

A MODEL COMBINING PSYCHOTHERAPY WITH SPIRITUALITY AND RELIGION IN THE AREA OF PALLIATIVE CARE AND BEREAVEMENT

Abstract

This paper presents a Model for working with the dying and the bereaved within the Maltese context arising from my years of practice in oncology and palliative care. The use of self is an important element. Self, from a Gestalt perspective, indicates cohesion over time – Integrity, and openness to change at the contact boundary – Growth (Yontef, 1993), two important characteristics in the Model. The interplay between the psychotherapeutic and the spiritual and religious is addressed, within a culture where the Roman Catholic Religion is a dominant tradition. The Model advocates that, apart from practising presence and inclusion, a practitioner needs to be prepared to stay with the client in the long space between Withdrawal and Sensation, with its dearth of figure-formation. This requires a deep level of conviction that sustains the practitioner in the ‘between’ to allow a natural, positive figure to emerge, with the resulting growth of both practitioner and client.

Introduction

In this paper I would like to present a Model for working with patients who are dying or in bereavement. I have worked in the area of palliative care in Malta for the last 17 years, setting up the Psychological Services in Malta’s only oncology hospital. The Model has emerged from my doctoral work, where, drawing on autoethnography, which “works to hold self and culture together, albeit not in equilibrium or stasis” (Holman Jones, 2005: 764), I focused on the interplay between self and culture, seeing that death, dying and bereavement are so strongly embedded within culture. It is a Model that combines the psychotherapeutic with the spiritual and religious since a dominant tradition of influence on the Maltese culture is the Roman Catholic religion. Through autoethnography, I examined those influences, both on myself as a psychologist and psychotherapist, and on the way I work with death and dying within my culture. I will first be giving a brief description of the ground from which the figure of the Model has emerged and then go on to describe the Model. I will be using the female pronoun ‘she’ when referring to the therapist.

Background

A key experience in my life which was to have a great influence on my work, was my first husband’s diagnosis of terminal cancer when I was three months pregnant with our daughter, and his death 15 months later at the age of 28. My father, who was diagnosed with lung cancer just before my husband’s diagnosis, died a month before my daughter was born. I was simultaneously living the experience of the dying of the two most important men in my life, and the experience of bringing forth new life. It was two years after my husband’s death, that I was invited by his oncologist to work at the oncology hospital. The first few years of my work, were characterised by my being painfully aware of each detail in my own bereavement process, while working with clients processing their own. Autoethnography often centres round pain (Ellis, 2004), “calling on the body as a site of scholarly awareness” (Spry, 2001: 706), thus serving the purpose of critically reflecting on the theme of the Wounded Healer which is integral to the model.

Two other factors of influence on my work, were my ongoing training in psychology and Gestalt Psychotherapy and my own spiritual formation; mainly Ignatian spirituality. Gestalt Therapy presents the concept of a self which “can account both for a concept of self that has cohesion, wholeness and continuity over time and for the self that at any moment is always constructed in a context” (Yontef, 1993: 290). It includes both integrity and growth, two major components of how I use myself in my work with clients as seen in my Model. Ignatian Spirituality is a holistic, Christian spirituality, emanating from the lived experience of Ignatius Loyola (1491-1556) and conditioned by the Roman Catholic tradition (Herrera, 2000). Ignatius Loyola was the founder of the Jesuits. My experience of the Spiritual Exercises of St Ignatius, with their emphasis on transformation through suffering (Lonsdale, 1990), complemented and reinforced my commitment to integrity and growth.

The Model is a growth-focused model. It focuses on the growth of both the practitioner and the client. Working with dying and bereavement on a daily basis, I was aware of a desire to deepen my understanding of how, as practitioners, we can reach out more effectively to this client group. I read extensively but also realised that, most of all, I had to look for the answers inside myself. Autoethnography with its emphasis on exploring the feelings underlying my actions (Bochner, 2000) was a natural progression from this deep-seated desire. At first I concentrated on client growth, a concept I was very familiar with through my own personal experience, and researched thoroughly through the course of my academic journey. Kubler-Ross’ (1969) seminal work proposes five stages of grief: Denial, Anger, Bargaining, Depression and Acceptance. As early as 1969, Kubler-Ross establishes two important facts; that dying and bereavement can be a time of great psychological suffering, and that a sense of peace can result if persons allow themselves to live the suffering. I began reflecting on how as therapists, we are instrumental to client growth.

It was at this stage in my professional life that I came in touch with the notion of the Wounded Healer (Nouwen, 1994; Jung, 1995), and the way that to be truly effective in accompanying our clients in their journey of growth, we need to be committed to our own growth. To join the client in the healing, we need to join them in the woundedness.

