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# THE FORMATION OF AFFECTIVITY

## A Christian Approach



# **The Formation of Affectivity**

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**The Formation of Affectivity**  
**A Christian Approach**  
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*To all those who,  
by sharing with me their eagerness to improve,  
have shown me  
the greatness of the human heart*



# TABLE OF CONTENTS

Introduction ..... 1

## I. PERSONALITY AND AFFECTIVITY

What Is Personality? ..... 11  
How Can We Assess Maturity? ..... 27  
Loving Oneself to Be Able to Love ..... 44  
What Do We Mean by Affectivity? ..... 55  
The Development of Affectivity Based on the Theological Virtues ..... 64

## II. INNER GROWTH THROUGHOUT THE LIFE CYCLE

The Life Cycle ..... 83  
Childhood and Adolescence ..... 95  
Adulthood ..... 113  
Improving Character in Adulthood: Taking Care of Relationships ..... 131  
Old Age ..... 142  
When the End Is Nigh ..... 162

## III. THE CHRISTIAN VIRTUE OF CHASTITY

Why Chastity? ..... 181  
The Addiction of the Twenty-First Century ..... 202  
Helping Others to Live Chastity ..... 220  
Christian Celibacy ..... 245

## IV. WHEN AFFECTIVITY IS DISTURBED

Affective Disorders ..... 271  
Personality Disorders ..... 297



## **EPILOGUE**

A Healthy Formative Style ..... 323

Bibliography ..... 342

# WHEN THE END IS NIGH

## 1. On Death and Dying

How should we approach the news that the time has come? What is the best way to confirm the terminal nature of an illness?

The Swiss psychiatrist Elizabeth Kübler-Ross (1926–2004) is well known for her description of the stages of grief, the psychological process of accepting the news that the end is near. She developed an interest in the topic as a student shortly after the Second World War, when she visited the Madjanek extermination camp in Poland. She was struck by hundreds of images of butterflies along the walls of the barracks. The butterfly would become the symbol of how she understood death—stepping up to a higher life.

She moved to New York in 1958. Initially she was keen on pediatrics, but ended up specializing in psychiatry. Over the following years she was often called upon to help dying patients who were suffering from depression. She listened to them for long hours. She kept them company with words and silence until they peacefully passed away, managing to add a great sense of humanity to her medical expertise. After she had been at the bedside of some 200 patients for the duration of the dying process (she would eventually follow thousands more throughout her career), she wrote her best-known book, *On Death and Dying* (1969).<sup>1</sup>

She describes the five stages her patients went through after they were told of their diagnosis: denial, anger, bargaining, depression and acceptance. Yet she repeatedly cautioned that some stages could overlap, happen in a different order or even be absent altogether, and that their duration could vary depending on the personality of the patients and their personal circumstances. Anger would be more intense for an irritable person, a “born

1 E. Kübler-Ross, *On Death and Dying*. Routledge, Abingdon, Oxon, 2009.

fighter” would bargain as much as possible, a pessimist would be more prone to depression, etc.

Kübler-Ross soon realized that the patients’ relatives went through the same stages she had described, and that when people were presented with bad news they generally went through the same process. Her ideas can help us understand the suffering of those who grieve, and provide us with tools to help them.

## **2. First Stage: Denial**

“No, not me, it can’t be true.”

The first reaction of patients when told the bad news is to act as if it had nothing to do with them: “The tests are wrong,” or, “They are from another patient,” etc. They continue to live as if nothing had happened, and wait for the tests to be done again, or seek a second opinion. Yet, this stage has its use: it gives time to “digest” the news.

According to Kübler-Ross,

This anxious denial following the presentation of a diagnosis is more typical of the patient who is informed prematurely or abruptly by someone who does not know the patient well, or does it quickly ‘to get it over with,’ without taking the patient’s readiness into consideration.<sup>2</sup>

This opens up to the first step to help someone die peacefully. The right person should break the news at the right time. Those of us who have worked in hospitals have often experienced the following scenario. The doctor informs the relatives, and they work out among themselves who the best person would be to talk to the patient. They often think that it could be the doctor himself (“It’s his job!”), or the chaplain who has already started talking with the patient. Although these are legitimate options, the best would be a relative who is closest to the patient, someone who has both moral high ground and enjoys a warm relationship with him or her. It is easier for the patient to share feelings and seek consolation (crying, hugging, etc.) from someone who is closer.

