Page 260 to 264

Volume 2 • Issue 5 • 2018

Case Report

Chronicle of Medicine and Surgery

ISSN: 2576-8298

The Specifics of the Work of a Hospice Psychologist in a Multicultural Environment.

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Received: August 20, 2018; **Published:** August 29, 2018

Abstract

The article is a description of the experience of psychologist working with multilingual palliative patients representing various ethnic groups and religions.

The Vilnius region in Lithuania is a place where representatives of many nationalities and different religion live. People who grew up in Vilnius region often use several languages on a daily basis, in a family, at work, in relations with friends. In many cases, people live and function in a heterogeneous, cultural, linguistic and religious environment. The work of a psychologist in such circumstances differs from working in a culturally homogeneous environment and puts special demands on the psychologist. This is especially true of working with patients in the hospice, most of whom are terminally ill, and requires the special care of many specialists.

Keywords: *Palliative care; Palliative patients; Multilingual patients; Psychological help for palliative patients; Hospice patients*

Volume 2 Issue 5 August 2018
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The specificity of the Vilnius region in Lithuania is that it is a region in which many nationalities lived for generations. Multiculturalism of the Vilnius region is a dynamic phenomenon that lasts over time. As a result of many centuries-long historical, social and political changes in this region, there has been diffusion and interference cultural, linguistic and sometimes also religious.

A lot of different, often unlike each other cultures, religions, value systems and languages have been mixed up. Vilnius region in Lithuania is a region where diverse cultures co-exist and interact, a territory where these cultures intersect and complement each other, but also a place where these cultures fight each other. The processes of acculturation and assimilation in the Vilnius region take place in a very complicated way.

Paradoxically, groups of people of different nationalities for generations living in this area, every few decades turn out to be in the situation of migrants in their own home and must adapt to the new socio-political situation, maintain their national identity or develop a new, more secure in given conditions . This situation is a source of many internal and external conflicts for many people and entire local communities, complicated psychological problems concerning self-esteem, language, national, cultural and social identities.

The rich ethnic and religious mosaic of the Vilnius region in Lithuania is not only a phenomenon that provides many interesting materials for an ethnographic research, but also a huge challenge for psychologists working with representatives of the multinational crucible.

There are differences in the work of the psychologist with people from homogeneous environments of nationality and with people assimilated in a different culture than that which their ancestors represented. This difference is particularly prominent in the crisis situation, which is the terminal period of the disease.

The patients of the Vilnius Hospice in Lithuania are representatives of various nationalities. Most of them communicate in parallel in two or three, sometimes even in four languages. Among the hospice patients are Lithuanians, Poles, Belarusians, Russians, Ukrainians, and representatives of other nationalities. Very often they are people from mixed families, or creating mixed marriages. Sometimes they do not know the state language, or know it only on the basic level, have a much limited ability to communicate in this language. Some patients do not know the language of the nationalities to which they belong.

In terms of religion, they are Catholics, Orthodox, Old-Believers, Protestants, Greek Catholics, Baptists, and atheists. A large group of patients are people who could be described as religiously undeclared, not belonging to any religious community, or belonging to a church on purely formal terms. Most often this group includes patients whose childhood and youth passed during the propaganda of atheism and the ban on active participation in religious rites in areas occupied by the Soviet Union.

National identity of Vilnius region in Lithuania residents is not always related to language or cultural identity. The patient's age and education, the socio-political situation in which the person grew up has a big influence on the culture and language of the patient. Many people changed their national and cultural identities in a result of historical changes. In the case when acculturation and assimilation occurred in early childhood and is deep enough, it rarely interferes with the functioning of the person experiencing the crisis.

In the event of late assimilation into another culture and language, as a result of extreme experiences, such as the terminal stage of a disease, the "new" value system breaks down frequently and that reduces the sense of patient's safety. Sometimes, these patients return to the language and values they have encountered in their early childhood. In working with such patient's one can notice that "old", repressed values can form the basis for regaining a sense of security and emotional balance.

A psychologist who works with such diverse patients should have a great sense of tolerance and acceptance towards people who think differently, in other words believers who have different value systems.

The work of a psychologist in such an environment requires: knowledge of the languages used by the patients; discernment in the cultural specifics of each national group; knowledge of the historical, social and political situation in which the patient value system was shaped; knowledge of the basics of religious studies; knowledge of the specificity of language disorders that may occur in multilingual people as a result of brain damage caused by the disease.