A Model for Therapy and Teaching: The Wounded Healer – Practitioner Presence

The Model has evolved from the key concepts of dialogic Gestalt Psychotherapy, of inclusion, presence and the ‘between’ (Yontef, 1993), and the spiritual concept of the Wounded Healer (Nouwen, 1994; Jung, 1995). It also takes into account the notion that deep emotional suffering can be a time of profound growth and that dying persons (who embrace growth) reach “a heightened sense of well-being” (Byock, 1996: 9). It is a Model which creates a space for growth for the client, and consequently contributes to the growth of the practitioner, too.

The five figures below illustrate the development of a growth-focused Model based on the Gestalt Contact Cycle presented by Petruska Clarkson (1989), for working with the dying and the bereaved in the Maltese culture. Gestalt is not only concerned with pathology. Its goal is to establish the healthiest level of growth, and contact with self, other and the environment (Clarkson). Therefore Clarkson’s Contact cycle is a fitting base for my Model which promotes the growth of both practitioner and client.

Figure 1

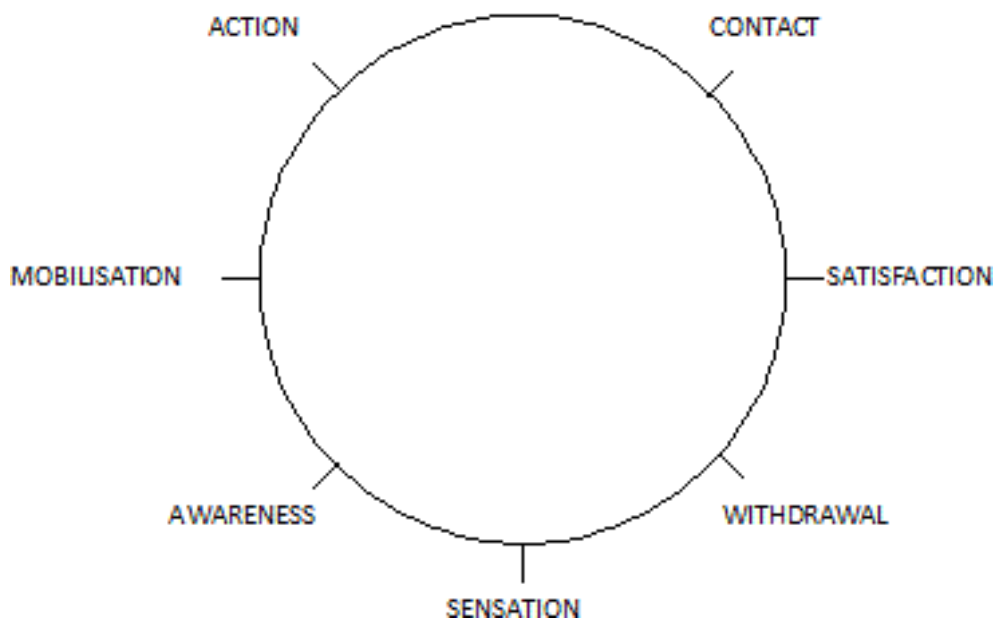


Figure 1

Figure 1 is the Contact Cycle as presented by Clarkson (1989: 29), illustrating the healthy flow of experience which leads to the growth of self at the contact-boundary. A figure emerges from the background – Sensation. The individual becomes aware of the figure or need, and is mobilised to take action to embrace the need (Contact). Once embraced fully, the organism is satisfied with the resulting growth of self. The individual goes into withdrawal ready for the emergence of another figure. Then the cycle begins again. Pathology happens when an individual gets stuck in one of the stages and does not complete the cycle. Therapy helps the individual to become unstuck and move on around the cycle.