2 *Ibidem*, pp. 31–32

While it does not happen as often as it used to, there are still cases where breaking the news is delayed as long as possible with the excuse—or good intention—to spare the patient a longer period of suffering. People may be tempted to sidestep the difficulty of speaking up. We should keep in mind first of all that patients have the moral (and legal) right to know the state of their health and the results of their diagnostic tests. Even when the results have been given to relatives initially, hiding them from the patient would be an abuse.

Patients can tell when something is wrong. Repeated and more invasive tests, stays in the hospital, being told that “the results are not clear,” reading some of the medical paperwork, or a simple search on the internet, will make them suspect that there is something seriously the matter behind all the fuss.

Excessive delays can give rise to silent *pacts*, where both patient and relatives “know that the other knows,” but they do not dare to talk about it. The result is that all suffer to avoid making other people suffer. For the sake of saving others from a hard time, they lose out on mutual support and the sharing of emotions that they would do well to express.

Dr. Kübler-Ross recommends that the topic be raised much earlier.

We are often accused of talking with very sick patients about death when the doctor feels—very rightfully so—that they are not dying. I favor talking about death and dying with patients long before it actually happens if the patient indicates that he wants to. A healthier, stronger individual can deal with it better and is less frightened by the oncoming death when it is still “miles away” than when it “is right at the door,” as one of our patients put it so appropriately. It is also easier for the family to discuss such matters in times of relative health and well-being, and arrange for financial security for the children and others while the head of the household is still functioning. To postpone such talks is often not in the service of the patient but serves our own defensiveness.<sup>3</sup>

The last sentence explains why communication can sometimes be lacking. Talking about death is uncomfortable for everyone because it raises

3 *Ibidem*, p. 32.

many specters. It forces us all to face the reality of our own death. This discomfort may be more prevalent now than it was when Kübler-Ross' book was published fifty years ago, when society had a more spiritual outlook towards death. Yet we only need to read the news to realize that death remains a reality. The problem is facing the possibility of *our own death*.

We can look at Leo Tolstoy, one of the classics of literature, to illustrate what we are talking about:

The example of syllogistic reasoning he had read in Kieswetter's Logic—"Gaius is a man, men are mortal, therefore Gaius is mortal"—had always seemed to him true only in relation to Gaius, not to himself. That it was true of this man Gaius, and of men in general, made absolute sense; but he was no Gaius and was not some man in general. He had always had something unique about him that separated him from others [...]. What to Gaius was the striped leather ball that little Vanya had loved so much? What did Gaius have to do with him kissing his mother's hand, and had Gaius ever heard the silken rustle of his mother's dress? Had he rioted over the pirogies at the law school? Had this Gaius ever fallen in love? And could Gaius ever preside over a courtroom the way he did? So of course, Gaius could be mortal, and it was right for him to die, but for me, little Vanya, for Ivan Ilych, with all my thoughts and emotions—for me it's a different story. It can't possibly be that I have to die. That would be too horrible.<sup>4</sup>

All the above does not mean that we should break the news to the patient in a sudden fashion or rebuke his denial. It is often best to proceed slowly, suggesting the idea, asking open ended questions to find out how he feels, and picking up what the patient wants to hear or is ready to take in. The best way to find out is not only the choice of words he may use, but also his body language and general attitude. In the meantime, it is good (within reason) to let him ask questions and keep up his hope, and request a second opinions or tests.

4 L. Tolstoy, *The Death of Ivan Illich*, VI.

Finding out what is best for the patient, and not for his friends and family, is what really matters. What is best for the person is giving him time and space to prepare himself in all areas. That includes work, family (saying goodbyes, reconciling with estranged loved ones, making a will, etc.), and the spiritual life. Needless to say, the better his actual state of health, the easier it is to handle all the issues.

