

The Journal of
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CHAPLAINCY

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Editorial

Meg Burton

Welcome to the first issue of the *Journal of Health Care Chaplaincy* for 2011. Unfortunately, because of illness, we were not able to publish a second issue before the end of 2010. Thank you for your responses to the Summer issue – it is good to know that it has been well received. Responses have been both verbal and written, and the latter have included two letters, both in response to Andrew Haig's sermon. I hope that Letters to the Editor will become a regular feature of the Journal. Written responses also included some prospective articles and Endpieces. Thank you to those who have written; I look forward to your responses to this issue.

This week I have had two different, but in some way related, encounters. On Thursday evening I watched an amazing performance of *Hamlet*, with Rory Kinnear in the title role of Nicholas Hytner's National Theatre production. Much to the chagrin of my companion, I confessed that it was my first *Hamlet* and because of that I had no preconceptions of what I was about to see. One of the things that struck me quite forcibly was the way in which Hamlet and Ophelia reacted to the deaths of their fathers in extreme ways, both, in this production, going quite mad and behaving in ways that would normally be very out of character.

The other encounter happened the day before. One of my roles is to counsel patients referred to me by different members of our Pain Management Unit, usually, but not exclusively, because they have experienced one or more bereavements or losses, are not coping, and it is felt that this is exacerbating their pain. I had seen one particular patient for several sessions. She had experienced multiple bereavements since a very small child, the most recent being that of her sister. She came to the unit because she had sustained an injury to her arm at work. She was pursuing a claim for compensation against her employer. She was very anxious. Her consultant could not do any more for the pain and so she was referred to one of our cognitive behavioural therapists. When, after several sessions, she showed no signs of either wanting, or being able, to change, and when he discovered that her sister was dying, he referred her to me so that I could support her during

this time. The last time she saw me I knew something had changed drastically as she had a smile on her face. She was a different person. What made the difference were three things. First, she had been told that she would not be able to pursue the claim as time had run out; second, this led her to accept the condition her arm will always be in, including the pain, and she had decided that she couldn't let that rule her life. Her goal for this year is to find a job. The third thing, she had not mentioned to any of us. It turned out that she and her family had been living in a state of heightened anxiety next to another family who were being, to put it mildly, horrible to them. Bucking against the current trend, she and her husband had managed to sell their house and had moved the previous week. The relationships between all the members of her family immediately improved and she was now able to cope with her chronic condition. This week I fed back to the MDT this good news, including her decision that she no longer needs to see me or any other members of the team. The one negative was the consultant, who came across as not understanding the importance all our contributions had made to the outcome.

Caring for people is our bread and butter, and the different forms this can take are reflected in our articles. Caring for ourselves first is vital (think of when you go on a plane and you are told that, in an emergency, you should put on your own oxygen mask before helping anyone else) and Martin Kerry follows up his article in the last issue (An Introduction to Pastoral Supervision) by suggesting how we might take supervision forward with an agenda for chaplains and chaplaincy.

Caring for those who present with difficult ethical situations can often bring a measure of anxiety, for the patient and for the health-care professionals involved. Using a case study, Andrew Fisher guides us through one ethical issue involving autonomy, suggesting that Martin Buber's philosophy of 'genuine dialogue' can help in the decision-making process.

Caring for our patients/service users can involve religious needs and wider spiritual needs. Keith Lowe asks whether we attend adequately to the spiritual needs of mental health service users when they are admitted to acute hospitals. He outlines the work he undertook while exploring this subject, looking particularly at the Recovery Approach and how we undertake spiritual needs assessments. Patricia Casey writes about separating religion and spirituality, saying that both are important and can have an influence on outcomes for patients. Julian Raffay suggests that spirituality

may hold the clue to more humane services, concluding that it is important to support staff and build their trust if chaplains are to be respected and effective.

Those of you who attended the CHCC Annual Study Course in Sheffield in September 2010 will remember Stephen Bushell's presentation. He reminded us that what we bring to our work as chaplains is ourselves and that we need to understand and be aware of ourselves if we are to be most helpful to our patients, their relatives and the staff who care for them. He used the fairy tale 'Little Red Riding Hood' as a very effective means to illustrate his points and has written it up so that all of us may share and learn.

What links the stories with which I began this editorial and the theme running through the articles is the importance of the care that we give to patients. What we see immediately in our patients, relatives or staff members may not be what is affecting them the most. We need, in an ideal world, to take the time to get to know people, so that they trust us enough to open up and let us see inside their world. Often we may not know what is going on in their lives outside the hospital, but it is our job to assess what their needs might be, religious and/or spiritual. However, we might want to define those terms, and then try to meet them. Sometimes, as in the case of Hamlet and Ophelia, behaviours that are out of character are exhibited, or, as in the case of the patient I was seeing, unknown factors may be at play, and other disciplines do not always recognize these. Then it is up to us to help and encourage others to think outside the box.

Before I finish I would like to pay tribute to Amar Hegedüs who, after many years of unstinting service to the *Journal of Health Care Chaplaincy*, has resigned. Amar was responsible for the production of the Journal in its two most recent incarnations and worked extremely hard to find us the best people possible to produce it. Thank you, Amar, for all you have done for us.

Meg Burton

Worksop

February 2011

Taking Supervision Forward: An Agenda for Chaplains and Chaplaincy

Revd Martin Kerry is Senior Chaplain and Chaplaincy Manager at Sheffield Teaching Hospitals. He is also on the Executive Committee of the Association of Pastoral Supervisors and Educators (APSE).

Abstract

This article follows on from the author's 'An Introduction to Pastoral Supervision' in the previous edition of the Journal. Some key questions are explored for developing the supervision agenda in Chaplaincy: Where should supervision sit in professional standards? Who should provide supervision? How might chaplains who supervise be supported? Why do some chaplains not receive supervision?

Key Words

Supervision; Professional standards; Supervisors

Main Article

Introduction

The previous issue of this Journal printed notes from my presentation, 'An Introduction to Pastoral Supervision' (Kerry 2010). In it, I briefly covered definition, benefits, models and methods. I also profiled some resources for supervising, including APSE. In this article, I consider some key questions for taking supervision forward within Chaplaincy, with the intention of stimulating discussion and action.

Where Should Supervision Sit in Professional Standards?

The now-disbanded Chaplaincy Academic and Accreditation Board (CAAB) stated (www.caabweb.org.uk [website no longer available]):

CAAB recognises the importance of supervision for chaplains and considers it an essential requirement of professional practice for both pastoral and ethical reasons.

CAAB's successor, the UK Board of Healthcare Chaplaincy (UKBHC), has adopted standards of capability and competence, including:

As part of the process of continuing professional development the chaplain demonstrates the ability to reflect upon practice in order to develop or inform his or her practice. (UKBHC 2009a: standard 4.1)

This is followed by a competency to demonstrate understanding of 'different models of reflective practice' such as clinical pastoral education, clinical supervision or pastoral reflective practice.

The Standards statement softens CAAB's requirement for supervision, and subsumes it under the rubric of reflective practice. The latter is a component of continuing professional development (CPD). The cross-referenced Chaplaincy Service Standard refers to a Chaplaincy Service 'committed to continuing professional development', followed by a lengthy list of examples of evidence which 'can include ... Reflective practice, e.g. Clinical Supervision or Clinical Pastoral Education' (UKBHC 2009b: standard 5.1).