Figure 2

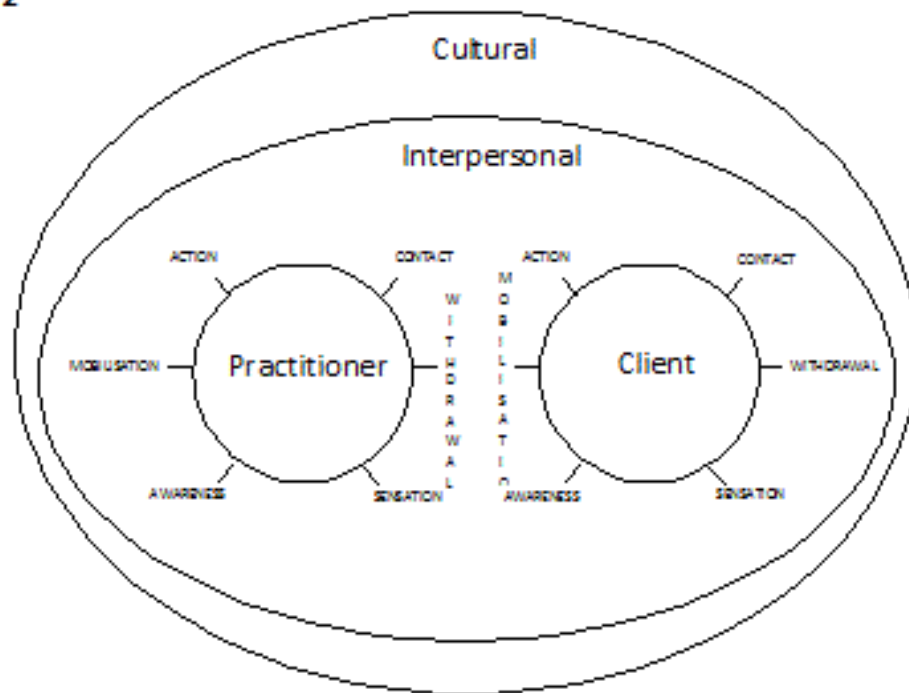


Figure 2

Figure 2 further develops Clarkson’s (1989) model and includes two cycles, representing both the practitioner and the client, emphasizing the co-created nature of personal growth. In my Model, I have left out the stage of Satisfaction that is found in Clarkson’s model, because I find that satisfaction automatically happens when there is full contact.

Surrounding both practitioner and client is a circle illustrating the interpersonal dimension that impacts both. For the dying and the bereaved, the interpersonal is crucial and heavily impacts the intrapsychic. Therefore the practitioner needs to be aware that she, too, needs to live her own interpersonal relationships with integrity to be authentic.

Interpersonal Relationships

The majority of my clients in the oncology hospital describe a new appreciation for the people they love. They express sadness that it needed an experience of serious illness or bereavement, for them to see their loved ones in this light.

Notwithstanding this new appreciation, many patients are reluctant to share their feelings with each other over the coming death, even when they are not in denial, in the fear that they will cause more pain to their loved ones. This is especially true when the patient has young children. This Model addresses relationships. It holds that expressing appreciation of the significance of the relationship and sorrow at the parting, is part of a growthful death and sustains both patient and significant other.

Byock (1996) says that in the face of impending death relationships need to be completed rather than severed and he proposes five important things that a patient and significant others need to tell each other: Forgive me, I forgive you, Thank you, I love you and Good-bye. This saying goodbye, which can take place over days or weeks or months, is intensely painful, but intensely holding. With children, it gives them the opportunity to share their grief with their loved ones while they are still alive to witness it (Sunderland, 2003) and then helps to carry the child through bereavement, after the death. I also encourage the dying person to leave mementoes for their loved ones as a reminder of their love. When children are involved, I encourage parents to leave hand-written letters or journals, where they talk about the importance of that particular child and their love for the child.

Another aspect that I have woven into my work in facilitating the ‘goodbye’, and which works very well in our culture, is asking the dying parent to bless his or her children (or the parent to bless the dying son or daughter), preferably with the laying-on of hands. In my family of origin, as in the majority of families in Malta, it was customary for us to ask our elders to bless us at every parting. I have gained a new respect for this custom since I have seen its therapeutic value within the dying process. Bestowing God’s help and protection on the child when the parents themselves are no longer in a position to protect the child, can be therapeutic for people who share a belief in God with their children.

As in other aspects of the dying process, a practitioner who is authentically present to the clients is going to be impacted by the good-bye process. When I facilitate goodbyes within a family, I feel drawn into the love of the family, while being clearly aware that I am not part of the family unit. It is truly a privileged position. Likewise, when family members, stuck in denial, do not take the opportunity to share their love for each other; or when in families where there has been abuse and infidelity, forgiveness is not asked for, I feel sad, frustrated and helpless. However, more importantly, I feel a heightened appreciation for my own significant others. I become aware of the importance of expressing my love and appreciation, and that life is too short for sulks and grudges. The interpersonal circle encompasses both practitioner and client. The practitioner, who is touched by the client's relationships, goes home with a renewed sense of appreciation for her loved ones, and the way she lives these relationships is then going to impact her work with her clients. Here, too, the practitioner needs to commit herself to living her own relationships with integrity.

Culture

The cultural dimension encompasses both the interpersonal and the personal. This is a Model that has evolved within the Maltese context where religion is intrinsically woven into the culture. Whereas more pluralistic cultures allow for different meaning structures, the predominant meaning structure in Malta is the Roman Catholic one.

