Are You Interested in Training for Muslim Chaplaincy?

Chaplaincy introductory 4-day course, February 2019

Ready to leave your desk job to serve your community directly, every day?!

This is the ideal comprehensive introduction for those of you who've been interested in working in our community with our people directly. Chaplaincy involves pastoral and spiritual care for the community.

It's a great way to increase your knowledge, skill, experience and wisdom in both Islamic spirituality and complementary pastoral care skills to support people who need advice and support, in hospitals, prisons, schools, universities etc.

In NZ there is a growing awareness of the need to offer accessible spiritual-care /chaplaincy from a Muslim perspective in a variety of contexts: health/correction/social work/education.

Chaplains can exercise a variety of roles, dependent where they serve e.g. supporting families and individuals in times of crisis, loss, grief and end of life; supporting individuals in their spiritual development; advising institutions on Islamic religious and cultural issues; providing ethics guidance; representing Islam at the institutional level. (https://asssocationofmuslimchaplains.org)
There is HUGE potential to serve our community in NZ that is greatly in need of being served!

The purpose of this three-day workshop is to:

- discern the current spiritual-care/pastoral needs of Muslims in NZ
- discern the formation needs of potential Muslim chaplains
- consider the potential of Clinical Pastoral Education (CPE) in assisting in the formation of Muslim chaplains: see www.cpe-nz.org.nz (CPE is an integral aspect of the formation of most Christian hospital chaplains in NZ)
- introduce some of the educational processes underpinning CPE
- develop some basic helping skills essential to any spiritual-care/pastoral chaplaincy work
- align the above with the teachings of the Qur'an, Prophet Muhammed and major Islamic classical and contemporary scholars

Date: Thursday, Friday, Saturday and Sunday 14-17 February 2019

Venue: Auckland Central location (free parking available).

Time: 9.00am – 4.30pm each day (see timetable for details)

Co-facilitators: Salih Yucel, Associate Professor, Charles Sturt University (AU). Experienced Chaplain, teacher, counsellor and interim CPE Supervisor.

John McAlpine, Veteran Supervisor/Educator accredited CPE Supervisor/Educator in NZ since 1988

This course was attended by 2 Kiwis who travelled to Sydney in 2018, and is endorsed by many well known community leaders in Sydney including Br Ahmed Khilani (Muslim Village).

Certificate of Attendance and Participation is issued upon completion of this 4-day workshop.

2019

Islamic Science and Research Academia of Australia
Level 3, 128-136 South Parade, Auburn, NSW 2014
ABN 7849 672 1249
Contact: A/Prof Salih Yucel
Phone:(02) 9649 9040
Email: syucel@csu.edu.au

In the name of Allah, the Entirely Merciful, the Especially Merciful.

Welcome to the 2018 Introductory CPE unit at ISRA from 2-6 July. We hope you enjoy this program, which will prepare you for pastoral visits to hospitals, correctional centres, schools and aged care facilities. The aim is to introduce you to basic Islamic chaplaincy.

Muslim chaplains fill a variety of roles, often dependent on the institutions where they serve. Responsibilities chaplains may have include: supporting families during times of grief, loss and end of life; advocating for religious freedom and rights; advising institutions on religious and cultural accommodations; providing ethics guidance; representing Islam at the institutional level; and providing instruction in Islamic sciences (Association of Muslim Chaplains, https://associationofmuslimchaplains.org/).

We look at what it means to be an effective listener; the distinctive features of pastoral care in comparison with other helping professions; begin the process of Islamic chaplaincy supervision; and focus on examining the ultimate concerns present in our pastoral interactions. An important theme of clinical pastoral education is "spiritual reflection", asking "What are the ultimate concerns?" "**What do the Qur'an, Prophet Muhammed (pbuh) and major classical and contemporary scholars say about this situation**?" and "What resources from our faith would be useful to help the people concerned?"

The program for each day this week is similar, with sessions on the practice of pastoral ministry; helping skills; learning from your pastoral interactions; spiritual reflection; and discussing the challenges and rewards that arise in our pastoral interactions with people in sickness, hospitalisation or other crises. You will be invited to present a report on a ministry opportunity you have had recently, receiving feedback from others in the course on what turned out well or what could have been done more effectively.

On the first day, 2 July, we meet at ISRA at Level 3, 128-136 South Parade, Auburn, starting at 10.00am and finishing at 4pm. Tea, coffee and biscuits are provided, and you can bring your lunch or buy locally. We will provide reading material, including teachings on pastoral ministry; a demonstration verbatim, giving you a model to follow; and articles you will find helpful.