### 3. The Second Stage: Anger

“Why me?” “Why not old George?” “It’s not fair.”

Reality imposes itself, and in the end the wall created by denial in the previous stage crumbles. The terminal patient realizes that things are serious, and he blames his family, his doctor, the healthcare system, society, etc. They did not listen to his initial complaints, they did not carry out diagnostic tests early enough, they did not get the treatment right .... I once saw a tombstone that clearly indicated that the deceased was caught in this stage. It read, “I told you that I was sick.”

Sometimes anger is expressed more vaguely by resenting healthy people. They may react with surprise. “Should I be blamed because I am healthy?”

According to Kübler-Ross,

The tragedy is perhaps that we do not think of the reasons for patients’ anger and take it personally, when it has originally nothing or little to do with the people who become the target of the anger. As the staff or family react personally to this anger, however, they respond with increasing anger on their part, only feeding into the patient’s hostile behavior.<sup>5</sup>

Indeed, the worst outcome in this case would be “mutual escalation” that puts other people off when they are most needed.

The key at this stage is to show empathy. Note the difference between these two responses: “You’re wrong, you’re being unfair,” and, “I can see you’re going through tough times. This must be very hard for you.” The idea is to show patients that people respect, care for, and love

5 Kübler-Ross, *On Death and Dying*, p. 42.

them, that his feelings are recognized, and that he is not blamed for having them.

When the patient feels emotionally overcome by the illness, he will find some consolation in being part of the decision making, because it gives him a sense of control. For instance, agreeing to how often he should have visitors, or setting a limit to the length of the visits or to medical consultations. In my opinion, a common practice in palliative medicine could also be applied here. I refer to patient-controlled analgesia, which often results in patients taking fewer pain killers.

Anger can also be directed against God: “How could he let me get sick and on top of that leave my family unprotected?” The believer’s convictions are tested. He has probably heard hundreds of times that God is good, a Father who provides, that “all things work together for good for those who love God” (Rom 8:28), but he may not have made those beliefs his own, and he rebels against his lot. The response of “defending God” or repeating “the same old advice” may be counterproductive because the patient may interpret them as a standard “ready-made” answer that solves nothing.

Someone with a serious illness is not ready for elaborate reasoning. And it may not be necessary in the long run. It may be better just to let him go on to God—which is the most important thing—with his mistakes. In the Lord’s presence the patient will realize how wrong he was. It may be more useful to look for a positive belief that will resonate with his mind and heart: “Despite everything God is your Father, and he loves you,” and, “He knows better because he has the perspective of eternity; we are too conditioned by the present moment.” We will come back to this at the end of the chapter.

#### **4. Third Stage: Bargaining**

“Give me time to see my children’s graduation.” “I will do anything to get two more years.”

This is the reaction of a child, who first demands, and later begs for something, with the promise of a change in behavior. The sick man can try to bargain with the doctor (to donate his body, to develop healthy habits, to stop smoking). More often he tries to strike a deal with God (to go to Sunday Mass, pray, avoid sin...). In return he asks for more time to live or at least to reduce the pain or disability.

Kübler-Ross states, “In our individual interviews without an audience we have been impressed by the number of patients who promise ‘a life dedicated to God’ or ‘a life in the service of the church’ in exchange for some additional time.”<sup>6</sup> However, she adds with a touch of irony that, “None of our patients have ‘kept their promise.’”<sup>7</sup> If they get what they asked for they do not change their behavior and they want more time than what they have already asked for. Doctors and relatives could initially respond, “we will do everything humanly possible,” but without committing to what they are not sure of being able to do.

There is another benefit that comes with patience and empathetic listening. We get to know the patient’s concerns better. What will happen to his family, remorse for the past, etc. Simply verbalizing his concerns helps remove excessive and irrational fears. For instance, we may say, “You are not going to miss my wedding. If you can’t make it in person, you will see it better from heaven,” or “Don’t worry so much about promises to God if you get out of this. I think that what he wants is for you bear your pain patiently.” These conversations have another positive effect—they help the patient to face some of his greatest fears, namely loneliness and being abandoned. “No matter what, I will be with you.”