Supervision has a wider focus than reflective practice in that it explicitly incorporates elements of accountability and support. In classic formulations, supervision has three characteristics: the normative, dealing with boundary issues such as ethical practice; the formative, concerned with developing the practitioner through, for example, improving skills and increasing self-awareness; and the restorative, supporting the supervisee by, for example, helping them reconnect with their sense of vision and vocation (Inskipp and Proctor 1993). As such, supervision underpins fitness to practise. The Code of Conduct for Healthcare Chaplains enjoins:

Ensure that you are fit to practise and that those in your care are not at risk of harm because of your conduct, performance or health. (UKBHC 2010: 7.2)

The normative element of supervision promotes safe conduct; the formative element encourages competent performance; and the restorative element helps sustain the practitioner and protect from burnout.

It is not that these dimensions of practice are absent from the Standards. Capability 1.2 covers practising ethically. Standard 4 requires using 'a structured form of reflective practice' to discuss, inter alia, managing the pressures of caseload, and personal and professional boundaries in the therapeutic relationship. Nor is discussion of supervision absent from UKBHC material outside the Standards. It has published a revision of Mark Sutherland's paper which calls for:

the identification of a suitable model of work supervision, which supports professional identity and strengthens good practice.
(Sutherland 2010: 2)

Who requires supervision? The answer is any practitioner requiring a space to reflect upon and learn from their work. (2010: 7)

In addition, the Chaplaincy Service Standards state 'Chaplaincy services should have access to professional supervision' (UKBHC 2009b: standard 6a.10).

All of this, nevertheless, stops short of an explicit requirement on chaplains to receive supervision in order to demonstrate fitness to practise. I am aware of my own formative influences in counselling and psychotherapy, where supervision is central to the culture. I acknowledge a range of models of Chaplaincy practice and wonder if my bias has made me unaware of understandings of Chaplaincy which would preclude supervision.

UKBHC has very helpfully developed a Code of Conduct and a system of recording and monitoring CPD. It has adopted Standards of Capability and Competence. It has introduced registration. As the profession looks to link these components in order to assure fitness to practise, has the time come to incorporate a requirement for supervision into professional standards? Expressed as a capability, it might read, 'to use supervision in order to maintain fitness to practise'.

Who Should Provide Supervision?

1. Managers?

The recent Members' Questionnaire conducted by the CHCC (CHCC 2010: 11 f.) asked for the first time about Clinical/Pastoral Supervision. From those who received supervision, 41 per cent received it from chaplains with a

further 7 per cent from their line manager. The survey comments: 'In the latter case it was not always clear if these were chaplains or not.' It might have added that in the former case it would not seem to be clear if the supervising chaplain was also their line manager.

Line managers exercise a supervisory function that is intrinsic to their role. This 'managerial supervision' addresses matters connected to the organization and performance of a colleague's work. It will involve appraisal, including the identification of developmental work. The managerial role does not necessarily involve processing the detailed content of the work in terms of the chaplain's pastoral practice. However, there may be situations where the two are combined. If this is the case, I suggest three safeguards.

First, it is important that the dual role is a conscious decision, where both parties are aware that clinical or pastoral supervision is different from managerial supervision.

Second, the competence of the line manager to supervise the content of the work needs to be considered. Where line managers are themselves chaplains, they will be able to draw on their own experience of offering pastoral care. However, experience may not in itself support the manager to provide the skills and awareness that are necessary for effective supervision.

Third, there needs to be acknowledgement of the potential disadvantages of the dual role. Frances Ward argues that pastoral supervision

is a bit like a safety net that offers the security that is necessary for challenging learning to happen. (Ward 2005: 5)

The task of the supervisor is to provide a safe and creative space for development. A key issue is whether this can be achieved within the power dynamic between a given line manager and their chaplain colleague; in particular, where the relationship with the manager is part of the chaplain's work problem. Again, does sufficient trust exist in the relationship to permit the non-defensive exploration of failure?

Learning often best happens ... through struggling with what has not worked in practice, when we are able to return to what we think of as failure. (Ward 2005: 94)

2. Chaplain or generic supervisor?

The CHCC survey reveals that in addition to other chaplains (41 per cent) and line managers (7 per cent), chaplains seeking supervision also used psycho-logists, psychiatrists or psychotherapists (24 per cent), counsellors (14 per cent), and the faith group (7 per cent). The survey does not reveal why these choices of provider were made – for example, the relative importance of availability, cost, perceived expertise and authority.

In his paper for the previous issue of this Journal, Richard Lowndes (2010) implied that his team turned naturally to counselling as a discipline with proven credentials in supervision. In my own chaplaincy team, we have typically sought supervisors from chaplains in other Trusts. We sense, I think, that knowledge and understanding of our Chaplaincy world is necessary in order for us to have confidence in the supervisor's effectiveness.

My colleagues on the APSE Executive have come from a range of disciplines: theological education, local church ministry, spiritual direction, health-care chaplaincy and training for ministry. On the one hand, their common experience is that the skills of pastoral supervision are generic and can be applied across pastoral contexts. On the other hand, two of them have also written persuasively of the developmental stages of supervisees. Jane Leach and Michael Paterson (2010: 97 f.) suggest that, particularly in the early stages of the development of the supervisee's professional identity, the focus of supervision is likely to be on the detailed content of the work. Here, it can be helpful to identify a supervisor from within one's own discipline. As the supervisee develops into a senior practitioner, so supervision is likely to address complex cases and wider contextual and organization issues. Here, the supervisor need not necessarily be acquainted intimately with the supervisee's work context.

How Might Chaplains Who Supervise Be Supported?

In 1999–2000, I and nine other chaplains attended a course on pastoral supervision sponsored by CHCC. Led by John Foskett and Mark Sutherland, it ran across six months, involving six brief residentials with a programme of work between stays. To my knowledge, this is the only extensive pastoral supervision course, before or since, that has run exclusively for health-care chaplains in England.

There are currently courses available for the training of supervisors in

Christian ministry contexts, counselling and psychotherapy, and for the clinical practice of health-care professionals. Many chaplains who supervise have received training from one or more of these areas. However, more than ten years on, could the profession appropriately commission another course for chaplains? This would be an opportunity to profile supervision and attract chaplains who want to develop their supervision skills specifically for other chaplains.

For those chaplains who already supervise, there is now the opportunity to join – and possibly be accredited by – APSE. One of APSE's aims is 'fostering groups for the support, accountability and continuing development of supervisors' (see website: www.pastoralsupervision.org.uk). The organization has just begun to establish professional networks, including one for health-care chaplains for which I am the lead. I envisage the purpose of the network to include:

- identifying other chaplains involved in supervising;
- developing a programme for our training and development;
- influencing the professional agenda;
- linking to local practitioners from our sister-disciplines in pastoral supervision.

Why Don't Some Chaplains Receive Supervision?

The CHCC survey reports 64 per cent of respondents receiving supervision. There is no information on why the remaining 36 per cent do not. A further, more detailed survey would inform priorities on taking supervision forward. If the principal block is cost (and only 44 per cent of those currently receiving supervision said it was funded by the NHS employer), then making supervision a professional requirement might provide leverage. Alternatively, a developed professional network might highlight opportunities for reciprocal free-of-charge agreements.