The emphasis in clinical pastoral education is learning from your supervised experience, so we do not look so much at what is the "right way" to go about Islamic chaplaincy, but rather what works for you and your *jamaah* or community, resident or patient. Throughout the course, we identify and practise the unique contributions of pastoral care to the inter-professional team, and focus on the type of pastoral visits that are explained in the Qur'an, Sunnah and scholarly works.

Alan and Salih

Rev Alan Galt OAM	Level 3 Supervisor
A/Prof Salih Yucel	Acting Level 1 Supervisor

Day 1,

10.00	**Opening (recitation of the Qur'an), welcome and housekeeping.**	Zeliha
	"Centreing" time: What am I doing here? How do I feel about being here?"	Salih
	Introductions and program outline.	
	The goal of pastoral visits: What people want from a chaplain.	Alan
	Exercise in pairs: Think about a time when you, or someone close to you, were in hospital. Tell your partner what message of spiritual comfort and hope you needed at that time. After 10 minutes, summarise to the group what your partner said.	
11.30	**Morning tea**	
11.45	**The *khalili* approach for visiting Muslim patients and inmates:** The spiritual approach should be inclusive, non-judgemental, compassionate and sincere, a combination I call the "*khalili* (friendly heart-centred) approach." The word *khalil* is a title given to Abraham by the Qur'an and Prophet Muhammad (pbuh) due to his tender-hearted nature as Abraham felt deep sorrow and pity towards all creation, including enemies and sinners.	Salih
	The method for pastoral visits: Strategies for hospital ministry: What should we do for an effective pastoral visit? Pastoral Ministry in Hospital involves forming relationships in which patients can speak openly and with feeling about their illness, injury and hospitalization, as well as about other life experiences, such as recent loss or current conflict, which may be related to their illness. Patients may express feelings of loneliness, anxiety, fear, anger, guilt, doubt, meaninglessness, grief and despair, but also gratitude, relief, security and optimism. Pastoral ministry demands sensitive listening, perceptive observation, careful response, emotional warmth and a capacity to confront ultimate questions of meaning in such a way that patients may be comforted and may come to use their experience of illness positively (McGregor 1987, 117).	Alan
	What chaplains and pastoral visitors do: The St George audio visual (from a survey of members of the St George Hospital chaplaincy team 1995).	
	Demonstration of pastoral ministry in a health crisis: Video of simulated interview.	
	During the day, note any issues, situations or interactions that puzzle or inspire you and bring them to the final session of the day.	
12.45	**Lunch and *zohr* prayer**	
1.30	**Introduction to group supervision:** Reflect on pastoral interactions and dealing with the issues arising in hospital ministry. Use verbatim reports to learn from your experiences. **Demonstration verbatim** in small groups. **Allocation of tasks:** morning recitation, noon prayer and verbatim roster.	Alan

2.30	**Introduction to theological reflection:** Essentials and outcomes of Islamic chaplaincy service.	Salih
	The theology of Islamic chaplaincy services: Discussion. The Prophet Said: "God, the Exalted and Glorious, would say on the Day of Resurrection: 'O son of Adam, I was sick but you did not visit Me. He would say: O my Lord; how could I visit You whereas You are the Lord of the worlds? Thereupon He would say: Didn't you know that such and such servant of Mine was sick but you did not visit him and were you not aware of this that if you had visited him, you would have found Me by him" (Muslim, 4661). **Reading: a: Imam Nawawi, Riyadus Saliheen, The Book of Visiting the Sick,** https://sunnah.com/riyadussaliheen/7 Based on these and other similar hadiths, some scholars state that visiting a patient or person who is ill is a very strong tradition or a confirmed **Sunnah (*sunnah mu'akkadah***). Other scholars argue it is ***fard al-kifayah*,** a communal obligation in Muslim legal doctrine. According to Ibn Taymiyya (1263-1328) it a social and spiritual responsibility and if no one does it, then every Muslim for will be accountable before God (al-Ikhtiyaaraat, p 85). The role of the Muslim chaplain can be classified into four categories: theological, spiritual, social and ethical.	Salih
3.50	**Approaching the end of the day:** Reflections on the day and closing *dua* (supplication).	