This approach presents us with the opportunity of developing a new way to relate to God, more mature and less selfish. If there’s going to be any bargaining with God, it should happen along the following lines: “give me strength to endure my illness and I promise that from now on I will do my best to grow in my love for you and for others.” It is the same thing that St. Augustine said many centuries ago. “God therefore does not command impossibilities; but in His command He counsels you both to do what you can for yourself, and to ask His aid in what you cannot do.”<sup>8</sup>

## 5. Fourth Stage: Depression

“I am so depressed . . . why should I keep on fighting?”

The illness has followed its natural course and bargaining has failed. God can work miracles but does not always do so. Multiple hospital ad-

6 *Ibidem*, pp. 67–68.

7 *Ibidem*, p. 67.

8 St. Augustine, *On Nature and Grace*, XLIII, 50.



missions and surgical procedures follow, more strength is lost, and autonomy is ever more limited. The relationship with the body becomes martial. So far, the body had been a faithful companion, but now it wants all of our attention. Weight loss and bodily sensations can even make it difficult for the sick person to recognize it as *his body*.

This is when depression comes in. Kübler-Ross identified two kinds: *reactive* depression and *preparatory* depression. It is important to distinguish them because they have different traits. Health personnel and relatives should approach them differently as well.

*Reactive depression* is the result of the loss of one's body image, autonomy, social and professional standing, the inability to look after one's family, the awareness of unfinished projects, self-blame for past mistakes, etc. This kind most needs the support of loved ones, who can help the sick person express his fears, see the future (both his and others') more objectively, sort out the causes of his worries as much as possible, be constantly engaged with things and feel as useful and productive as his condition allows.

When the individual falls into severe depression it is hard to keep up a minimum of activity. Other people may have to accompany him in his tasks, or ask for his assistance as a favor (a kind of emotional blackmail). Instead of telling him, "You have to get out," asking for help is more likely to succeed. "I need someone to help me with the shopping, could you come with me?" or "I feel like going for a walk, could you accompany me?"

The role of health professionals (doctors, psychologists, psychiatrists, etc.) is crucial. Even if their job is to look after clinical manifestations of the illness, they cannot neglect its subjective aspects. Medical or psychological intervention will often be required as well.

During this stage, the wish to die as soon as possible is not uncommon. There are even cases of suicidal ideation or requesting euthanasia.<sup>9</sup> The key is to interpret *the real message* that the patient wants to transmit.<sup>10</sup> "I don't want to live anymore," may really mean, "I don't want to live *like this* anymore" (with pain, fear and loneliness). Behind a request "to die with dignity" we may find that they really want

9 Along these lines I would recommend H. Hendin, *Seduced by Death. Doctors, Patients, and Assisted Suicide*, W.W. Norton, New York (NY) 1998.

10 I don't refer here, of course, to cases where there is definite clinical depression, which should be managed for what it is: clinical depression.

“to *live* with dignity.” These requests are often based on fear of the future more than the present: fear of pain, of being left alone, of being totally dependent on others, of being a burden, etc. There is not much need to fear pain nowadays, thanks to progress of palliative care and pain medication (including sedation). For most, death will not come in the midst of extreme pain. More difficult is the fear of lost autonomy, as we already saw when we looked at old age.

The second kind is what we call *preparatory depression*. It is the result of being aware of the loss of life itself. Unlike the first kind, it is a *silent* depression. There are no complaints or laments, because it is much more difficult to verbalize the problem. According to Kübler-Ross this kind of depression helps prepare people psychologically for imminent death, and helps move them to the final stage, acceptance.

The attitude of health professionals and relatives should change. Words of encouragement are not required, arguments against pessimism or listing all the things that they can still enjoy are not useful. In other words, there is no point in trying to convince them to see things from a different perspective. The cause of this depression comes from an incontrovertible truth: the patient is in fact leaving this life behind.