Religion can be a vehicle for spiritual growth in dying and bereavement. On the other hand deformative religion can distort the insight of spirituality (Kennedy, 1994) and can feed into denial and instil anxiety and guilt (Dein, 2009). The practitioner needs to be constantly addressing her own religious beliefs and allow the religious and the psychotherapeutic to inform each other.

When faced with dying and suffering, most people go back to the faith and rituals of their childhood (Byock, 1996). "Nothing makes God more real to people than the prospect of death", claims Benson (1996:209, 196), who, drawing on his experience as physician and researcher, proposes that humans are "wired for God" in a profound physical way. Dein (2009) states that although there is increasing evidence that patients would like professionals to enquire about the patient's religious and spiritual beliefs, Western doctors rarely address these issues, and many advanced cancer patients do not have their spiritual needs met by the medical profession or religious communities. To a certain extent, this does not seem to apply in Malta. Whereas most professionals are wary of supporting 'magical' religious beliefs, everywhere else in our hospitals, religion features prominently and implicitly. In other Western countries it might be alien for religion to be mentioned, in Malta it would be alien for religion not to be mentioned. Patients 'talk' religion freely with professionals assuming a shared belief system, or at least, an understanding of the common belief system. To discard religion completely, as well as being impossible in the area of death and dying, would also be a significant loss. Rich in rituals, symbols and metaphors, religion provides an array of shared images which serve as a background as client and practitioner embark on a journey of meaning-making. The nature of the work, requires the practitioner to not only continuously address her clients' religious belief systems, and the way these are helping or hindering, but also her own. The approach illustrated in the Model, likewise requires she allows herself to be impacted by her clients, and to allow the 'between' to take over. The practitioner considers the strength of religious experience, the clients' and her own, embraces it, and harnesses it to accompany her clients in their journey of growth.

Lived Example:

A client informs me that the operation she was about to undergo is life-threatening. She says the following in a matter-of-fact way: 'the first thing I did was go to Confession'. Without going into the deeper theological meaning of the sacrament, for this woman, and for many of my clients, it is a ritual which is therapeutic. Settling matters with God - and the absolution from the priest assures them of God's part in the matter - gives them strength to travel into the unknown. I marvel at the way a religious ritual I had grown up with, questioned the value of, and gave a low-priority place in my life, can, in such a simple way, offer hope and meaning. Once again, as a therapist, I revisit my own beliefs regarding the sacrament and am challenged to address them more deeply both from the theological and psychological point of view. I reflect, read, discuss and reflect some more, wanting to assimilate a deeper understanding of this phenomenon, so that I can meet my clients on a level of understanding that is spiritual rather than simply cognitive.

The way I do this is congruent with Gestalt Therapy. I am open to contact with the world of psychology and with the world of religion and this creates possibilities and challenges. This, then, gets transmitted to my clients through my presence and, many times, gives the clients permission to question beliefs, to be open to experience and to own it and to create something which is meaningful for them. By bridging the two worlds, I aim to become a vehicle for growth for the client and for myself.

With the above in mind, my work with the dying and bereaved in Malta, addresses two major areas:

- The first is to support clients who have different systems of meaning or to facilitate the creation of a new meaning system which is not the Roman Catholic one. This is an extremely difficult task because the culture might not allow for different meaning structures.
- The second is to address religious beliefs in such a way to facilitate growth, rather than to stunt it. Dying and bereavement can be areas of profound spiritual growth. Religion, which "is the garb that spirituality wears when it is culturally articulated" (Kennedy, 1998:98), can actually distort the insight of spirituality (Kennedy, 1994). This happens so frequently with my clients. Every day in my practice, I see the way clients use religion to feed their denial and not to take responsibility for their actions

The Model with its emphasis on the contact boundary is in a position to address these two areas, because the therapist who is committed to presence, inclusion and the 'between' (discussed below) holds clients, giving them the space to move freely around their cycle, to challenge previous belief-systems, and to create a new more meaningful one, whether it lies within the dominant belief-system of the culture, or outside.