Roster

	3 July	4 July	5 July	6 July
Morning Qur'an recitation				
Noon prayer				
Verbatim report				

Day 2,

10.00	**Opening (recitation of the Qur'an)**	
	Centreing time: How do I feel as I approach day 2?	
10:10	**Pastoral ministry in a hospital** What does the hospital chaplain do? … As a start, the chaplain meets patients at their level of immediate distress, seeking to comfort and sustain them. The chaplain will ***seek to engage the sufferer***, to ***discern the patient's personal experience of suffering*** and ***to respond to it***. If physical distress is seen as the precipitating event of disease, then suffering is the personal experience of that event. While both the physical distress and the resultant suffering are important, and intertwined, it is to the latter that the chaplain seeks to make a contribution (Holst 1990, 8-9). **The method for pastoral visits: Strategies for Correctional Service ministry Salih**	Alan
	Videos of helpful and unhelpful interactions: Simulated interviews: • Alan and "Dorothy": A chaplain visits an elderly resident in an aged care facility • Anna and "Dorothy": A pastoral visitor calls on same resident. • On the Verge: What is Islamic Chaplaincy? (mcuoft, 2013). What did you see that was helpful or unhelpful in these interviews? (discussion).	Alan
	During the day, note any issues, situations or interactions that puzzle or inspire you and bring them to the final session of the day.	
11:30	**Morning tea**	
11.45	**The art of pastoral visits:** Applying Egan's helping skills (Egan 1982). • Video: Active listening • Simulated interview: Pastoral intervention with a medical patient • Demonstration with students **Overview of the Egan model** (summarised by Rev Alan Galt for *P8577Pastoral Theology and Ministry*) • **Stage 1 – Primary Level Accurate Empathy** ***Attending*** verbally and non-verbally, ***listening,*** and ***showing that you have heard*** what the patient is saying. The helper *attends, listens, probes, understands*, to encourage the patient to explore the problem situation. The helping relationship is based on ***respect, genuineness, concreteness*** and ***social influence*** (what the helper means to the client). • **Stage 2 – Developing New Perspectives and Setting Goals based on Self-understanding** As the helper ***summarises, gives information*** and shows ***advanced empathy***, the patient begins to see the problem in a clearer way, understands the need for action and chooses behaviours that are more effective in managing problem situations. The helper uses ***confrontation, counsellor self-sharing*** and ***immediacy*** to encourage this process.	Alan

	• **Stage 3 – Action** The patient and helper together work out a ***specific program for action*** and ***explore strategies for achieving goals*.** The helper encourages ***self-help*,** as the client ***explores ways of reaching goals***, searches for inner resources and external supports, decides on courses of action, ***implements programs***, manages problem situations, copes with living and ***evaluates*** the action taken.	
12.45	**Lunch and *zohr* prayer**	
1.30	**Group supervision using verbatim reports:** Reflect on verbatim reports of pastoral interactions, dealing with issues arising in hospital ministry, and learning from your own experiences and feedback from the group.	
2.30	**Coffee break**	
2:45	**What are the spiritual issues involved in this situation?** (Kowalski 2009) On the one hand, looking at our interactions with people in health crises from the perspectives of Islamic theological understanding, to clarify what we really believe the sacred writings are saying; and on the other hand, examining our theological interpretations in the light of our real life experiences, highlighting any inconsistencies between our faith and practice. Looking at issues arising during the day, everyone will write one or two sentences on what aspect of our faith we would use to offer comfort and hope in a specific health crisis.	
3:30	**Theological reflection:** Make sense of our life experiences by applying theological understandings and evaluating our theological concepts in the crucible of life. Reflect on people you have "met" today, what stories from your faith tradition could you use to help them survive and grow through their experience?	Alan
3.50	**Approaching the end of the day:** Reflections on the day and closing *dua*.	
	Report from day 1: Message of hope and comfort needed when I or someone near me was in hospital.	