If the principal block is availability of supervisors, then this might give weight to the suggestion that a dedicated training course be run for chaplains. Alternatively, wider networking (e.g. via APSE) might reveal possibilities for pastoral supervision from other disciplines.

If the principal block is scepticism or opposition to supervision, then

advocates of supervision such as myself need to engage in a dialogue that not only profiles the benefits that we perceive, but engages with the dis-benefits or irrelevance perceived by others.

Summary of Issues for Discussion and Action

- 1 Where does supervision sit in professional standards? Specifically, should there be an explicit requirement for chaplains to receive supervision in order to be regarded as fit to practise?
- 2 Who should provide supervision? What are the pros and cons of chaplaincy managers supervising their own colleagues? Given a choice, where would chaplains seek supervision – with other chaplains, or outside Chaplaincy?
- 3 How do we develop supervising capacity? Is it desirable to commission a training course exclusively for chaplains? How do we set up effective networks?
- 4 What further information is needed to take forward supervision? For example, why do some chaplains not receive supervision?

References

- CHCC (2010). Full Report on the Members' Questionnaire conducted January 2010. London: CHCC.
- Inskipp F and Proctor B (1993). *Making the Most of Supervision* (Part 1). Bend, OR: Cascade Publications (referenced in Leach and Paterson 2010, p. 19).
- Kerry M (2010). An introduction to supervision. *Journal of Healthcare Chaplaincy* 10(1): 13–17.
- Leach J and Paterson M (2010). *Pastoral Supervision: A Handbook*, London: SCM Press.
- Lowndes R (2010). Supervision five years on. *Journal of Healthcare Chaplaincy* 10(1): 18–24.
- Sutherland M (2010). *A Theory and Model for Pastoral Supervision of Chaplains within the Healthcare Setting*. Cambridge: UKBHC.

UKBHC (2009a). *Spiritual and Religious Healthcare Competencies for Healthcare Chaplains*. Cambridge: UKBHC, standard 4.1.

UKBHC (2009b). *Chaplaincy Service Standards*. Cambridge: UKBHC, standard 5.1.

UKBHC (2010). *Code of Conduct for Healthcare Chaplains*, Cambridge: UKBHC, p. 7.2.

Ward F (2005). *Lifelong Learning: Theological education and supervision*. London: SCM Press, p. 5.

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'My Will Be Done': Liberating Patient Autonomy through Genuine Dialogue

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Abstract

Respect for patient autonomy undergirds many ethical commitments in health care, such as seeking patient consent for operations and treatment. However, the promotion of autonomy does not come without its own implications. Often, health-care practitioners objectively present patients with options and withhold their own experience and recommendations to avoid overly and overtly influencing patients. This supposes a practitioner's influence can reduce a patient's sense of autonomy and their ability to choose freely. In this article I suggest a more liberating approach towards patient autonomy, building on the philosophy of 'genuine dialogue' as put forward by Martin Buber in his classic work, *I and Thou*. I suggest Buber's principles can encourage patients and practitioners to interpose ideas and deliberate differences in order to serve the patient's best interests. Such an approach promotes collaboration between patients and practitioners so that patients are liberated to make autonomous decisions informed by both medical facts and the practitioner's experience.

Key Words

Buber; Genuine dialogue, Autonomy; Bioethics, Hospital

Main Article

Introduction

Over the last decade, health care has moved away from a paternalistic approach to patients towards an emphasis instead on patient autonomy. Autonomy is now one of the most significant values promoted by medical

ethicists. It is seen as a vital aspect of the relationship and interaction between patients and health-care practitioners (Beauchamp and Childress 2001: 57). Respect for patient autonomy forms the basis of many ethical commitments in present-day health care, such as seeking patient consent for operations, procedures and treatment (Mason and McCall Smith 2002: 8).

Autonomy is one of the four key principles of biomedical ethics, together with beneficence, non-maleficence and justice (Beauchamp and Childress 2001), but the promotion of autonomy does not come without its own implications. This is apparent in the so-called 'informed model' approach to medical decision-making (Bury and Gabe 2003: 231). In the 'informed model' approach, health-care practitioners objectively present patients with medical options but choose to withhold their own professional experience and informed opinion to avoid influencing patients one way or another (Faden and Beauchamp 1986: 240–1; Bury and Gabe 2003: 231). Therefore, the 'informed model' approach tends to confuse concepts of independence and autonomy by assuming that a health-care practitioner's influence will diminish a patient's ability to choose freely. The 'informed model' approach can also discourage active persuasion when differences of opinion exist between the health-care practitioner and patient.

Elaine: A Case Study

Patients contemplating serious medical decisions can sometimes be over- or under-influenced by their health-care practitioners. Consider Elaine, for example. I was asked to visit Elaine as the hospital chaplain and I listened to her story. Elaine was nearly 80 years old and very competently minded. She was married to Bill, and Bill and Elaine had been together for 60 years. They had an only child, Barry, who was married himself. Barry was in his fifties and his daughter, Elaine's granddaughter, was pregnant, almost full-term. Elaine had been admitted to hospital with a chronic illness. The health-care practitioners had discovered an aggressive, malignant tumour growing in her bowel. It was causing a blockage and subsequently Elaine could neither go to the toilet nor keep her food down. The health-care practitioners presented Elaine with two options: either an emergency operation to remove the tumour, or to receive palliative care instead. The health-care practitioners explained to Elaine that she would die if she did not have the tumour removed, but also, because of her age and the risks involved in

the operation, that the procedure would only have a 50 per cent chance of success.

Elaine talked with various health-care practitioners about the best way forward. Some over-emphasized Elaine's small chance of recovery and gave strong opinions that Elaine should never 'give up' and that she should choose to have the operation. Others made sure that Elaine understood her options and the associated statistics, but purposely chose to withhold their opinion that Elaine should choose not to have the operation. Finally, one doctor entered into an open conversation with Elaine. In the conversation, the doctor explored all the alternatives and he recommended that Elaine choose to have palliative care rather than the operation. Elaine, however, continued to insist on having the operation, and the doctor struggled with Elaine about her decision.

It was through this conversation that the doctor learnt the rationale behind Elaine's decision. Elaine had come from a nursing background and she had worked in hospitals for over fifty years. Elaine knew that she would die soon if the tumour was not removed. She knew that her chances of surviving the operation to remove the tumour were small. However, she also knew that her granddaughter was pregnant and Elaine desperately wanted to see her great-grandchild and hold the little baby in her arms. Through their conversation – their 'genuine dialogue' – the doctor could assure himself that Elaine was both competently minded and fully aware of her situation. And, because of their 'genuine dialogue', Elaine's autonomy had been liberated rather than compromised and, following Elaine's wishes, the doctor could begin preparations for her operation.

Decision-making, Patient Autonomy and Paternalism

Data from the 1995 Study to Understand Prognoses and Preferences for Outcomes and Risks of Treatment (SUPPORT Principal Investigators 1995) suggests that the method most used for medical decision-making is the paternalism exemplified by some of Elaine's health-care practitioners. However, respect for patient autonomy has increased over time and there are now cohorts of health-care practitioners that have been trained in a more 'patient-centered' approach (Laine and Davidoff 1996). Some 'patient-centered' practitioners have gone beyond involving patients in the decision-making process, and instead leave patients to make medical decisions almost

independently. In my case study, for instance, some health-care practitioners allowed Elaine to take full control of the decision-making, the practitioners purposely choosing to avoid the dialogue that would have resulted if they had shared their reservations. These health-care practitioners respected Elaine's autonomy, but they did so at the cost of withholding their own informed, professional opinions.