Much more help can be provided to the terminally ill by allowing them to express their pain and by supporting them in silence, with non-verbal communication. Patients are grateful when people sit by their side, ready to listen, respecting their silence, not insisting that the sick person “cheer up.” But sometimes they may want to be left alone. How can we leave them alone but show our love at the same time? How can we assure them that we are close by and available for anything they need? One idea may be short but frequent visits, dropping in to ask or tell them something like, “Do you need anything? I’ll sit with you for a little bit.”

Another trait highlighted by Kübler-Ross is that the spiritual dimension often comes up because the dying person thinks more about what lies ahead than what he leaves behind. We will return to this aspect in the last section of the chapter.

## 6. Fifth Stage: Acceptance

“Everything will be all right.” “I have no more fight in me, I have to get ready to jump.”

According to Kübler-Ross,

If a patient has had enough time (i.e., not a sudden, unexpected death) and has been given some help in working through the previously described stages, he will reach a stage during which he is neither depressed nor angry about his “fate.” He will have been able to express his previous feelings, his envy for the living and the healthy, his anger at those who do not have to face their end so soon. He will have mourned the impending loss of so many meaningful people and places and he will contemplate his coming end with a certain degree of quiet expectation.<sup>11</sup>

The purpose of this whole chapter is to provide relatives and doctors with tools to help patients reach this unique stage as soon as possible. But before we dive in, let’s anticipate an easy mistake. “Acceptance” does not mean “returning to normal” and having the patient’s mood be the same as it was before the diagnosis.

Acceptance should not be mistaken for a happy stage. It is almost void of feelings. It is as if the pain had gone, the struggle is over, and there comes a time for ‘the final rest before the long journey’ as one patient phrased it.<sup>12</sup>

This stage completes what we have described in the previous chapter as “detachment from this life.” There may be no depression (there is no sadness, tears or despair) but there remains a degree of apathy or indifference to the outside world. The things the patient was passionate about (hobbies, interests, a favorite sports team, even some family traditions) may no longer have an emotional impact. He sees them as belonging to another world. The fact is that in his own mind he is further and further away from them.

He often wishes to be on his own, and becomes less and less com-

11 Kübler-Ross, *On Death and Dying*, p. 91.

12 *Ibidem*, p. 92.

municative, but he still needs and appreciates the closeness of his loved ones.

The patient may just make a gesture of the hand to invite us to sit down for a while. He may just hold our hand and ask us to sit in silence. Such moments of silence may be the most meaningful communications for people who are not uncomfortable in the presence of a dying person.<sup>13</sup>

Keeping him company will reassure him that many people love him, respect him, and accompany him in his pain, that his life has been meaningful because he has loved and has been loved.

At this stage, the family may be in greater need of help. In the previous stages they had done all they could to support the patient and alleviate his suffering. Now that he is calm and composed, the relatives can settle down and face the situation. In addition to looking after their loved ones they themselves will need to overcome the five stages of grieving. Indeed, we have already stated that Dr. Elizabeth Kübler-Ross applied the same model to the relatives' grieving process, and extended it to coping with all sorts of bad news.

We can finish with a smile by seeing how a wise old professor applied the stages of grieving to his students.

Whenever I had to fail a student he first *denies* it, assuming that I made a mistake adding the score, or that I have given him someone else's grade; then he becomes *angry* because I asked something which I had not explained with enough detail, or because I have been too severe. Then he asks for a review of the exam and tries to *bargain* for an extra point here or there, and he promises that he will study over the summer break. Then he becomes *depressed* thinking that he will never pass the subject and will have to change degrees or go to another university. But in the end most students *accept* that they need to work harder, put in more hours and just pass the subject without further ado.

13 *Ibidem*.

## 7. Keeping Company for a Christian Death

Looking at the stages of mourning has helped us to “enter the mind of the patient.” Learning about the grieving process in addition to the illness itself will help us be close to him and respect his space and time with warmth and thoughtfulness. So far, we have mentioned little that would offend a non-believing patient. But the Kübler-Ross approach is also open to a transcendence and takes into account our spiritual dimension. In this last section we will go over a few points that can help others *die well* from a Christian perspective.