Day 3,

10.00	**Recitation of the Qur'an**	
	Centreing time: How do I feel as I approach day 3? Prophet says: "He is not of us who does not have mercy on young children, nor honor the elderly" (Tirmidhi).	
10.15	**Pastoral ministry with the elderly:** Mental change and loss associated with ageing Common conditions include arthritis and heart disease … Physical disease may lead to emotional and psychological stress. This is particularly true of cancer and strokes because of their dramatic consequences. Stress may result in manifestations of anxiety, with agitation, restlessness and tremor and may even lead to depression, which is not uncommon in the elderly. Mental illness may exacerbate or even take the form of a physical disease. A vicious circle is soon entered upon, made worse if the physical symptoms are misinterpreted. Inappropriate drug treatment results in an unwanted reaction to that drug, and the new symptom is treated with yet another drug (Williamson 1987, 10). The main disability of old age is undoubtedly the memory loss and confusion that comes through dementia. Alzheimer's disease, strokes, brain damage due to injury, infection or substance abuse, and degenerative neurological illness, produce the inexorable and irreversible ravages of thinking and remembering that threaten the very identity of often high functioning individuals. Scientific investigation is closing in on a means of isolating the core causes of neurological impairment that are characteristic of dementing illness (Goldsmith 2004, 27-30). We still find it hard to understand what happens when the brain breaks down. The analogy with a computer helps, but is incomplete (Galt 1992, 210). "Although infinitely more complicated than the most sophisticated computer, the human brain is a physical organ. While waves of depolarisation in neurones are not the same as electrical impulses in conductive microchips, the thinking machine in our heads is subject to physiological limitations." In the meantime, psychological understanding, aged care nursing and pastoral care are promoting methods of maximising the resources of the elderly for coping and happiness. The other side of neurological impairment is the more temporary impact of delirium, the acute and reversible brain syndrome that may look like dementia, but without its permanent impact. There is a reduced clarity of awareness of the environment, impaired ability to focus, sustain or shift attention, being easily distracted by irrelevant stimuli. Urinary tract, respiratory or gastric infection, or a mild stroke, can produce a temporary confusion and disorientation, slurred speech and mobility difficulties, which passes with appropriate treatment, largely antibiotics, reduction of fever and rest.	Alan
	Changes with dementia: Videos of mild, moderate and severe dementia	

- **Mildly dementing:** "Usually, a person with a dementing illness becomes gradually more forgetful, and his or her personality and ability to think are also affected… The first stage often passes unnoticed as the symptoms can be ignored or written off as unimportant - the person becomes increasingly forgetful, finds it difficult to take in new information, loses his or her way or sense of time occasionally and becomes less spontaneous."
- **Moderately dementing:** "the memory and ability to take in new information continue to deteriorate. This may lead to serious mistakes, such as turning on the gas and forgetting to light it, and the person may need supervision. A sufferer may forget what he or she was saying mid-sentence, forget the meaning of words, have trouble calculating or making plans or decisions, and become much slower in speaking and understanding. Other problems in this stage include changes in personality, such as becoming paranoid, obsessional or even violent; wandering and becoming lost; and difficulties with personal hygiene."
- **Severely dementing:** "sufferers generally become apathetic, fail to recognise people and even their own reflection and can no longer control their bladder and bowel functions. Finally, they seem unable to make any sense of the world or to manage even simple tasks such as dressing or washing. By now, full time professional carer is usually needed."

(NSW Department of Health, *The Dementias - Memory Loss and Confusion*)

11:30	**Morning tea**	
11:45	**The art of pastoral visits:** Applying Egan's helping skills. **Review of Overview** **Stage 1 - Initial Problem Clarification** The helper *attends, listens, probes, understands*, to encourage the client to explore the problem situation. The helping relationship is based on *Respect, Genuineness* and *Social Influence* (what the helper means to the client). **Stage 2** - **Developing New Perspectives and Setting Goals based on Self-understanding** As the helper *summarises, gives information* and shows *advanced empathy*, the client begins to see the problem in a clearer way, understands the need for action and chooses behaviours that are more effective in managing problem situations. The helper uses *Confrontation, Counselor* *Self-sharing* and *Immediacy* to encourage this process. **Stage 3 - Action** The client and helper together work out a *specific program for action* and *explore strategies for achieving goals*. The helper encourages *self-help*, as the client explores ways of reaching goals, searches for inner resources and external supports, decides on courses of action, implements programs, manages problem situations, copes with living and evaluates the action taken. Summary of Primary Level Accurate Empathy (p98) Effective, skilled helpers will attend both physically and verbally; listen for basic or "core" messages; respond frequently, briefly, flexibly; will be gently directive; will respond to both feeling and content; will move gradually in exploring sensitive	Alan

topics and feelings; will check the accuracy of their own responses; and will evaluate signs of stress and resistance. They will avoid inaccurate empathy, pretending to understand and "parroting".

Egan Stage 2 - Developing New Perspectives and Setting Goals based on Self-understanding (Egan 1982)

The Aim (p39) is *for the client to set appropriate and reachable goals.*

Clients are *challenged,* that is *invited to explore a problem situation more fully*, so that they can get on to doing something about it (p154).

Understanding themselves more fully and more objectively (p157), they are better able to see the need for more effective action (p155).

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Stage 2 – Developing New Perspectives and Setting Goals based on Self-understanding

- The aim (Egan 1982, 39) is for *the client to set appropriate and reachable goals*.
- Clients are *challenged,* that is *invited to explore a problem situation more fully*, so that they can get on to doing something about it (Egan 1982, 154).
- *Understanding themselves* more fully and more objectively (Egan 1982, 157), they are better able to see the need for more effective action (Egan 1982, 155).

