Living with the "Unfixable"

BY NEIL SOGGIE, DMin

Our society has a deep and unquenchable need to reclaim the humanity of health care and wellness. I was struck, at a recent ethics conference on health care and pain management, by what I think of as the deep "unfixableness" of humanity. At this conference, as at any such meeting of health care workers, "fixing," "healing," and "curing" were recurring themes. However, some other underlying themes were even clearer: suffering, pain, hopelessness, frustration, and despair.

Modern medicine assumes that if pain cannot be traced to a biological etiology, it is not genuine. But to assume that only puts us in another quandary: "What is suffering?" Why is it that one person suffers from pain for which no physical reason can be found, while another person, who endures incredible pain, is *not* suffering? This mystery points toward a realm into which the professionals at the conference dared not travel. For it was clear that they were all well trained—trained, that is, not to venture into a realm beyond the bounds of their biochemical education. It seemed an area well suited to health psychologists, yet they dared not to venture into it.*

It was clear that although the conversation did not touch on the "spiritual," the spiritual was in fact the topic that begged to be discussed. It was evident from the tone the doctors (both physicians and psychologists) used to discuss their case studies that the deepest questions to be asked were: "How can we learn to live with the unfixableness of life?" "How can we care for those who are living the very depth of unfixableness?" and "How can we find joy in this state of utter and apparent hopelessness?"

Dr. Soggie teaches health psychology at Atlantic Baptist University, Moncton, New Brunswick.

As a psychologist, I too have been forced to ask these questions. How can I sit here and try to "do therapy" when, deep in my heart, I know that this person will not be "cured"? A neurologist I know recently lamented that, as she put it, "I have the most hopeless of professions because I know that my patients will never get better and that in the end I am powerless to help them." It is such professionals, and the medical and psychology students who long to struggle with these issues, whom I address here.

BEYOND THERAPY

To put it simply, health care must be more than therapy, whether that therapy is physical or psychological. Health care must also involve community and spirituality. Indeed, I argue that health care truly exists only when community and spirituality are allowed to flourish, for community and spirituality are the most fundamental modes of humanity in dealing with brokenness, pain, suffering, and death.

Undoubtedly some will argue that, in a secular society, we must separate the physical from the spiritual. However, as the great psychologist Carl Gustav Jung pointed out, the deepest and most human psychological function is spirituality.* Definitions of "spirituality" among biblical languages implied that it is something "innate" in the physical realm. The ancients plainly believed that something intrinsic to the natural physical world is moved, formed, and given life by the spiritual.

According to the ancients, the Platonic idea of a separation of the physical and the spiritual—a notion shared by modern "secular" thinkers—is false. These mysterious elements of life cannot be separated—and must not be separated, as any patient in a hospital will tell you. A person is a

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*Health psychology, a branch of psychology, applies psychological principles and research to the enhancement of health and the prevention and treatment of illness. Its concerns include social conditions (such as the availability of health care), biological factors (such as family longevity and inherited vulnerability to disease), and even personality traits (such as optimism). The work of a health psychologist is similar to that of a counseling psychologist.

*This theme, which runs throughout Jung's work, is central to his *Modern Man in Search of Soul* (Harvest Books, New York City, 1955).

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person spiritually *and* physically, and to treat him or her as no more than a sick or broken object is to deny that person genuine care. Indeed, to ignore the fact that a person is inseparably physical and spiritual is to do harm, for it denies the reality of life.

So what should we health psychologists do when we encounter someone in a hopeless situation? We must first recognize that we have moved beyond the proper limits of health psychology and into the realm of spiritual care. Our goal is no longer "therapy"; it is simple human caring in its purest, most spiritual sense, for the person's spiritual needs. First and foremost, we must recognize that the person is spiritual—not religious or "otherworldly" perhaps, but spiritual nonetheless. There is, within any person, a need for community, meaning, purpose, love, understanding, peace, and belonging. All these basic ontological needs will inevitably have an impact on the physical, just as physical well-being (or the lack of it) will affect these foundational spiritual needs.

Keeping this in mind, we must meet this person in the midst of his or her life—including his or her current circumstances; life story (and its meaning for him or her); and sense of direction and purpose, love, peace, and belonging. We must also be aware of our *own* sense of direction and purpose, love, peace, and belonging—or lack thereof. Caring for someone spiritually is a fully human act of intimacy, demanding that there be no "healthy healer" on one hand and no "sick patient" on the other. Instead, there are only two people, both of whom are unfixable in this life, lost in their search, and longing to share their story of journey in life.

An Essential Vulnerability

The defining difference between health psychology, as it is commonly understood, and the higher calling of "psyche (or spirit) care" is the essential need for vulnerability that the context demands. Typically, the health psychology model dictates that a healthy therapist function with a rational detachment that provides a psychological mirror for the sick. However, this very limited model fails in the most difficult situations in life, and then we are called to pick up the basic theme of spiritual care. And the basic theme is this: If genuine care is to be provided, rational detachment must be left behind. The therapist must not simply give without receiving, for doing so frustrates the *sick person's* own deep psycho-spiritual need to give to and care for others; sharing one's suffering with another gives it meaning. We are physical creatures, to be sure, but it is our capacity to love others in community and to find meaning in suffering that separates us from the rocks and stars.