Figure 3

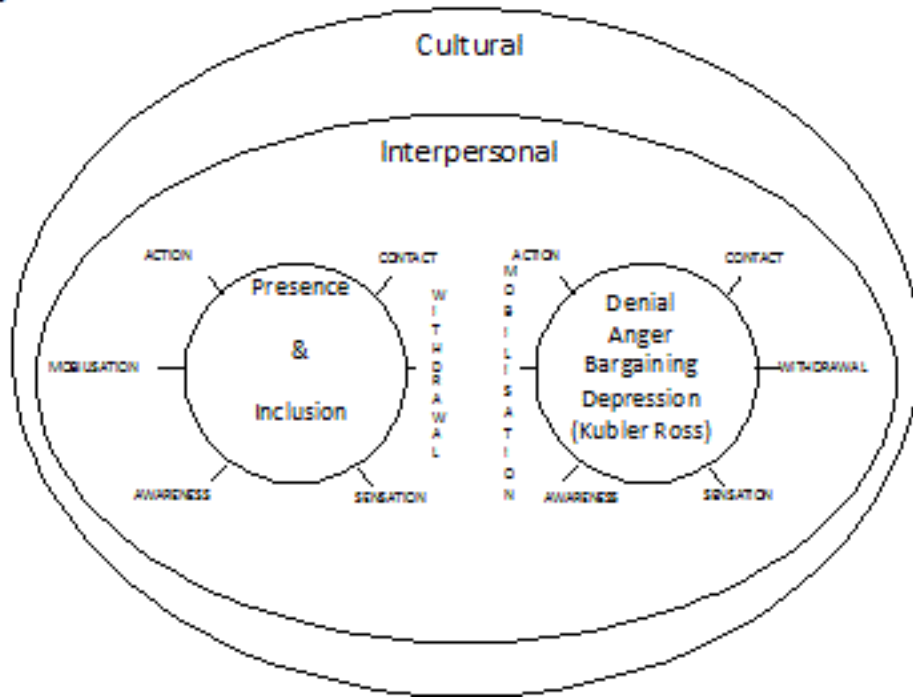


Figure 3

A further development to Figure 2, Figure 3 focuses on the dialogic concepts of presence and inclusion, where the practitioner empathises and confirms clients in their grief process. Through presence and inclusion, the practitioner emphasises the positive and the growthful while staying with the pain and staying with clients as they journey through the stages of grief.

Presence

In an area of intense suffering and loss, where there are no solutions to work towards and no skills that can be learned to remove the source of the pain, all the therapist can offer is herself through her presence. Towards the end of his life, Rogers (1986: 198) spoke about those experiences in therapy when “simply my presence is releasing and helpful...when my inner spirit has reached out and touched the inner spirit of the other”.

Zinker (1994) points out the powerful effect of therapist presence on the client when he describes presence as “ground against which the figure of another self or selves can flourish, brighten, and stand out fully and clearly” (p.157). He later says that for most, presence is acquired; “the acquired state of awe in the face of an infinitely complex and wondrous universe” (p.158), and that we are more capable of it when we are older and more seasoned. This ties with what the Model proposes that the practitioner needs to be committed to her own growth and thus be more authentically able to be present – to be “bodily and emotionally engaged, receptive and transparent” (Finlay & Evans, 2009: 109) within the therapy process.

Inclusion

Inclusion is the ability to be present and empathise fully with the client without losing one’s own sense of separateness (Finlay & Evans, 2009). The capacity for this is of particular significance in the area of dying and bereavement. The practitioner needs to have a clear sense of where the client stops and she starts, to be able to be fully present with the client, without becoming burnt-out through confluence.

According to Yontef (1993: 36), “Inclusion is the highest form of confirmation”, and that it through confirmation that people become “unique selves”. He goes on to say that confirmation also includes confirming what a person is called to become, which is very relevant within a growth-focused model. When faced with a terminal illness, or when grieving the loss of a loved one, people tend to become wrapped up in their suffering. They fail to see a larger picture of who they are, what they have achieved and what they can become through the experience, three aspects that I believe are so important in the process of meaning-making. The experience below illustrates both the simplicity and the therapeutic powerfulness of inclusion.

Lived Example:

I was having a session with a woman who was terminally ill, her husband and her grown-up children. The woman’s distress was palpable although she kept insisting that she didn’t need psychotherapy. The strong bond between the family members became figure for me and I commented on how much love she must have invested in her family, to have brought up children who were capable of such great love. The woman’s distress instantly lifted as she acknowledged that it had been her main aim in life, to give her children the love that had been missing in her own up-bringing.

Frankl (1984: 117) asserts “in some way, suffering ceases to be suffering at the moment it finds a meaning”. Presence and inclusion allow the therapist to walk with the client in the journey of meaning-making.

