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"No one looks for me": Spiritual care and meaning-centered psychotherapy (MCP)

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Essay/Personal Reflection

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A rule of thumb in spiritual care is that life is lived in relationship at we define as the meaning of our lives, our self-worth, and dignity through family, wage-earning and personal work, unfinished tasks, faith, and love relationships, past, present, and future. We can also define ourselves by how we do or do not measure up to the lives of significant others in our lives or to the teachings and lives of religious figures, past or present. From these perceived relationships, real or imagined, we gain our sense of intrinsic and attributed dignity, our self-worth, value, and hope. Intrinsic dignity is our sense of worth from simply being human. Attributed dignity is conveyed through one's power, status, or productivity (Sulmasy, 2006). Hope is a value that transcends the threat of death, a value that comes from one's intrinsic dignity (Sulmasy, 2000). When one is ill, these meaning-bearing relationships are stressed. A hospital patient loses control of the body and of social distance, as medical caregivers may enter the patient's room at will. Family and work are more distant. The patient may worry about the loss of the meaning of financial stability and of mortality. A patient can become demoralized, lose faith in his or her capacity to live a meaningful life. Dignity and hope are threatened. This is especially true at the end of a patient's life (EOL).

A pastoral caregiver works to restore a patient's dignity, meaning, and hope by encouraging the patient to access all spiritual resources available to the patient. Resources such as family and friend contact, religious or spiritual communities, religious or spiritual practices, and unfinished life tasks may offer a distressed patient new meaning, dignity, and hope. The caregiver does this by listening to the patient's perceived source of distress, assessing the patient's need, and developing interventions to restore hope, dignity, and meaning. Such interventions may include, suggesting unrecognized blessings or meanings in the patient's life, and encouraging the patient to access meaningful rituals, practices and to reaffirm meaningful relationships. Relationships can be with family, friends, work, or religious figures such as spiritual leaders, past and present, or images in the patient's faith or spiritual tradition.

Meaning-centered psychotherapy (MCP) has similar goals in that it encourages a patient, especially at EOL, to addresses a patient's despair, demoralization, hopelessness, or a desire for hastened death by encouraging the patient to regain a sense of meaning, dignity, and hope in the face of death (Breitbart et al., 2017, Figure 3.1, 42, 50). Clinically trained therapists use individual and group-centered psychotherapy to encourage patients at EOL to achieve a sense of love, beauty, and humor in their lives (Breitbart et al., 2017, Box 3.7, 50).

One MCP tactic, among others, toward this goal is to encourage the patient to regain a sense of agency (attributed dignity) by reviewing the skills, capacities, and sensibilities that the patient used to successfully overcome past challenges in the patient's life. The patient is made aware that these same abilities can be addressed to the patient's current life situation (Breitbart et al., 2017, Box 3.6, 49, 50).

In my experience as a spiritual caregiver, life review encourages one to acknowledge life's limitations and to reconcile with the living and the dead, repent of past misdeeds and hopefully to make amends with the wronged. It may also be a trigger for addressing a patient's hopes, dreams for, and advice for loved ones before the patient's death in a medium that may outlive the patient.

For those patients addressing EOL who use faith or spiritual tradition as a source of meaning, considering their relationship with the divine may be a model for reconciling with past failures and getting past them so that they can move on to address the challenges of EOL.

Many faiths and spiritual traditions encourage such spiritual goals. Some use the image of an ambivalent deity/God or religious personage to encourage the faithful to consider their own lives.

For example, in various avenues of the Jewish faith tradition, the inner life of God is considered. God's regrets and ambivalences for past deeds, even if for just cause, offer a model for a patient struggling to get past life's mistakes. God is pictured as feeling isolated and struggles with responsibility. So too can our patients at EOL.

Our patients wonder if they handled their responsibility well in each situation. A patient's faith may offer a model of confronting past struggles with strong feelings. The Talmud relates (*B'rachot* 7a) how God prays, "May it be My will that My compassion overcome My anger."

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The Ruler of the Universe struggles with emotion and responsibility, with anger and compassion. So do our patients engaging in life review. At EOL, a patient may struggle with regrets about how responsibilities were or were not properly handled in the patient's life.

Patients of faith, confronting EOL, may want to consider their regrets for deeds which seemed correct at the time. The Jewish spiritual imagination offers a model of confronting and acknowledging past mistakes, even if committed in the name of what the patient saw as good. A rabbinic legend describes God rebuking the heavenly host for rejoicing after God has wiped out the Egyptian army at the Sea of Reeds to liberate the Israelites (Talmud, Megillah 10b and Sanhedrin 39b). God regrets taking life on a grand scale for what had to be done in the cause of freedom.

A disease such as cancer impacts patients' relationships with the body, family, occupation, finances, and the future, leaving patients isolated. Here too, the religious imagination offers a model of acknowledging isolation. A Chasidic legend describes the grandson of Rebbe Baruch of Medziboz, Yechiel Michael, running and weeping to his grandfather because his playmates did not seek him out during a game of hide and see. Rebbe Baruch relates that God too plays hide and seek with humanity and yet none seek Him out (Chassidic legend). Just as our patients can experience a sense of isolation, so too does God in this legend.

It is the task of the caregiver, whether offering MCP or spiritual care to encourage the patient at EOL to open the door to the past so that the patient can live in the present and plan for the future. I encourage other spiritual caregivers to offer additional examples of their faith traditions that enhance the goals of MCP and spiritual care.

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