One doctor, however, did not take the excessive paternalism or 'informed model' approach. Instead, he encouraged Elaine to make the final decision, but only after he had explored all the implications with her and shared his opinion that the operation was not in Elaine's best interests. In this 'genuine dialogue', the doctor liberated Elaine's autonomy by helping her make a decision that fully integrated his informed, professional opinion with her own knowledge and experience.

In ages past, major medical decisions were left in the hands of the health-care practitioners alone. Dr Ingelfinger once wrote: 'If you agree that the physician's primary function is to make the patient feel better, a certain amount of authoritarianism, paternalism and domination are the essence of the physician's effectiveness' (cited in Gillon 1995: 67). Decisions were usually made in the spirit of beneficence but without any open discussion, nor the full participation of the patient (cf. Szasz and Hollender 1956; Perry and Applegate 1985; Emanuel and Emanuel 1992: 2221–6). This excessively paternalistic approach did have some benefits. Health-care practitioners struggled to make the best possible decisions on behalf of chronically ill patients, and they saved their patients and their families from having to agonize over procedures that had little chance of success. However, present-day medical ethicists now see the obvious problems with excessive paternalism. Raanon Gillon notes that

Kantians and pluralist deontologists will argue that there are many circumstances in which a person's autonomy must be respected even if to do so will result in an obviously worse decision in terms of the patient's, the family's, or, even, a particular society's happiness ... this conclusion is also supported by many utilitarians on the grounds that respect for people's autonomy is required if human welfare really is to be maximised. (1995: 71)

In cases of excessive paternalism, it can be difficult to identify what a patient's best interests might be (Schneiderman *et al.* 1993). Inappropriate

judgements based on gender, race, culture, religion and social and economic background can affect decision-making (Burstin *et al.* 1992; Harris 2001: 295). The opportunity for patients to make decisions that reflect the reality of their condition can be taken away. However, some of the beneficent potential of paternalism has also been lost (Illich 1976). Too often, 'autonomous' patients like Elaine can be asked to make critical decisions on the basis of neutrally presented statistics, without any bias or influence from the health-care practitioners. There are a number of factors that have contributed to this:

- 1 Consumerism has encouraged patients to question practitioners' recommendations, and to insist on interventions that might otherwise be withheld (Illich 1976; Barsky 1988).
- 2 Many health-care practitioners feel that giving patients the full range of options while withholding their own informed, professional opinion is a safeguard against litigation (Katz 1984: 35–44; Kassirer 1989).
- 3 The information and technology explosion in health care has left practitioners and patients uncertain about whether limitation in a given treatment is inherent in medicine or is a gap in the practitioner's expertise (Light 1979: 310–22).

Thus, many health-care practitioners feel that the safest course of action is to withhold their informed, professional opinion and instead give patients the choice of any treatment they might want. However, by following this so-called 'informed model' approach, practitioners are failing to use their power appropriately by withholding their informed, professional opinions, and so patients are being constrained in their decision-making (Bury and Gabe 2003: 238). The health-care practitioner as a person with skills, knowledge and experience has become a stumbling block rather than a resource for autonomous decision-making.

The 'informed model' approach illustrates a limited concept of autonomy (Ryan 1992: 1–56; Bury and Gabe 2003: 238). It holds that an independent choice is best made with no external influences. Instead, I would like to suggest a more subtle approach, arguing that autonomous medical decisions are not undermined by the input of a knowledgeable, skilled and experienced practitioner, but are instead liberated. I would like to suggest that it is only after participating in a 'genuine dialogue', in which practitioner and patient

aim to influence one another, that a competent patient might better appreciate their options and an experienced practitioner better appreciate the rationale behind their patient's thinking. One person who knew a lot about this was Martin Buber.

Martin Buber and 'Genuine Dialogue'

Martin Buber was born into a Jewish family on 8 February 1878 in Vienna (Kramer and Gawlick 2003: xv–xvi). As a young man, he studied in Vienna, Leipzig, Berlin and Zurich and he entered into the Zionist Movement for cultural and religious reasons. Buber became the editor of a renowned Jewish magazine and he lectured in Jewish religion and philosophy at the University of Frankfurt from 1924 to 1933. Before his death on 6 June 1965, Buber made many efforts to improve the understanding between the Israelis and the Arabs, and also to re-establish the dialogue with German thinkers and institutions. Throughout his life, the Hasidic movement heavily influenced Buber's thought and work. Hasidism was a popular movement in Judaism with a deep religious mysticism and longing for God (Kramer and Gawlick 2003: 88–90). For Buber, Hasidism represented a protest against legalistic faith, casuistics and intellectuality and it emphasized emotional values, piety, joy and active love. These commendable themes can be detected throughout Buber's writings.

In 1923, Buber published his classic work, *Ich und Du* (first translated into English in 1937 and published as *I and Thou*). In it, Buber concluded that all real living is meeting and all actual life is encounter. His philosophy of 'genuine dialogue' views human existence in terms of relations. An 'I-It' relation is the normal everyday one of a human being towards the things that surround them. A person can also consider their fellows as an 'It', viewing one another from a distance, like a thing, a part of the environment. Radically different is the 'I-Thou' relation. This we enter into with our innermost and whole being: in a meeting, in a 'genuine dialogue', this is what both of the partners do:

Our life with men is marked out. Here language is consummated as a sequence in speech and in counter-speech. Here alone does the word that is formed in language meet its response. Only here does the primary word go backwards and forwards in the same form, the word of address

and the word of response live in one language, I and Thou take their stand not only in relation, but also in the solid give-and-take of talk. The moments of relation are here, and only here, bound together by means of the element of the speech in which they are immersed. Here what confronts us has blossomed of the full reality of the Thou. Here alone, as reality cannot be lost, are gazing and being gazed upon, knowing and being known, loving and being loved. (Buber 2000: 102–3)

Building on his philosophy in *Ich und Du*, in his later work, *Between Man and Man*, Buber holds that there are three levels to dialogue (1947: 22). We can detect these in the conversations Elaine had with her various practitioners:

- 1 *Monologue disguised as dialogue*. That situation in which ‘two or more men, meeting in space, speak each with himself in strangely tortuous and circuitous ways and yet imagine they have escaped the torment of being thrown back on their own resources’ (Buber, in Kramer and Gawlick 2003: 33).
- 2 *Technical dialogue*. That communication which is ‘prompted solely by the need of objective understanding’ (ibid.).
- 3 *Genuine dialogue*. ‘Whether spoken or silent ... each of the participants really has in mind the other or others in their present and particular being and turns to them with the intention of establishing a living, mutual relationship between himself and them’ (ibid.).

‘Genuine dialogue’ happens when two people completely meet one another, just as it did with Elaine and her doctor. The dialogues between Elaine and her health-care practitioners only became ‘genuine’ when both Elaine and her doctor were fully present one to the other, and when they were openly attentive to all voices, and when both were willing to be non-judgemental. To Buber, ‘genuine dialogue’ moves and liberates us beyond the exchange of mere informational content, beyond simultaneous or duelling monologues, to an immediate, direct engaging and being engaged, in which attentive listening and inclusive responding flow back and forth (Kramer and Gawlick 2003: 33–4).