Figure 4

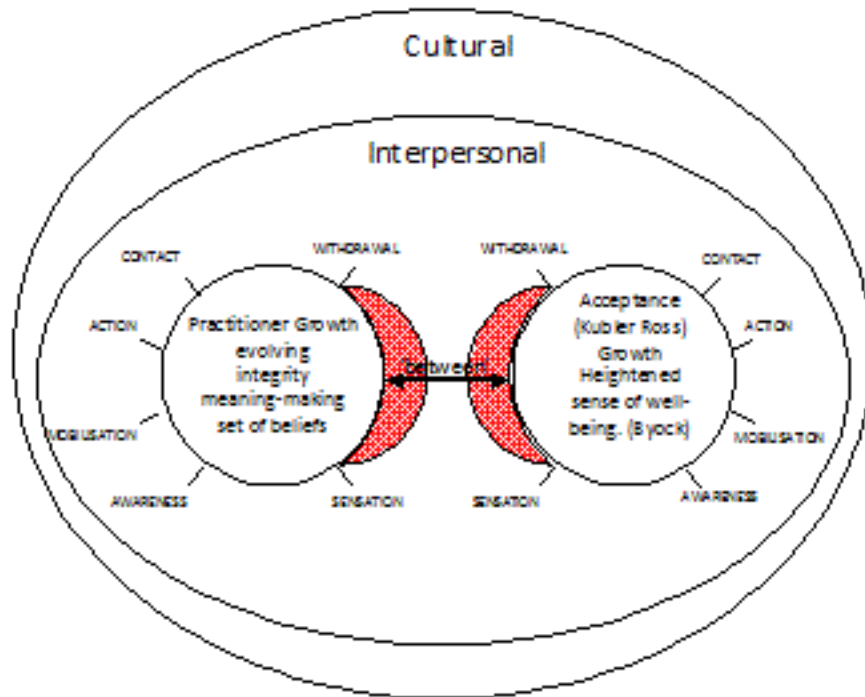


Figure 4

Figure 4 emphasises the concept of growth for both practitioner and client. The practitioner needs to be committed to her own growth, both personally and professionally; to addressing her own woundedness, to working on her own evolving and integrity and to addressing her own meaning-making and set of beliefs. Then by being open to the ‘between’ and presence and inclusion, she sets the stage for growth to happen on the part of the client.

The ‘between’

Yontef (1993: 41) states that when committed to dialogue, the dialogic therapist allows the ‘between’ to determine the outcome. “Dialogic contact starts with bringing one’s will to the boundary, and the rest requires response from the other person and grace”. Commitment to the ‘between’ requires surrender on the part of the therapist (Finlay & Evans, 2009), and it mirrors the growth process in dying and bereavement where clients need to surrender control of their life to open themselves to something bigger; to experience what Byock (1996:9) calls “a heightened sense of well being”. The surrender to the ‘between’ is truly a spiritual experience, and in the above quote Yontef uses the word ‘grace’ which alludes to a gift which is beyond our control. In religious terms, this would be divine intervention. I strongly believe that it is in the ‘between’ that healing and growth take place for both client and therapist, because each impacts the other.

Practitioner and Client Growth

It is precisely because therapist and client impact each other, that the practitioner needs to be committed to her own continuing growth and integrity, and to addressing her woundedness as she attends to her own evolving. It is in this way that she joins the dying and bereaved client in the ‘growing’.

The Wounded Healer – Jungian and Christian Perspectives

“Only the wounded physician heals”, Jung (1995: 156) asserts, saying that the doctor has to be affected to be effective. Jung refers to the wounded healer archetype, emphasising the importance of countertransference in the healing process (Sedgwick, 1994). The practitioner needs to confront the depth of woundedness in herself, to internalise her shadow side, her wounded pole (Laskowski and Pellicore, 2002), and it is only when she is committed to doing her own inner work that the client begins to heal (Kearney, 2009). Jung draws from the ancient symbol in Greek mythology where illness was considered divine action and so needed divine intervention to be treated (Laskowski and Pellicore). “We need to be aware that in caring for another in suffering, the most we can do, as psychotherapist David Findlay puts it, is ‘to prepare and hold the space where the miraculous may happen’”, (Kearney, 2009: 186). This is similar to the dialogic Gestalt notion of the ‘between’.

From a Christian perspective, Nouwen (1994: 82-83) likewise emphasises the importance of the practitioner tending her own wounds to be able to heal others: “Thus like Jesus, he who proclaims liberation is called not only to care for his own wounds and the wounds

of others, but also to make his wounds into a major source of healing power". Jesus of Nazareth is a powerful figure of the Wounded Healer within the Christian tradition. With his broken body, he paves the way for a new life. To imitate Jesus, a person does not live a life like Jesus, but lives one's life authentically and with integrity. As in the case of presence in dialogic Gestalt Therapy, and of the integration of the shadow pole in the Jungian notion of the Wounded Healer, the authenticity of the practitioner is paramount in the Christian perspective that holds that being open to the other, and allowing herself to be influenced by the other sets the stage where; "new ideas are born... new visions reveal themselves and ... new roads become visible" (Nouwen, 1994: 100).