The patient's health card tells a lot about the history of his disease, but there is no clear information about the patient's cultural identity, the language in which he communicates, the values he professes. All this information is necessary to establish a good contact with the patient, to help effectively support him mentally. Therefore, the task of a psychologist is to build contact with the patient so that he would talk to him about it.

One of the first things needed to make contact is a language that is understandable to both sides, using which both sides feel comfortable. Therefore, immediately after the greeting, I ask the patient in what language he prefers to talk to me: in Lithuanian, Russian or Polish. If I ask a question in Lithuanian, the majority of patients asked about the language in which it is easier for them to communicate lists two or three. Mostly, such patients say that language does not matter to them. This is not always true. Often this is only the declared knowledge of languages, not the actual knowledge. Many indigenous residents of the Vilnius region, or Russians, Ukrainians or Belarusians, who settled in the Vilnius region after the Second World War, are ashamed to admit that it is difficult for them to speak Lithuanian

that they do not understand everything. They prefer to falter and pretend that they understand everything rather than risk awkward comments at their address. It is best to ask a question: In what language do you speak at home? In which language did you talk to your home at your childhood? In which language do you speak with your mom?

Talking in a language that is closer to a patient makes it easier to make contact with him, also it strengthens his sense of security, increases psychological comfort, makes easier to discuss the physical and emotional problems of the patient, diagnose more precisely, sometimes, some diagnoses can be avoided (such as assigning damage neurological, not trouble with understanding the language that the patient has problems with understanding commands, expressing himself and cannot say what time it is or what is the month now). A patient who has the opportunity to communicate in a language close to him is often more willing to cooperate with the team that looks after him. When a patient has the opportunity to talk to a psychologist in his mother language, the psychologist ceases to be a representative of the institution for him and becomes a man who can be trusted. This makes the therapy much easier.

However, a multilingual patient can cause difficulties for the psychologist. Proficiency in several languages for some patients is a tool supporting the use of psychological defense mechanisms. The language you have learned in school age or in adulthood is a kind of safety belt that allows you to keep your emotions in check, talk about what the patient wants to feel and not about what he feels. A well-taught, but well-mastered foreign language allows you to often construct a false image of yourself, hindering effective psychological help. This is probably because the second or third language appeared in the life of a person when he was able to regulate his emotional states, control them, so it is easier to speak about emotions in this language without allowing them to feel them. Sentences then flow smoothly and syntactically, the patient controls the situation, emotions remain under the layer of words that in the consciousness of this person do not connect with feelings. It happened that people whose first language was Polish stubbornly talked to me in Lithuanian or Russian, Russian-Russian used Lithuanian, Lithuanian people speaking about emotions turned to Russian, and the Belarusian began to speak Polish. Each time they were people avoiding talking about feelings, trying to suppress their emotions.

It happened that a Belarusian patient, when during therapy touched deeper emotional problems, started to talk to me in Polish, when he calmed down: he switched to the Belarusian-Russian medley. When such a patient begins to weaken physically it is more difficult for him to control his way of speaking. Often these people have something like the clarification of the language in which a person spoke in childhood. There are quotes, sayings, which these people or their surroundings used in childhood, with time, whole sentences. The first language seems to begin to shine through the network of words learned by a patient at a later age. The language of childhood flows to the surface of consciousness even if people have not used it for several decades. In this situation, it is very important that the psychologist notices and carefully began to speak the patient's language, adapting his style to the style of the patient.

Very often, the transition to the language of childhood means that the patient weakens and neurological changes occur, which make it easier for him to find the necessary words in the first language. Sometimes the transition to the first language is a harbinger of impending death, appearing a few or dozen days before the first physiological symptoms. On several occasions, patients who assimilated to a different culture than the one in which they were born and spent their early childhood, integrated with it, changing their cultural identity and seemed to forget the language from childhood before their death began to use their first language, often to the surprise of a family who did not understand them.

It happens that the younger generation does not understand what the older person is saying, because the exact language of their grandmother's or father's childhood is a foreign language. They are concerned about this situation, and anxiety is passed on to the patient and tension increases. In such a situation, it is important that next to it is a person who can bring the situation to the right and sometimes play the role of translator. In Vilnius hospice, there are almost no national conflicts in Vilnius. Rarely, patients or their relatives express dissatisfaction with the fact that there is a person of a different nationality in the room. Sometimes, however, there are quarrels between religious patients. In such situations, the psychologist conducts conversations with patients about the nature of ecumenical or interreligious dialogue. It helps in this knowledge about the rites and basic assumptions of different faiths that patients represent.