God’s idea for a Christian is based on two premises: God is my Father, and he loves me. These two great truths can never be exhausted, though crisis challenges them. We can all think of unexpected deaths that destroy the survivors’ well-being and plans for the future, bringing them pain and uncertainty.

People might benefit from the path proposed by St. Josemaría in *The Way*:

Stages: to be resigned to the will of God; to conform to the will of God; to want the will of God; to love the will of God.<sup>14</sup>

The first two steps (to resign and to conform) seem achievable, but is it possible to want or even *love* God’s will when it means losing one’s life prematurely? The answer is Yes. We naturally reject death, but for a believer it is the gateway to heaven, a much greater good than any partial evil (loss, pain, suffering, etc.). God is powerful enough to draw good out of evil, and greater goods out of greater evils. This argument provides serenity because it opens the door to the hope of future joy.

However, what is the meaning of the *present* suffering? I recommend reading St. John Paul II’s *On the Christian Meaning of Human Suffering*.<sup>15</sup> This letter offers a reflection from both the human and divine perspectives. In the limits of this section I can only provide a few brief brush strokes, but I do so because they fit in quite well with the purpose of the book.

14 St. Josemaría Escrivá, *The Way*, Little Hills Press, St Peters, Australia 1986. n. 774.

15 St. John Paul II, Apostolic Letter *Salvifici doloris*, 11 February 1984.

First of all, pain is an effect of sin. There was no pain in God's original design for us. Pain entered through the disobedience of Adam and Eve (cf. Gen 3 16–19). Pain is part of the punishment that everyone has to assume, though they may not be directly related to our sins. The Book of Job displays this with great drama. Given the extreme misfortune that afflicts him, his three friends insist that he must have done something wrong to deserve it. But Job insists that he has always behaved properly before God. The Lord's actions at the end of the book are a surprise on two counts. Firstly, because he does not explain why we suffer, he simply appeals to his own power and wisdom, and asks Job to trust him and to accept the situation. The second point of interest is that Job recovers both his health and the goods he had lost, and it looks like he goes back to enjoying the reward of his virtue even in this life.

The mystery of pain can only be understood by looking at Jesus Christ, the true just man, who takes up suffering “to the point of death—even death on a cross” (Phil 2:8). He shows how he loves his Father's will (the highest stage proposed by St. Josemaría) and also his love for those he ransomed from sin through his blood (cf. Isa 53:5). Just like in Job's case, the meaning of suffering remains somewhat unclear. But our Lord's passion absolutely confirms that suffering and God's love are compatible. Jesus never doubted his Father's love and never stops loving him.

The gospels point out a dimension of suffering that deserves more consideration. As St. Paul summarized it, “in my flesh I am completing what is lacking in Christ's afflictions for the sake of his body, that is, the church” (Col 1:24). Sharing the mind of the Lord (cf. Phil 2:5) means also sharing—each with his own life—in his Passion, and thus contributing to the salvation of mankind

This overview is too brief to solve every uncertainty about suffering, and is no answer to the mystery. It only offers a little light. If God chose suffering as the instrument to show his love for and save the human race, there must be something to it. As the Second Vatican Council states, “Through Christ and in Christ, the riddles of sorrow and death grow meaningful. Apart from His gospel, they overwhelm us.”<sup>16</sup>

16 Vatican Council II, Pastoral Constitution *Gaudium at Spes*, December 7, 1965, n. 22.

Looking at Christ's suffering has more direct consequences for the patient than we might have expected.<sup>17</sup> Jesus himself gave voice to a sort of *bargaining stage* before his Passion. This is how he prayed in the garden of Gethsemane: "My Father, if it is possible, let this cup pass from me; yet not what I want but what you want" (Mt 26:39). He began by appealing to his Father's goodness while trustingly accepting his will. We should not be surprised if we, poor creatures that we are, overstep the bargaining and get angry with God, and proceed to make up and acknowledge that he knows better. When it comes to sickness and pain, freedom often has less to do with doing and more to do with facing up to the inevitable.