The Wilderness Experience

Figure 4 is a further development of Clarkson's (1989) original model, and challenges the classic Gestalt notion that people move at an equal pace around the cycle. Just as the fact that people do not necessarily move from stage 1 through stage 5 in Kubler-Ross' (1969) model (Corr, Nabe and Corr, 2003), and that, as my experience with clients has shown me, reaching acceptance does not mean that the cycle of grief has been completed, the Gestalt Model (Clarkson), too, has its limitations. With its cycle of quick-forming figures, from Sensation through Withdrawal, it does not allow space for the Wilderness Experience between withdrawal and the forming of another figure, which in the case of the dying and the bereaved can be as long as weeks and even months of helplessness. Through commitment to the 'between', the practitioner stays with the client through the long space between Withdrawal and Sensation, with its dearth of figure-formation.

My Model emphasises the creative space between Withdrawal and Sensation, referred to in Gestalt theory as 'the fertile void' (Williams, 2006) and which needs to be respected in its entirety for a new figure to emerge and growth to happen. I call it the Wilderness Experience to emphasise the dryness, emptiness, and sometimes despair that characterises this space. The practitioner needs to be able to stay in the Wilderness with the client for as long as it takes, resisting the temptation to put an end to it prematurely. So the practitioner needs to be able to stay with her own feelings of helplessness and vulnerability, because it is in 'staying with' that growth happens.

The importance of attending to the Wilderness Experience in dying and bereavement cannot be emphasised enough. For the person who is terminally ill, the process of physically dying can sometimes take weeks and months. After having come to terms with dying psychologically, there can also be a long wait for death. The challenge for the dying person is to emerge from self-absorption, realising that what is said and done at that stage can significantly support the ones who are left behind.

For the bereaved, the challenge is to go against cultural expectations that a person has to cut off ties with the deceased and move on. Recent theories are now supporting a continuing relationship with the deceased (Klass, Silverman and Nickman, 1996).

In the Wilderness Experience, the therapist is buffeted between the client's highs and lows in this long journey. Therapist presence and inclusion are paramount here, but I believe that the therapist also has to have a set of beliefs held with conviction, not to get caught up in the futility and hopelessness of the Wilderness Experience. Staying with the helplessness, vulnerability, uncertainty, and at times, also the physical pain of the patient, requires a deeper level of conviction to sustain us in the 'between', a level of conviction that psychotherapy does not adequately take into account.

A therapist's value system can make a qualitative difference here. For some it might be a deep faith in the human potential. In my case, my model and path for engaging positively with the Wilderness lie in the Spiritual Exercises of Ignatius Loyola. It is a spirituality that reconciles presence to the world with presence to God (Coghlan, 2005), and the aim of the Exercises, is the growth of inner freedom to enable the person to respond to the personal call. Of particular relevance to my work with my clients in the Wilderness, is a parallel exercise within the Exercises which involves contemplating the Passion, where, according to Sheldrake (1991: 298), "the choice 'for Christ', will be deepened, probably painfully, often in dryness, powerlessness and waiting on God in silent trust". Drawing on the Gestalt dialogic method I can engage on a deeper level with clients, and my Christian beliefs according to the Ignatian discipline which advocates a similar way of being, give me a positive sense of staying in the Wilderness. When faced with opposition, denial and lack of reciprocity of the client in the 'between', my belief that there is something higher than ourselves that holds us in our humanity, supports me to hold the relationship with the client in the Wilderness Experience between Withdrawal and Sensation.

