers show great differences between attitudes towards death: 23 answered that there was no need to discuss more about death; though 77 people considered death a subject we should deal with. It is obvious that we have people to work with, yet we have to decide, in which form we should work with them. The following numbers could be helpful: 64 answers chose conversation (a very useful finding for counselling), 9 would like to read books, and 4 chose readings. The 23 negative answers warn us that there are still many people who prefer to avoid this subject.

For me it is a positive result that a great number of subjects consider conversation about death an important thing. This confirms that counselling is purposeful in this domain, and that we have to do a work of quality. As for the manual, it would be helpful first of all for those who carry out this hard work with great responsibility: for counsellors and helpers.

The Conclusions (V.2. Conclusions) have to parts, one dedicated to personal and the other to professional conclusions.

Personal conclusions are those experienced during the writing of a dissertation. While counselling dying people and their relatives, he/she can observe what can be transmitted to others from this knowledge based on experience.

Personal conclusions:

1. Awareness of our own mortality. Our dying patients make us understand how mortal we are.
2. To experience the value of silence. In company with incurable patients as a counsellor I experienced the silence that I have never had met before. When two people sit next to each other, one of them is dying and the other tries to mitigate his loneliness and pain by his presence, this silence doesn't need words anymore. There are only feelings.
3. Experiencing God's presence in hospital rooms.
4. Acquiring a different communication. Communicating about the taboo, in the taboo.

5. Counselling dying people for many years, one will either „die" from the lot of pain surrounding him, or he begins to „grow" and to learn how to live. Signs of learning how to live are: humbleness in regard of the things of existence, an even stronger relationship with God, and a conscious experience of every moment of life, distinguished by certain watchfulness, responsibility for ourselves and for the others.

Professional conclusions:

I have drawn conclusions concerning three aspects: 1) the instruction of counsellors; 2) the apprentice helper, and 3) the care receiver.

In relation with the training of counsellors it is essential a) the acquirement of theoretical and practical knowledge, as well as b) the self-knowledge and the development of personality.

Beside the acquiring of theoretical and practical competence, the counsellor's training should put a greater stress upon the work of self-knowledge and the development of personality.

For the apprentice helper it is important: a) to receive further instruction in the fields of mental hygiene and hospice; b) to prevent anxiety, depression and burnout.

The instruction of already practicing priests and counsellors should include mental hygiene and hospice, as well as the prevention of burnout.

As to care receivers there are some important things: a) to have more opportunities to talk about death; b) to have access to useful manuals; c) to receive individual and collective aid in times of mourning.

In the case of the receivers of counselling, we must find occasions to talk about death; we have to distribute accessible books concerning this subject. In times of mourning we have to give more attention to mourners, whether it is about individual care or about creating and leading mourning groups. Confrontation with death means confrontation with ourselves, accepting our mortality. While we are confronting death, we learn to live. This knowledge should be there in our behaviour, we should transmit it to our followers, patients and receivers of counselling. Priests and counsellors have a very big responsibility, for if there is someone that people would like to share their thoughts with, our put him questions, we are those. I think we cannot avoid this important mission. We have to be ready for this presence and we have to use to opportunity to be able to take up responsibility in diminishing the fear of death of people, and thereby in teaching them a new knowledge about how to live. And we have to be ready physically,

psychically and spiritually to be present in this wholeness: the counselling of dying people and their relatives.

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