Patient Autonomy and ‘Genuine Dialogue’

Mindful of my case study about Elaine and Martin Buber’s philosophy, I suggest that, in order to respect fully a patient’s autonomy, health-care practitioners need to engage in ‘genuine dialogue’. In Elaine’s dialogue with her doctor, the doctor informed Elaine of the therapeutic possibilities and their chances of success. He also explored Elaine’s values and his own, and finally he initiated recommendations that considered both his and Elaine’s opinions. Buber’s philosophy of ‘genuine dialogue’ is strongly relationship-centred and it embodies a strong ethic of care (cf. Noddings 2003). It does not deny the potential imbalance of status and power between the health-care practitioner and the patient, nor the fact that some patients might be inappropriately coerced by an overzealous practitioner. A ‘genuine dialogue’, in which the practitioner openly admits his or her informed, professional opinion, is ultimately a better protector of the patient’s autonomy than any artificial neutrality would be. Indeed, empirical studies demonstrate that, in cases where patient autonomy is liberated, there are better outcomes in the treatment of substance abuse, obesity and the adherence to treatment regimes (Kaplan *et al.* 1989; Ryan *et al.* 1995; Williams *et al.* 1996).

A ‘genuine dialogue’ allows the health-care practitioner to liberate and guide a patient’s autonomous decision-making without surrendering the practitioner’s skill and knowledge on which the patient depends. The ‘informed model’ approach assumes that if the patient is to have the power to make autonomous choices, the practitioner must correspondingly lose their power, but in a ‘genuine dialogue’ the power between patient and practitioner is equal (Kleinman 1988; Bury and Gabe 2003: 238). Accepting the health-care practitioner’s power to offer an informed, professional opinion, while obligating the practitioner to fully understand the patient’s reasoning when those opinions are rejected, ‘a genuine dialogue’ liberates rather than compromises the patient’s power and autonomy.

Liberating Patient Autonomy

To use medicine in a more personalized way, Buber’s philosophy urges health-care practitioners to become experts not only in medicine but also in understanding patients as unique human beings, with their own individual values and stories that must be used to guide treatment. In the case of Elaine,

performing a dangerous operation on an elderly lady with cancer made no sense from a purely medical point of view. However, through their 'genuine dialogue', the doctor was able to understand Elaine's hope of seeing and holding her great-grandchild and in the end the doctor concurred with Elaine's decision to have the operation.

Although final decisions belong to patients, the decisions that result from the discussion of information, values and experiences between a practitioner and patient are usually more autonomous and informed than those made solely on the basis of a patient's wants.

So how can a patient's autonomy be liberated? Following Buber's philosophy of 'genuine dialogue', health-care practitioners need to share their expertise fully, while also listening fully to the patient's perspective. The patient needs to be respected as 'Thou', not 'It'. Information should be given in appropriate amounts and in a way the patient can understand. Time should be allowed for any questions, clarification or discussion. The medical ethicist David Seedhouse comments:

It is not possible for a person to express a free wish unless she knows the possibilities open to her. So if there are three types of surgery available, and the patient thinks there is only one, she may opt for it, but she will have done so with a lower level of autonomy than she might have had. (2003: 185)

As in the case of Elaine, health-care practitioners must learn about the personal meaning medical decisions will have in light of their patient's values and experience. Differences between the patient's values and experiences and those of the health-care practitioner will require careful exploration, and such exchanges will take time.

Any recommendations made by health-care practitioners must consider both the medical facts and personal experience. Most patients want to hear their practitioner's perspective, but the patient's values and experience should also be integrated into any recommendations. If a health-care practitioner has strong personal views about a dilemma a patient might be facing, the practitioner should openly acknowledge those views and help the patient understand them. Biases and relevant experiences should not be hidden but should become an integral part of the 'genuine dialogue'.

Disagreements should initiate a process of mutual exchange. This is all

part of a 'genuine dialogue'. When the health-care practitioner's recommendations and the patient's wishes differ, the patient and practitioner will need to discover areas of agreement as well as difference (Fisher and Ury 1981; Lazare *et al.* 1989; Quill and Suchman 1993). Agreement about treatment is unlikely when a patient and practitioner disagree about the nature of an illness, the prognosis, or the goals of treatment. Carefully breaking down a problem into its component parts and exploring each aspect in its own right usually leads to a more meaningful understanding and the opportunity for creative problem-solving. Dr Rita Charon takes just such an approach in her influential work, *Narrative Medicine*:

A 46-year-old Dominican man visits me for the first time, having been assigned to my patient panel by his Medicaid Managed Care plan. He has been suffering from shortness of breath and chest pain and he fears for his heart. I say to him at the start of our visit, 'I will be your doctor, and so I will have to learn a great deal about your body and your health and your life. Please tell me what you think that I should know about your situation.' (2006: 177)

It is hoped that through 'genuine dialogue', the health-care practitioner and patient will reach a shared understanding of the medical dilemma, the underlying stories and values involved, and the best course of action to follow. If a chosen course violates a health-care practitioner's fundamental values, he or she should let the patient know and perhaps help the patient find another practitioner.

Conclusion

Health-care practitioners need to continuously refine and express their own voices. They need to articulate values and opinions in an open yet sympathetic manner. As in the case of Elaine, a health-care practitioner's informed, professional opinion can form the beginning of a 'genuine dialogue' that will ultimately determine the operation, treatment or procedure a patient chooses. Health-care practitioners have a duty to support patients' autonomous choices. By taking the risk of informing patients like Elaine about their own feelings, values and recommendations, health-care practitioners can liberate medical decisions so that they are made both practical

and personal. Medical decisions always carry consequences, so how much better it is that they should be made in the context of a 'genuine dialogue' of ideas, values, feelings and experiences between the health-care practitioner and patient. The 'genuine dialogue' that characterizes decision-making by people who care deeply about the patient's well-being is a huge improvement on the coerciveness of excessive paternalism and the remoteness of the 'informed model' approach. In end of life cases like that of Elaine, and in so many other scenarios, final choices – whatever their outcome – belong to the patient. But these choices are liberated and gain meaning if they are the result of a 'genuine dialogue' of shared influence and understanding between the health-care practitioner and the patient.

References

- Barsky A (1988). *Worried Sick: Our troubled quest for wellness*. Boston: Little, Brown.
- Beauchamp T and Childress J (2001). *Principles of Biomedical Ethics* (5th edn.). New York: Oxford University Press.
- Buber M (1947). *Between Man and Man*. Abingdon: Routledge and Kegan Paul.
- Buber M (2000). *I and Thou* (trans. from the standard German edn, *Ich Und Du*, by RG Smith). New York: Scribner.
- Burstin H, Lipsitz S and Brennan T (1992). Socioeconomic status and risk for substandard medical care. *Journal of the American Medical Association* **268**: 2383–7.
- Bury M and Gabe J (2003). *The Sociology of Health and Illness: A reader*. Hove: Routledge.
- Charon R (2006). *Narrative Medicine*. New York: Oxford University Press.
- Emanuel E and Emanuel L (1992). Four models of the practitioner–patient relationship. *Journal of the American Medical Association* **267**: 2221–6.
- Faden R and Beauchamp T (1986). *A History and Theory of Informed Consent*. New York: Oxford University Press.
- Fisher R and Ury W (1981). *Getting to Yes: Negotiating agreement without giving in*. Boston: Houghton Mifflin.
- Gillon R (1995). *Philosophical Medical Ethics*. Chichester: John Wiley.