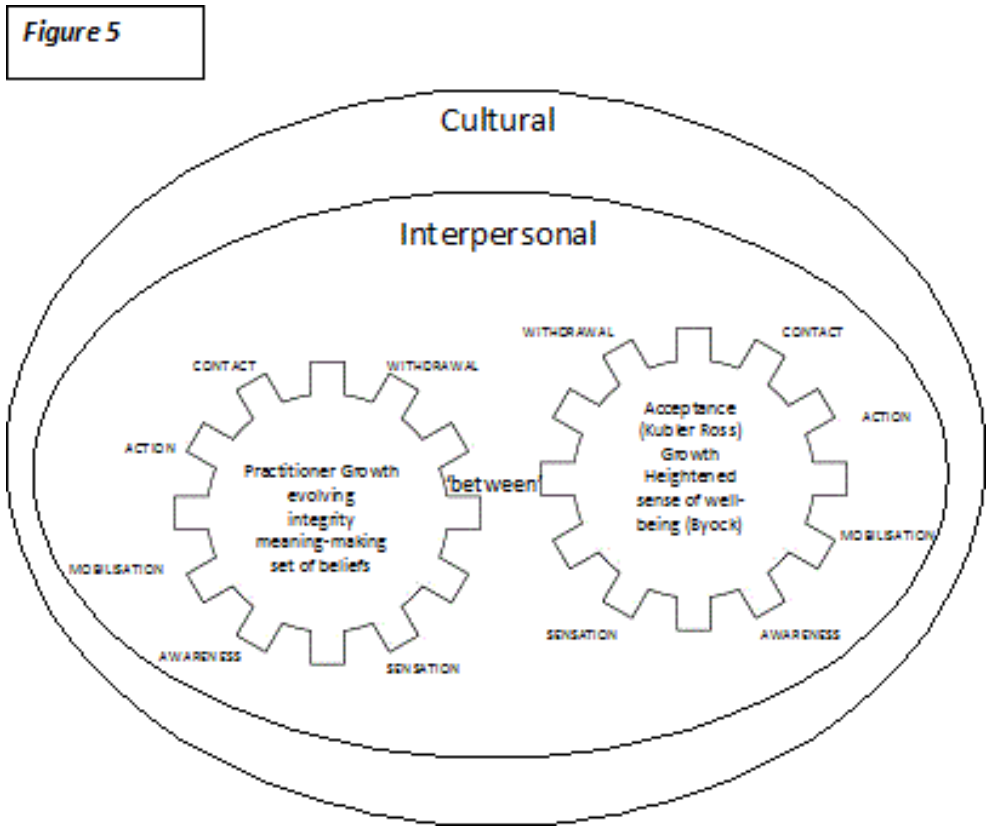


Figure 5

Figure 5 illustrates how the practitioner and client are engaged in a dynamic co-creation whereby one person’s cycle of experience may not simply touch the other, but somehow deeply impacts the other. So, as one person moves through their own cycle of experience, the impact on the other moves them through deeper levels of their own experience, if they are open to the other at the contact boundary. The cogs in figure 5 intertwine and interpenetrate to produce movement between both persons. It is also the case that the cogs can, and often do, interlock. This happens when one person may be more or less closed to the experience of the other, for example with responses such as ‘pull yourself together’ or ‘or you should be through this by now’, thus blocking movement in the other and clogging up the communication process.

Lived example (names have been changed, and permission to use the experience, granted):

I had worked with this client who I will call Mark, and his wife, Christine during Christine’s last months. Mark kept coming to therapy, for a year after her death. For a number of months, all he experienced was a deep, deep sadness, where the blackness of grief hovered over him like a cloud on a windless day. Life had no meaning and no purpose for him. I stayed with him in it, respecting the sadness, I too feeling the heaviness of it, and my helplessness in the face of this raw pain. Then one day Mark came in very excited. He began to relate an experience he had had. He had gone on Christine’s grave with a workman who was to put Christine’s name on the gravestone. He told me of the sense of despair that he was experiencing at that time. He desperately prayed to Christine to give him a sign. Suddenly, as the workman was hammering Christine’s name, the letter ‘p’ fell from the name ‘Josephine’ which was above Christine’s name on the gravestone, leaving the words ‘Jose’ and ‘hine’. The workman swore out loud, saying that it had never happened to him before. For my client, however, this was to jolt him out of the blackness of his experience, because ‘Jose’ had been Christine’s pet name for him. He told me that Christine had sent him a message that she was still with him.

I could easily have told him that it was all a coincidence and the ‘sign’ was his interpretation. This would have clogged the machinery. Instead as a psychotherapist I allowed myself to experience awe at this new figure that had emerged. As a person who is open to religious experience, I allowed myself to contemplate the unexplained. As I stayed with him and allowed his experience to penetrate me, I experienced a deep sense of sacredness and being held by something bigger than myself, feelings he was probably experiencing, too. However, it moved me to newer depths in my experience, as together, and at the same time individually, we allowed our co-created experience of the moment take us to deeper depths within ourselves.

Conclusion

I have presented a Model which has developed over years of experience with clients, academic application, self-reflexivity and commitment to personal growth and integrity. I have taught this Model, both aspects of it and in its entirety, to various professionals, as well as members of the clergy, in Malta. The psychological and spiritual insights could also have a more global application especially in countries where the Catholic Church has influence, and possibly relevant across Christian traditions.

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