Dropping one's detachment is the first step toward treating the patient as a valued human being.

It was a failure to recognize this basic principle that, at the conference I attended, kept the medical professionals from asking the deeper questions. To have asked such questions, we would have had to admit that human life goes beyond the bounds of our professions—and, in the end, reveals those professions to be utterly powerless. Human life is broken, in both the physical and spiritual sense, and anyone who doubts either of these points should visit a hospital nurse in the morning, a palliative care patient in the afternoon, and a chaplain in the evening. Human life is both a gift and a burden that demands to be lived authentically. Sooner or later, life will force a person, sometimes violently, to recognize that fact.

To try to care for psychological needs, from the perspective of the strictly rationally detached health psychologist, is—if one is, for example, dealing with a terminally ill patient—inauthentic. It will utterly fail to meet the challenge of suffering. To take the step beyond the bounds of professional rational detachment, when one caring for the psychological needs of a person in the depths of suffering, is the difference between living as a rock and living as an authentic human being. At times, indeed, dropping one's detachment is the first essential step toward treating the patient as a valued human being, a creature having the common human experience of being unfixable. This is also essential for our own professional self-awareness, because it forces us to realize the unfixableness of *our* context, our own unloveliness, our own unworthiness. It helps us to recognize why there is all the suffering and pain we see in life. However, it also shows us that we are unfixable people who need other unfixable people to love us and to be loved by us.

Undoubtedly, this process will lead to some emotional and existential pain as we are forced to ask the question: "Is this all there is to life?" Unfortunately, we must start with what we know before looking for what we need. So, here we are, broken people who are guilty of continuing the "breaking" in life. We are standing on a common plain, with common needs and desires and with a common burden. The question is: What is the next step? What is it that we all need?

Another Realm

The next step in the process leaves all remnants of therapy behind, as we enter the realm of the existential and the spiritual.

Much suffering is life teaching us to frame our questions in a way that helps us recognize "who we are" and "what we need." A great deal of this pain could be avoided if only we knew how to frame questions about our longings and were willing to forgive those with whom we have had conflicts. For forgiveness is an external thing that we *must* experience. And life always points us to that fact—that life is experienced only in relationship and hope is found only in forgiveness.

Therefore, we health care professionals have to recognize that at times we must go beyond the limits of our professions, including health psychology, and enter the very human realm of spiritual care. Indeed, this type of health care is nothing more than living authentically, the way life forces us all to live. It is simply trying to discern the way life has grabbed one by the head and forced him or her to gaze in the direction of his or her true existence. For, too often, we fight to look in another direction. It is in such moments, as one struggles to turn one's gaze away from life, that one's neck and back begin to feel the stress of the fight.

In community, people find out who they are; they discover the meaning of suffering, life and of death; and, above all, that they are loved. To care for people in the unfixableness of life is to allow them to live toward death in relationship with their caregiver. Doing so requires us to allow them to share of themselves and to remind them that they are loved. This is the simplest, most authentically human act there is. Unfortunately, in an age in which professionalism and technological change increasingly dominate health care, this simple, authentically human act is sometimes absent.

Still, the fact remains: It is only in forming a community of love around the person and allowing him or her to express his or her spiritual self that both the patient and the professional find joy in the midst of the unfixable. □

THE NURSING COLLABORATIVE

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Collaboration with colleagues and others is integral.

and information systems departments, thereby facilitating planning and accountability. Collaboration with clinical colleagues, physicians, pharmacists, and others is integral to the model.

As a result of the collaborative's work, BSHSI's nursing leaders today have a clearer view of the resources that will be needed for current and future development. However, the collaborative's work is not prescriptive; it provides guidance and direction, which can be applied in daily operations in each setting. Johnston and Greenberg say that networking with colleagues, support for renewed commitment to the future, and energy to deal with the chaos of daily operations are just some of the benefits from the collaborative's efforts. Also important, they add, is a shared vision and attitude, which have a profound impact on the nursing staff. Acknowledgement of the importance of nursing in each local system and the system as a whole goes a long way to let nurses know they are respected and trusted.

Johnston says that the Nursing Collaborative:

> has been an invaluable resource for nurse executives throughout BSHSI. Through the collaborative, nurse executives and their managers can readily network with colleagues through e-mail, conference calls, video conferences, and in face-to-face meetings. We use the collaborative to share policies, protocols, and best-demonstrated practices. It also affords smaller local systems the ability to consult with clinical experts who may only be employed in a larger local system. Nursing across the system has been strengthened because of this effort.

The Nursing Collaborative is a wise investment for both the present and the future, McCutcheon says. "Thoughtful deliberation about the future enables everyone to plan for the ongoing changes that will be needed to continue the BSHSI legacy for quality nursing care," she says. "It adds value to the system." □

NOTES

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