Conversations about spirituality are very difficult, especially difficult if they are conducted with people who share different values. However, these are conversations unavoidable in a place like a hospice. Before starting such a conversation, it is important to know what value system represents the patient to which religion belongs. The question whether a patient believes in God will not explain us much. It is better to ask what his attitude towards religion is. Sometimes we get the answer to the question about faith that a person goes to church, so he is a believer. Very often, going to church or to the church is limited to visiting the temple during solemn holidays, weddings, baptisms and funerals. Approaching these people as believers carries the risk of misunderstanding. Both sides can interpret the term "believer" differently. Many people who declare themselves as Catholics or Orthodox are only formally, like they used formally to be October, pioneers, komsomolts or communists. Formal affiliation with any religion does not give them the sense of security and sense of existence that almost every religion offers to their followers, does not give faith in the eternal life that Christianity offers to its followers.

It is paradoxical that many of our patients say that they are afraid of talking to their priests about faith-related topics. A priest, Orthodox priest, or pastor, are representatives of institutions for these people, and a post-Soviet representative of the institution honors and respects, but is not necessarily honest with him. He will take part in the mass, he will receive communion, but fear that he does not believe that he is afraid of his disbelief with him he will not share. That is why it is often much safer to feel with a psychologist than with a priest in conversations about eternity, about the "other" world, about the fear of dying, the fear that there is no faith in the fact that there is something beyond the border of life. "Priest urged me to believe, you accept my unbelief ..." one of the patients told me once.

Persons who in childhood had foundations of faith, for whom religion was a tradition in which their family lived, which came into contact with religion not only as a formal phenomenon, in an extreme situation (and life-threatening disease is such a situation) easier to return to the bosom of their church. Faith is easier to regain to those who once possessed it, but lost, away from it, than those who treat faith, church, religion as an additional remedy for their disease. Sometimes, however, despite the efforts of religious sisters, priest and psychological help, it is impossible to restore faith where it was not, or to build a system of values if foundations were not established.

The most difficult is conversations about spirituality with people who, "freshly", in adulthood have converted to faith. They defend their religious system with the ferocity of neophytes, sometimes accusing other patients of lack of faith, "ungodliness", because, for example, those who do not study intensively are praying or studying the Holy Bible. Such patients most often mask their fear, anxiety and fear of death in this way. Their not-yet-superficial faith, based on recently acquired rituals, does not give them a sense of security. They need support not only psychological but also spiritual. Not to convert and lecture only to understand their human, terrified and lost nature.

Knowledge of rituals, customs adopted in various churches functioning in the Vilnius region allows to better understand the behavior of patients, it is easier to make contact with them, answer the questions that torment them, avoid some of the errors of interpretation. For example, do not be afraid that the Orthodox person, on the day when she is to visit her Orthodox priest with Holy Communion, suddenly felt worse because she lost her appetite and refused to eat from the morning. A strict fast on the day of receiving communion is part of the rite for her. Or do not worry about the patient's mental state, which states that as everyone begins to speak in incomprehensible languages, she prefers to be silent because glossolalia is one of the elements of the Pentecostal church ordinances to which she belongs.

During conversations with the psychologist, spiritual topics and questions related to the faith, rituals or nuances of this or that religion are very often discussed.

Where does the soul live? What happens after death with the soul of a Catholic? Where is the Orthodox soul wandering? Where does my soul live if I was born as a Jewess and now I am a Christian? What is the difference between a Baptist and an atheist? Who has closer to God: a Russian or Pole? If I do not believe in purgatory, will I also find it?

Patients in the Vilnius Hospice are able to surprise the psychologist with questions that are not answered in specialist psychological literature. However, you can find them in mindfulness, experience and listening and hearing skills, which sometimes allow the questioner to give such a response that will bring him relief. The cultural, linguistic and religious diversity of patients at the Vilnius Hospice makes working here a chance to learn a lot of new things about different communities, cultures and denominations. It is also an opportunity to learn about your limits of tolerance and acceptance of Another Human.

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