Stage 2 techniques of advanced accurate empathy (Egan 1982, 159-174)

- Summarising
- Information giving
- Expressing what has previously been only implied
- Identifying themes
- Connecting isolated experiences, behaviours and feelings
- Helping clients draw their own conclusions from premises
- Offering alternative frames of reference.

Specific stage 2 skills

- **Confrontation** (Egan 1982, 186-197): Pointing out clients behaviours and interactions which interfere with fuller self-understanding or movement towards constructive change; Revealing discrepancies, tricks, distortions, games, smoke screens and evasions, in a caring, involved, not punitive way.
- **Counsellor self-sharing** (Egan 1982, 198-200): Referring to your own experiences, behaviours and feelings, where appropriate, in a constructive and non-intrusive way, in order to encourage further self-exploration by the client.
- **Immediacy** (Egan 1982, 200-206): Discussing directly and openly what is happening here and now between you in the helping interaction.

12:45	**Lunch and *zohr* prayer**	
1:30	**Key principles of Islamic chaplaincy services:** *istigh'na*, *ithar*	Salih
2:00	**Fellowship, mentoring and youth psychology:** A guest youth worker will share his personal experience in the hour seminar. (See also Khan 2006.)	Guest
2:45	**Coffee break**	
3:00	**Group supervision using verbatim reports:** Reflect on verbatim reports of pastoral interactions, dealing with issues arising in hospital ministry, and learning from your own experiences and feedback from the group.	
3.50	**Approaching the end of the day:** Reflections on the day and closing *dua*.	

Day 4

10.00	**Recitation of the Qur'an**	
	Centreing time: How do I feel as I approach day 4?	
10.15	**An Islamic approach to mental illness:** Religion can play important role in reducing fear levels. Prominent physician and philosopher Ibn Sina (980-1037) argues that religion plays very important role in regard overcoming fears. Similarly, Contemporary Islamic scholar Said Nursi supports this view (Nursi,2001). Ibn Sina and Nursi recognised the value of overcoming fears and using willpower in the therapy of mentally ill people. Ibn Sina illustrates this by saying if a plank of wood is put across a street and someone is asked to walk on it, he will be able to do so quite easily. But if the same plank of wood is placed across a gorge, the same person will probably be able to walk on it and may well fall if he tries. The more importance they [fears] are given, the more they grow. If you give them no importance, they die away. If you see them as big, they grow bigger. If you see them as small, they grow smaller. If you fear them, they swell and make you ill. If you do not fear them, they are light and remain hidden. If you do not know their true nature, they persist and become established. While if you do know them and recognize them, they disappear (Nursi,2001).	Salih
	The art of pastoral visits: Ministry with psychiatric patients The term '**psychiatric' or 'mental' illness** includes a range of distressing disturbances of thinking, feeling and behaviour, from psychotic illness - schizophrenia and bi-polar illness - to neurotic breakdowns, where there is uncontrollable feelings of anxiety, despair or physical distress. Inadequate, ineffectual living and inability to cope with overwhelming stress, can also indicate psychiatric illness. (Galt 2016, session 11.) **Depressed people** can be very difficult to live with. Low self-esteem and apathy can be unattractive traits, often resulting in isolation for the sufferer. Effective pastoral care involves perseverance, forgiving when hurtful things are said or done, listening when you have heard it all before. Exhortations to cheer up are lost on someone who thinks there is no point to life. Simply be there for them, and for their families (Carson 2008, 5). **Video 1 – David and "Joel":** Encountering a suicidally depressed person for the first time, Theological Student David listens to Joel's fears and regrets, and reflects on helpful teachings from the scriptures and church history, to bring encouragement and hope, rather than condemnation and despair. David, drawing on his own experiences as a son, husband, father and pastoral visitor, recognises what his parishioner is going through, shows compassion, and avoids attempting to instruct Joel on matters that Joel knows much more about than David does! **Video2 – Loren and "Tony":** "People in hypomanic or manic phases can be very charismatic, creative and vibrant. For those with less cruel levels of the illness, there may even be an advantage in terms of pursuing leadership careers in politics or theatre or the arts. It is thought that that some great leaders, such as Theodore Roosevelt, Winston Churchill and Abraham Lincoln, as well as an impressive list of poets and creative artists, may have had bipolar disorder … Pastoral carers need to learn to allow the expression of the anxieties and concerns which those with bipolar disorder and their families may experience" (Carson2008, 12-13).	Alan