What most helps us sanctify sickness and death is placing ourselves—or helping others place themselves—squarely before Christ and reading the gospel, particularly the scenes of the Passion. We can ask Jesus: "How could you put up with all this? Could you help me cope with my suffering?" Having a crucifix on hand will help. Two are even better, one that can be seen from bed, and another to hold tightly in the hand during extreme physical or moral suffering. Lastly, suffering at the foot of the cross puts us in good company—Mary most holy (cf. Jn 19:25) is there too, consoling Jesus, and so is St. John. St. John represents each of the disciples her Son loved.

We may not quite understand why we are in this position. But we need to keep on praying. It is enough to sense and trust God our Father. The best way to help a patient pray is to pray with him and ask him to pray for specific intentions. Then he can feel useful. When a patient is very disabled, simple vocal prayers, like the holy rosary, can fill hours of external inactivity.

Some patients may undergo a crisis at this point. "What if I made a mistake? What if there is no life after this?" It is not usually a real doubt of faith, but a kind of scruple that sneaks in. The solution is to clarify their desire to be with him, to see him face-to-face. Yet sometimes it reveals a faith that is still immature and staggers when put to the test. In neither case is elaborate reasoning appropriate. It is the time for abandoning oneself, humbling the mind if necessary, and return to the simple faith of children. "Let the little children come to me, and do not stop them; for it is to such as these that the kingdom of heaven belongs" (Mt 19:14).

17 It is interesting to point out that "patient" comes from the Latin verb *pati*, which means "to suffer." A patient is literally "someone suffering."

Those who have the most direct contact with these patients (relatives, hospital chaplains, volunteers, etc.) should know what materials are appropriate to the occasion—books and brochures, websites, etc. Biographies can be very useful, because rather than explaining they show that it is possible to endure illness with a Christian outlook. They move the mind and the heart to assert, “I would like to die the same way.” They provide more meaning to the suffering of the patient. That can mean leaving behind a memory and an example for the loved ones. Kübler-Ross herself explains that for many relatives who have been with their loved ones right down to the acceptance stage the experience is a surprise, “as it will show him that dying is not such a frightening, horrible thing that so many want to avoid.”<sup>18</sup>

Victor Frankl wrote that “Man should not ask what the meaning of life is, but rather he must recognize that it is *he* who is asked.”<sup>19</sup> Likewise, it will help the sick person to ask himself what God expects of him in his situation and to focus less on what the pain is doing to him but on what he can do with his pain. He can do a lot, both for his own good and for the good of many other people.

All this sounds beautiful, but is it too much for the average person? It may be, and this is the reason why we need outside help. We can trust in the grace of God that comes from the sacraments. Three sacraments are particularly relevant here.

The first is the sacrament of confession. Knowing that no matter how badly we have behaved throughout life, God will forgive us always, is a supreme consolation. It is never too late to reconcile with God, and through him we be at peace with ourselves and with other people.

Second is anointing of the sick. It should be offered to the patient in a timely manner, and not be delayed too long, with the risk that the patient may no longer be conscious. Sometimes the mere mention of the sacrament raises fear, but this fear is similar to breaking the news of the fatal diagnosis. The relatives are more scared than the patient himself.

Finally, holy Communion, which receives a special name when received

18 Kübler-Ross, *On Death and Dying*, p. 92.

19 V. Frankl, *Man's Search for Meaning. An Introduction to Logotherapy*, Hodder and Stoughton, London–Sydney–Auckland–Toronto 1992, p. 111.



### *When the End Is Nigh*

by terminal patients: *viaticum*, food for the journey, the last stage of our journey to heaven. That food is nothing other than the very Body of Jesus. I was told some time ago of a conversation between a dying lady and her son at the bedside. He asked her, "Mom, do you think that our Lord will welcome you to heaven right away?" Her answer reflected her great faith: "If I received him every day for so many years, how will he not welcome me today? Yes, he will welcome me."