- Harris J (2001). Micro-allocation: deciding between patients. In Singer P and Kuhse H (2001). *A Companion to Bioethics*. Oxford: Blackwell.
- Illich I (1976). *Medical Nemesis*. New York: Bantam Books.
- Kaplan S, Greenfield S and Ware J (1989). Assessing the effects of practitioner–patient interactions on the outcomes of chronic disease. *Medical Care* 27(3 Suppl.): S110–27.
- Kassirer J (1989). Our stubborn quest for diagnostic certainty: a cause of excessive testing. *New England Journal of Medicine* 320: 1489–91.
- Katz J (1984). Why doctors don't disclose uncertainty. *Hastings Centre Report* 14: 35–44.
- Kleinman A (1988). *The Illness Narratives: Suffering, healing, and the human condition*. New York: Basic Books.
- Kramer K and Gawlick M (2003). *Martin Buber's I and Thou: Practicing living dialogue*. New York: Paulist Press.
- Laine C and Davidoff F (1996). Patient-centered medicine: a practitioner evolution. *Journal of the American Medical Association* 275: 152–6.
- Lazare A, Eisenthal S and Frank A (1989). Clinician/patient relations II: conflict and negotiation. In Lazare A (ed.). *Outpatient Psychiatry: Diagnosis and treatment*. Baltimore: Williams and Wilkins.
- Light D (1979). Uncertainty and control in practitioner training. *Journal of Health and Social Behaviour* 20: 310–22.
- Mason J and McCall Smith A (2002). *Law and Medical Ethics*. London: Butterworth LexisNexis.
- Noddings N (2003). *Caring: A feminine approach to ethics and moral education*. Berkeley: University of California Press.
- Perry C and Applegate W (1985). Medical paternalism and patient self-determination. *Journal of the American Geriatric Society* 33: 353–9.
- Quill T and Suchman A (1993). Uncertainty and control: learning to live with medicine's limitations. *Humane Medicine* 9: 109–20 [Electronic Journal]. At: www.humanehealthcare.com/Article.asp?art_id=400 (accessed 11 June 2010).

Ryan RM (1992). Agency and organization: intrinsic motivation, autonomy and the self in psychological development. In JE Jacobs (ed.). *Developmental Perspectives on Motivation*, vol. 40 of *Nebraska Symposium on Motivation*, Lincoln: University of Nebraska Press, pp. 1–56.

Ryan R, Plant R and O'Malley S (1995). Initial motivations for alcohol treatment: relations with patient characteristics, treatment involvement and dropout. *Addictive Behaviour* **20**: 279–97.

Schneiderman L, Kaplan R, Pearlman R and Teetzel H (1993). Do practitioners' own preferences for life-sustaining treatment influence their perceptions of patients' preferences? *Journal of Clinical Ethics* **4**: 28–33.

Seedhouse D (2003). *Ethics: The heart of healthcare*. Chichester: John Wiley.

SUPPORT Principal Investigators (1995). A controlled trial to improve care for seriously ill hospitalized patients: the study to understand prognoses and preferences for outcomes and risks of treatments. *Journal of the American Medical Association* **274**: 1591–8.

Szasz T and Hollender M (1956). The basic models of the doctor–patient relationship. *Archives of Internal Medicine* **97**: 585–92.

Williams G, Grow V, Freedman Z, Ryan R and Deci E (1996). Motivational predictors of weight loss and weight-loss maintenance. *Journal of Personal and Social Psychology* **70**: 115–26.

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Do We Attend Adequately to the Spiritual Needs of Mental Health Service Users when They Are Admitted to Acute Hospitals?

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Abstract

When 'cutting my chaplaincy teeth' in an acute district general hospital, my ministry included four inpatient wards for people with a variety of mental health diagnoses. My contact with them was limited but most valuable. Then Acute and Care Trusts went their separate ways and I moved to a large acute teaching hospital where non-psychiatric diagnoses predominated in my attention. Reading Cobb's (2008) *Mental Health Strategy for Sheffield Teaching Hospitals* was a wake-up call. If 20++ per cent of acute hospital patients have mental health-care needs, was I noticing them adequately? Was my assessment of their spiritual and religious needs different now from those early years? Moreover, given that I had not undertaken any training in mental health care since, what was the quality of my ministry? Was I actually competent in attending them? This article first summarizes my conclusions and then describes what led to them.

Key Words

Recovery approach; Spiritual needs assessment

Main Article

As my exploration of the questions listed in the Abstract, I undertook the following activities between August and December 2009:

- Participation in seven sessions of a weekly open forum, 'coffee and chat' run by chaplains and chaplaincy volunteers, for self-referring, residents

of the Sheffield Health and Social Care (SHSC) Longley Centre adult and elderly wards. The chaplaincy team host and facilitate conversations, largely around matters raised by service users – whether sacred or secular, light or substantial, general or specific. An excellent forum in which to re-encounter the diverse span of conditions, hopes and issues pertaining to folk with mental health difficulties.

- Consequent on the above, visits to the general wards of Longley Centre – Hawthorne (elderly), Maple and Rowan (under 65s).
- One accompanied visit to the SHSC Forest Lodge low secure unit (mainly for patients on forensic sections) to celebrate Holy Communion with two service users.
- Participation in three open group sessions in the PICU (psychiatric intensive care unit) of SHSC. These were themed: one on ‘our origins – where we come from’, one on ‘hopes – our aspirations for the future’ and the third a Christmas Carol service with reflection and prayer. Service users who wished to ‘opt in’ attended. One session led to further time with a distressed, recently admitted patient.
- Attendance at a day of the CHCC-sponsored Mental Health Chaplains Annual Study Conference titled ‘Recovery – putting us back together’. This included two lectures, four workshops and time for plenary and individual discussions.
- Reading – see the References, below.

Overall Benefits of the Above to This ‘Pupil’

- Contact with service users noticeably increased my confidence in being with them.
- An appreciation of current mental health-care philosophy, especially the ‘Recovery’ approach, coupled with renewed and new perceptions of how this is applied through nursing, occupational health, chaplaincy and other disciplines. A ‘work in progress’ is considering areas of applicability for ‘Recovery’ in acute hospitals.
- A renewed and deepened appreciation of service users: their lives; some of

their challenges; a little of their social, relational and other issues; and their use of, and interaction with, health services (including chaplaincy).

- With the above taken together, my increased capability. I became more attentive, perceptive, discerning and appropriate in making spiritual care assessments. I also felt that my practice will be safer – for the service user, for hospital staff and for myself.

Philosophy of Care: Recovery Approach

Hugh Middleton, former consultant psychiatrist, now with an academic base at Nottingham University, spoke to the Mental Health Chaplains Annual Study Course. The following is a précis of what he said:

- Neuroscience and pharmacology are beneficial, but within limits. More holistic approaches are being developed and applied aimed at encouraging and nurturing post-traumatic psychological recovery and growth. Similarities between these approaches and the support and encouragement that occur through faith practices are apparent. Spiritual care, not least delivered through chaplaincy, is affirmed as appropriate and potentially beneficial.
- Key drivers of recovery include: (a) acceptance: by self, for self, and by others; (b) recovered locus of power and control (societal issues – the sociology of illness); (c) dependence/independence/interdependence (finding balances).
- Particularly sensitive understanding is required with regard to chronic conditions (e.g. dementia). What does ‘recovery’ mean for them? How can we give attention to small moments of grace?
- Clinical categorizations and diagnosis (e.g. psychosis, neurosis, psychopathology) are not always helpful. They can get in the way of attending to the human need that is before you.
- The person-centred approaches to therapy of Carl Rogers, Martin Buber and others are particularly relevant.