	Video3 – Chris and "Maureen": "Schizophrenia is a serious mental illness which affects one person in a hundred. The term covers a number of related disorders, all with overlapping symptoms. However, in all types of schizophrenia, the illness interferes with the mental functioning of a person and, in the long term, may cause changes to a person's personality. First onset is usually in adolescence or early adulthood. It can develop in older people, but is not nearly as common. Some people may experience only one or more brief episode in their life. For others, it may remain a life-long condition. The onset of illness may be rapid, with acute symptoms developing over several weeks, or it may be slow, developing over months or even years. During the onset, the person often withdraws from others, gets depressed, anxious, has phobias (extreme fears) or obsessions" (Department of Health 2007, 1). **Video4 – "Frank" and Loren:** CPE student Loren listens to "Frank's" disjointed speculations without arguing about them. He demonstrates pastoral sensitivity by spending time with Frank, listening to his strange theories, not contradicting him, but showing that he enjoys being present with Frank. As a result, Frank does not need to push his ideas in order to feel respected and appreciated. **Video5 – Alan and "Albert":** Chaplain Alan notes "Albert's" deep concerns about the direction his world is going in, and offers encouragement for him to feel safe and protected. While Albert is not overtly religious, he accepts Alan's offer of prayer, and appears to be comforted by being taken seriously. ***Video 6 Katie and "Carol"*** The student stays with "Carol" while she complains about the anguishing incidents in her past and present life, offering pastoral comfort and support without trying to make sense of her ramblings.	
	Islamic approach to schizophrenia patients: Discussion	Salih
11.30	**Morning tea**	
11.45	**The art of pastoral visits:** Egan helping skills stage 3 **Review of Stage 2: Developing New Perspectives and Setting Goals based on Self-understanding: Advanced accurate empathy** **Specific skills:** Immediacy, helper self-sharing, confrontation and stage 3 action The client and helper together work out a *specific program for action* and *explore strategies for achieving goals*. The helper encourages *self-help*, as the client explores ways of reaching goals, searches for inner resources and external supports, decides on courses of action, implements programs, manages problem situations, copes with living, and evaluates the action taken.	Alan
12.45	**Lunch and *zohr* prayer**	
1:30	**Group supervision using verbatim reports:** Reflect on the interviews, noting the elements of Egan's listening skills that were, or could have been, used in an effective pastoral response.	
2.30	**Group supervision using verbatim reports:** Reflect on verbatim reports of pastoral interactions, dealing with issues arising in hospital ministry, and learning from your own experiences and feedback from the group.	Alan
3.30	**Spiritual reflection:** Reflect on people you "met" today, what stories from your faith tradition could you use to help them survive and grow through their experience?	Salih

3.50	**Approaching the end of the day:** Reflections on the day and closing *dua*.

Day 5,

10.00	**Recitation of the Quran**	
	Centreing time: How do I feel as I approach day 5?	
10:10	**Pastoral care in bereavement** **Submission and hope .** Applying pastoral theology in the practical situation of grief and loss. And We will surely test you with something of fear and hunger and a loss of wealth and lives and fruits, but give good tidings to the patient, Who, when disaster strikes them, say, "Indeed we belong to Allah, and indeed to Him we will return" (Qur'an 2:155-156).	Salih
	Pastoral care in grief and loss **SECOND QUESTION** Verses like the following in the All-Wise Qur'an, the Criterion of Truth and Falsehood, *"Who creates death and life that He may try you, which of you is the best in conduct*"(Quran,67:2), make it understood that "death is created like life; it too is a bounty." Whereas apparently death is dissolution, non-existence, decay, the extinction of life, the annihilator of pleasures; how can it be created and a bounty? *The Answer :* As was stated at the end of the answer to the First Question, death is a discharge from the duties of life; it is a rest, a change of residence, a change of existence; it is an invitation to an eternal life, a beginning, the introduction to an immortal life. Just as life comes into the world through an act of creation and a determining, so too departure from the world is through a creation and determining, through a wise and purposeful direction. As for the aspects of death that are bounties, we shall point out four of them. **The First**: It is a great bounty because it is to be freed from the duties and obligations of life, which become burdensome, and is a door through which to join and be united with the ninety-nine out of a hundred of one's friends who are already in the Intermediate Realm. **The Second**: It is a release from the narrow, irksome, turbulent, and agitated prison of this world, and, manifesting an expansive, joyful, trouble free immortal life, it is to enter the sphere of mercy of the Eternally Beloved One. **The Third**: There are numerous factors like old age which make the conditions of life arduous and show death to be a bounty far superior to life. For example, if together with your very elderly parents who cause you much distress were now in front of you your grandfather's grandfathers in all their pitiful state, you would understand what a calamity is life, and what a bounty, death. **The Fourth**: Just as sleep is a comfort, a mercy, a rest, particularly for those afflicted by disaster and the wounded and the sick, so too is death, the elder brother of sleep, a pure bounty and mercy for those struck by disaster and suffering tribulations which drive them to suicide… (Nursi 2006, 25).	Salih

11:00 **Pastoral ministry at the end of life** Alan

Normal death: The 20th century guru on death and dying, Elisabeth Kübler-Ross, describes the way death ***should*** be handled.

> I remember as a child the death of a farmer. He fell from a tree and was not expected to live. He asked simply to die at home, a wish that was granted without question. He called his daughters into the bedroom and spoke with each one of them alone for a few moments. He arranged his affairs quietly, though he was in great pain, and distributed his belongings and his land, none of which was to be split until his wife followed him in death. He also asked each of his children to share in the work, duties, and tasks that he had carried on until the time of the accident. He asked his friends to visit him once more, to bid goodbye to them. Although I was a small child at the time, he did not exclude me or my siblings. We were allowed to share in the preparations of the family just as we were permitted to grieve with them until he died.
>
> When he did die, he was left at home, in his own beloved home which he had built, and among his friends and neighbours who went to take a last look at him where he lay in the midst of flowers in the place he had lived in and loved so much. In that country today there is still no make-believe slumber room, no embalming, no false makeup to pretend sleep. Only the signs of very disfiguring illnesses are covered up with bandages and only infectious cases are removed from the home prior to the burial (Kübler-Ross 1969, 5-6).

Sadly, that is not the way most people are allowed to die today, and as a community we are feeling the consequences of inadequate grieving. Part of the problem is that, in a modern medically oriented world, we see death as an obscene intrusion, rather than a normal part of life.

Common fears and anxieties approaching death (Speck 1987, 78-9):

- Fear of loneliness, pain and suffering
- Fear of loss of dignity and self-control
- Fear of loss of family, friends, identity and own body
- Fear of the unknown.

Secular understandings of grief ("Now what? Understanding grief" Australian Government Department of Health and Ageing pamphlet) downplay the importance of pastoral ministry. They mention: "draw on religious and spiritual beliefs *if this is helpful*". However, pastoral care "has been a part of palliative care from the beginning as a consequence of the hospice movement's commitment to care of the whole person" (Rumbold 2000, 291).

Pastoral care in palliative care deals with the ***spiritual needs of the dying person*** (Johnson 2015). **Spirituality** is:

> "That which lies at the core of each person's being, an essential dimension which brings meaning to life. Not only religious practices but understood more broadly as: Relationship with God, however God or ultimate meaning is perceived by the person and in relationship with other people" (MacKinlay 2006).
>
> "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their

	connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al. 2009). Palliative care has for 50 years provided physical, psycho-social and spiritual care and of these, caring for physical symptoms is the most straightforward. The area we find most challenging, and are seeking to learn more about, is how to care for the spiritual needs of people. For the person facing their last days, spirituality becomes huge. It can be easier to support people in this area if they have religion, because we have an understanding of what religion means to people. But a lot of Australians don't have religion so we need to get to know each patient so we can develop an understanding of what gives their life meaning. All people have spiritual needs whether they recognize it or not. They have a need for meaning and purpose, the need to give and receive love, and the need to have hope. "Pastoral Care can provide patients and families with an opportunity to express their feelings and to reflect on their life, to find meaning in it and their current circumstances. When a patient comes into our palliative care unit, it can be one of the greatest opportunities for extending pastoral support and yet one of the most challenging. It can be a time of heightened anxiety for the patient, and their family. What dying people often fear most is the loneliness that may accompany their dying. Whilst dying is hard, many patients tell me that it is the process of dying that they fear most." Often, this is something that they can't talk about with the family. Sometimes their relatives can't deal with feelings and don't know what to say. So my most important role is to journey with the patient and their family, and to be a caring presence, always ready to listen.	
11.30	**Morning tea**	
12:00	**Friday prayer and lunch**	
1:15	**Pastoral ministry:** How is it similar to and how different from other health disciplines?	Alan
	Simulated ward: Experiencing the roles of various health professionals in a typical hospital ward.	
1:45	**Appropriate use of spiritual resources, prayer, recitation of the Qur'an and dhikr** (Imam Nawawi n.d.).	Salih
2.15	**Where to now? Joining a pastoral care team and the opportunity for further training in pastoral ministry:** 400 hour basic units in aged care or mental health ministry (July – December)	Alan
3.00	**Presentation of certificates and reflections on the course:** • One thing I have learned about pastoral ministry with people in hospital, nursing homes, etc.	