Hugh listed barriers to the outworking of the recovery approach – risk-averse health structures, bureaucratization of care, corporate governance,

professional interests, commercial interests (particularly pharmaceutical), public perceptions and positivism (science, evidence-based practice, notions of the deserving/undeserving poor).

People speaking of the recovery approach, both at the conference and locally, speak as though from a base assumption that mental ill health, while affecting individuals in particular ways, is a condition of society as a whole. This is reflected in SHSC Trust's Strategic Aims, which are very societal in approach. (I remembered a GP once referring to a young male patient with a psychiatric condition as 'the repository of that family's mental ill health'.)

He concluded by saying that respect for the service user's humanity is highly valued.

Application of the Recovery Approach in Residential Mental Health Care

- All the spaces visited appeared substantially clean, well-decorated and ordered.
- Service users were seen participating in aspects of their own care, e.g. a group discussion (service users and nurses together) to resolve some issues to do with ward organization.
- Substantial investments in providing appropriate stimulations to nourish recovery, by nurses, occupational therapists and chaplains, were seen. Examples would include the chaplaincy-run 'coffee and chat' and an Eid party led by Sabia Rehman (chaplain).
- I was told of positive efforts to recruit (former) service users into caring roles, either as volunteers (e.g. service user volunteering with chaplaincy services) or contractually (mental health nurse who herself has psychiatric illness history).
- Authority, while clear and firm, showed respect and focused on reason and negotiation. Notably, many of the nurses were younger, female, of moderate stature, yet appeared respected, trusted and were cooperated with. No doubt, robust intervention is needed at times (and is at hand) but this was not made unnecessarily evident.

Relevance of the Recovery Approach in Acute Hospitals

I asked two of our ward managers about dementia care (with which they are very experienced). Both resisted the idea of a different philosophy of care for some patients. All patients should be treated with the same approach of care, adapted to suit individuals' needs if/as necessary. It was helpful to be reminded *not* to start from a notion that psychiatric service users are a different species. However, they may, and often do, have particular characteristics. I noted the following:

- In residential mental health care, service users are not encouraged to spend their days either in their bed or immediately adjacent to it. They have a degree of autonomy in their daily regimes and will be encouraged to use it. They may therefore find acute hospital regimes constraining and difficult to relate to or accept.
- In residential mental health care, service users are commonly allocated their own bed space and allowed to personalize it. In an acute hospital the absence of such privileges may give rise to anxiety, paranoia or related behaviours.
- Where permissible, service users are able to leave their ward to undertake chosen activities. Being far more interventionist, acute regimes may find this difficult to accommodate.
- Compared with most acute admissions, the stay in mental health care is relatively long. Relationships between service users and staff, therefore, tend to be more enduring, stable and trusted. By contrast, when in acute care, relationships with staff are often transitory. Service users may find this difficult and destabilizing.
- Compared with acute medical consultations, consultations with mental health professionals are frequently longer and may be more holistic, e.g. include greater consideration of social dimensions of a client's life.
- Acute hospitals (especially those with a surgical specialism?) depend significantly on patient compliance in order to achieve high productivity. People with mental health problems can be either excessively compliant, have difficulty achieving compliance, or may be manipulative. Any of these can be sources of tension.

Notwithstanding the above, it would be an interesting and potentially useful study to consider the relevance of Recovery Approach principles to acute hospital care as a whole. In some areas at least, some of the ideals are already evident in practice (e.g. when recovering from a spinal injury) but other areas may have more to learn/gain.

Theology and Spiritual Care

To have a mental illness is not to have different needs and hopes of God. The desire for something of ultimate goodness, to look to, trust, live by and be loved by, sounded much the same as it does in conversations in other places. Ethical discussions *may* have been *more* sophisticated and self-pity less frequently expressed – I have insufficient evidence to make these into statements – but I feel there is work to be done here into differing theologies of suffering which may be in play.

As in the community at large, these spiritual aspirations may be drawn upon through one religious identity (e.g. Roman Catholicism) but today it is not unusual for an individual to be working with a complex of religions and philosophies. Perhaps because with mental illness the search for health and peace may be long and hard, or simply because of a natural interest, some service users acquire a considerable body of such knowledge, which may or may not be accurate/orthodox/coherent.

As with any health distress, when service users are unwell there are added risks of distortions in perceptions about God, which may reflect the condition (emphasis on dark or satanic forces, aggrandizement of the persona, e.g. 'I am Jesus', and others). These can sometimes be obsessive and in some situations are potentially harmful.

Mostly I felt the approaches of spiritual needs assessment and care delivery that I would commonly use in the acute hospital remained relevant and adequate (which was affirming) but I noted some particularities:

- Some conversations about God could have been very lengthy but perhaps increasingly philosophical and lacking in spiritual care direction. I need to have a focus and keep with it.
- The desire of some to engage exceeded their capacity to focus and sustain. Fewer words, fewer demands and brevity in prayer may be most effective.

- As with chronic conditions we meet elsewhere, aspirations in prayers need sensitivity. We do not denigrate the possibility that God might make them well, but ‘you will be able to sleep tonight’ may be a more appropriate grace to pray for.
- It may take longer to build the relationship, establish trust, agree on matters of substance.
- Results of exchanges may be less tangible, less susceptible to quantification.
- Some service users are wary of other people’s agendas and hence may become defensive/withdrawn/uncooperative. Agendas need to be kept to a minimum and there needs to be openness about them.

Memorable Glimpses / Some of my ‘Growing Moments’

Faith burnt out or realized eschatology?

A mature female with a bipolar history, now mostly a managed condition for her. When well and active she does voluntary work. Some weeks into our acquaintance, while we were washing up, she told me she didn’t believe in God any more, explained that she used to believe, prayed, went to church, ‘even through the years of my husband’s abuse and my worst times of illness; but not any more’. She went on: ‘Now I live alone quite happily and it’s enough that I love my life, the people I live among and visit, the beauty of nature. That’s enough for me and I have peace with it. Maybe you think I shouldn’t be involved with chaplaincy?’ (my précis of her words). I disagree strongly, but find it difficult to explain why.

Defining sanity?

I’m taken to meet a service user Julian Raffay has been seeing, for religious discussion. She is educated, articulate and has significant knowledge of her religion (Christianity). Her religious thinking is coupled with a world philosophy that might be described as ‘idealistic Marxism’. Her expressed thoughts have, to my ears, more than passing similarities with the Sermon on the Mount. It’s only a glimpse. I know nothing of her psychiatric history or how it affects her living. That she is an admitted service user suggests there are problems with her well-being. But within this is there a possibility her faith/world ideology clashes with the Western capitalist etc. structure which

has described, and set about caring for, her condition? How do I know that she isn't 'sane', even 'super-sane' – 'visionary' – and it is 'us' finding her self-presentation unacceptable that leads 'us' to describe her as 'unwell'? I haven't nearly enough data to develop any rationale, but can't quite put out of mind the old Christian 'saw' about Jesus – was he mad or was he the Son of God?