- One thing I have learned about myself
- One thing I enjoyed about this course
- One thing I found difficult about this course

3.30 **Closing *dua***

References

Carson, Marion. *The Pastoral Care of People with Mental Health Problems.* London: SPCK, 2008.

Department of Health. *What is Schizophrenia?* (booklet). Canberra: Department of Health, 2007.

Egan, Gerard. *The Skilled Helper*, 2nd ed. Monterey, California: Brooks/Cole Publishing, 1982.

Galt, Alan. "Ministry and Dementia." *Ministry* 2, no. 13 (1992):.

Galt, Alan. *Pastoral Care in Mental Illness and Dementia*. PT101A/401A Introduction to Pastoral Theology, 2016, Session 11.

Goldsmith, Malcolm. *In a Strange Land.* Southwell Notts: 4M Publications, 2004.

Holst, Lawrence. "A Ministry of Paradox in a Place of Paradox." In *Hospital Ministry*, ed. Lawrence Holst, . New York: Crossroad, 1990.

Imam Nawawi. "The Book of Visiting the Sick." In *Riyad as-Salihin*. n.p.: n.d. https://sunnah.com/riyadussaliheen/7.

Isgandarova, Nazila. "Effectiveness of Islamic Spiritual Care: Foundations and Practices of Muslim Spiritual Care Givers." *The Journal of Pastoral Care & Counseling* 66, no. 3 (2012): 1-16. doi: 10.1177/154230501206600304.

Jalalzai, Sajida. "Translating Islamic Authority: Chaplaincy and Muslim Leadership Education in North American Protestant Seminaries." PhD diss., Columbia University, 2016, https://academiccommons.columbia.edu/catalog/ac:198602

Johnson, D. "Pastoral Ministry in Palliative Care." Lecture to Hornsby Chaplains, August 2015.

Khan, Muhammad G. "Towards a National Strategy for Muslim Youth Work." *Youth and Policy*, 92 (2006): 7-18. http://www.mywf.org.uk/uploads/mywf_timeline_files/y&p%2092.pdf.

Kowalski, Mumina. "Names of God: Practical Theology for Muslim Chaplains in CPE." *Reflective Practice: Formation and Supervision in Ministry* 29 (2009): 178-186. http://journals.sfu.ca/rpfs/index.php/rpfs/article/viewFile/234/233.

Kübler-Ross, Elisabeth. *On Death and Dying.* New York: Macmillan, 1969.

MacKinlay, Elizabeth. *Spiritual Growth and Care in the Fourth Age of Life.* London: Jessica Kingsley, 2006.

McGregor, T. S. "Hospital Chaplaincy." In *A Dictionary of Pastoral Care*, ed. Alastair V. Campbell,. London: SPCK, 1987.

mcuoft. "On the Verge: What is Islamic Chaplaincy?" YouTube video, 3:08, September 17, 2013. https://www.youtube.com/watch?v=5UzZ6xmvXoc.

Nursi, Said. The Message for Sick, Flashes. Istanbul: Sozler Publication, 2001.

Nursi, Said. *The Letters*. Istanbul, Sozler Publication, 2006.

Ozboyuk, Ibrahim. *Qualities of a Devoted Soul*, pp. 1-25. New Jersey: Tughrah Books, 2010.

Puchalski, Christina, Betty Ferrell, Rose Virani, Shirley Otis-Green, Pamela Baird, Janet Bull, Harvey Chochinov, George Handzo, Holly Nelson-Becker, Maryjo Prince-Paul, Karen Pugliese and Daniel Sulmasy. "Improving the Quality of Spiritual Care as a Dimension of Palliative Care: The Report of the Consensus Conference." *Journal of Palliative Medicine* 12, no. 10 (2009): 885-904. doi: 10.1089/jpm.2009.0142.

Rumbold, Bruce. "Pastoral Care of the Dying and Bereaved." In *Death and Dying in Australia*, ed. A Kellehear, 284-297. Melbourne: Oxford University Press, 2000.

Speck, Peter. "Dying." In *A Dictionary of Pastoral Care*, ed. Alastair V. Campbell, . London: SPCK, 1987.

Ibn Taymiyya, al-Ikhtiyaaraat. Yarmuk: Daru'l Asima, 1997.

Williamson, James. "Ageing." In *A Dictionary of Pastoral Care*, ed. Alastair V. Campbell,. London: SPCK, 1987.

NSW Department of Health, *The Dementias - Memory Loss and Confusion*