Snakes in the bed

(Remembering an early chaplaincy experience.) A night call to a mature female experiencing distress. She was articulate and explained she had a psychiatric history. When well she worked as a nurse consultant, she knew that her distress that night arose from a psychotic episode, but was not coping with its effects. I asked how I might help. She said, 'This bed is full of snakes.' What did I do then (can't remember much detail) and how would I do things differently now? This proves a limited reflection because so much depends upon the specifics and details of the moment, *but* it is good to find myself listing the many, many ways I/we make assessments of spiritual needs, to recognize that experience has given me confidence to take time to do this, and how much more I'm now focused on 'them and their needs' rather than 'me and my solutions'. This is affirming.

De-escalation matters

(Another early chaplaincy experience.) I approach a doorway towards another section of the ward. A patient, previously unnoticed, moves and blocks the doorway facing me. My reaction is slow and I only just avoid walking into him. Not yet confident on the ward, I am not ready with an appropriate response. The meeting of our eyes and his body language are challenging. I've walked into difficulty. A (thankfully sharp-eyed) nurse says in an even tone from somewhere behind me 'OK "Bill", that's enough of that. Let the chaplain through.' And he does. Later in the session, I thank the nurse. She responds coolly. The learning penny drops. By necessitating her intervention, I've let down not only the care team but also the patient. I'd put his healing/recovery momentarily at risk.

Motives: 1

After a few weeks of visiting, some comfort and confidence grows in the company of service users. They are complex, interesting and rewarding. Most are gratifyingly accepting of my involvement, but then questions of my

motives start coming in. Do I truly have something to give, a competence to minister? Why am I doing this? Is there some element of pride in being able to be with these people whom the world finds strange, an ego trip in being able to 'hack PICU'? I become grateful for the questions. They lead to useful self-examination. As ever, my own motives prove multi-layered and complex. There's nothing new in that, but it's a duty of ministry to be self-examining in this way, and in this place it seems especially important because some of the service users are highly sensitive to any falseness.

Motives: 2

I'm requested to attend a mature, female patient in my base hospital. The referring nurse seeks a meeting prior to the visit in order to explain the patient's psychiatric needs. Julian Raffay and I visit together – first the nurse, then the patient. The patient deflects questions that seek to establish how chaplaincy might positively help but is keen to have us empathize with her problems. She is also personally intrusive, asking questions about our private lives. Three months later the patient remains in hospital and is visited by the RC chaplain for sacramental care. Our perception is of developed hypochondria, to the extent of generating care from others as the prime focus of her life. Our perception is that she is highly manipulative, a trait we seek to deflect/avoid. Our perception is that her hospitalization is a (medically fruitless) manipulation of her own. Who will move this forward? Psychiatric services? Medics? Chaplaincy?

Personal space and physical contact

(1) A young female resident has her hand/wrist painted with henna at the Eid party organized by a chaplain colleague. I have been advised she is severely damaged; this is apparent in the outward evidence of extensive self-harm. I have not spoken to her before and this seems an opportunity for a gentle, non-threatening approach. 'What a wonderful design. May I see?' I am perhaps a bit less than a metre away and not making any sign of intention for physical touch but it is immediately apparent I am too close. Possibly my manner and the clerical collar are enough to enable her to decline my approach in an orderly way. Another male service user comes up minutes later and makes a similar approach to her (copycat?); she reacts negatively with considerable agitation; occupational therapists and nurses intervene. Calm is restored.

(2) I was called early in the morning to pray with a patient from a secure hospital prior to his surgery. In a single room, nurses are busy prepping him for theatre, timed for 'very soon'. With difficulty, I negotiate time and space to do what he clearly desires. With all this, although I find their presence a bit odd, I don't attend much to the four other men (friends?) in the room, who are not very responsive to me anyway. The patient is 'sluggish' (pre-med.?) but otherwise engages well and ministry proceeds. At the end of prayer time I lay a hand on his shoulder to say words of blessing. This is a pivotal moment of knowledge. I become aware of sudden attention from the four men behind me (they are actually mental health nurses), but the hand feels in the right place. It was that particular sense which occasionally comes when you touch someone while praying for them. Reflection later suggests the touch would probably not have taken place if my prior 'situation appraisal' had been 'proper'. So maybe incompetent practice was redeemed, or grace prevailed? More likely it was God working through the mess as usual and me learning a bit more.

(3) A young male, recently admitted to PICU, is distressed. In the course of ministry to him from Julian, with myself attending, the man becomes distraught, overcome with tears, steps towards me and throws his arms around me. He's young, big and feels very strong. I receive his embrace. Julian and three nurses skilfully move us to a seated space where we can continue the ministry safely. Later Julian gives more helpful teaching on self-protection – escape plans and the danger of strangulation in this case. I take this seriously, but also recognize again the loneliness of mental illness. When I'm upset I want a hug.

The Coventry Carol in Sheffield PICU?

(This carol contrasts the image of a newborn baby Jesus with the suffering which will befall him in adulthood.) It is Christmas Eve in PICU and Julian leads a carol service. We (an occupational therapist and, from time to time, between two and four service users) take it in turns to choose the next carol, and we talk a bit between times. One talks of a past life experience; another struggles to deal with the carol sheet and participate but is clearly motivated to do so; another comes and goes from where we are with raised hands tracing things unseen by us around the walls. And so on. It has a strange but tangible beauty. It is their Christmas service and Julian leads with gentleness, respect and integrity. There was gladness and thankfulness expressed by the residents. It was a great privilege to participate and I wouldn't have missed

it, but I do find myself needing a good cry when I get home. Madness is a terrible place to be sometimes.

Grace in mutual recovery

It is Thursday afternoon and time for 'coffee and chat'. There is a good response this week with about seven service users present. One seems to have an anxiety attack, vomits and elects to withdraw. The cleaning-up and escorting is done unobtrusively and gently. The response is 'low-key'. Another is approaching discharge date. There are mixed feelings for her and for those she is close to on the wards. All responses to her from the service users seem utterly appropriate and sincere. It would be silly to get utopian about this; this is a good, easy moment, there are others, but in times like this you can see so clearly that a philosophy embracing the notion that they can be their own best therapists makes great sense.

To see ourselves ...

To sit with the mentally unwell with any openness is to be invited to look into our own mental health. They are a mirror to the mind. So I've just been offered, and I hope have received, a mental health check. From this I'm aware of a couple of areas about myself I want to ponder further. I've been helpfully reminded that none of us is yet complete in mental health, and all of this I owe to the service users. They are emphatically not another category of human being.

Personal Conclusions and Recommendations

- 1 The separation of Acute and Mental Health Trusts has been a loss to the training and skills base of acute chaplains, with regard to attending to the spiritual needs of mental health service users. In particular, the loss of engagement with service users and nurses in residential mental health care leaves (some) acute hospital chaplains less well equipped to give support than was formerly the case.
- 2 Many first-line acute hospital care staff (nurses, support workers, etc.) have as little, often less, training/experience in this field as chaplains.
- 3 Some models of contemporary acute chaplaincy have common ground with the 'Recovery Approach' deployed widely in mental health care. Thus

acute chaplains, potentially, are well placed to provide spiritual care to these clients.

- 4 Means to fulfil this opportunity could at least include:
- exploring cross-Trust skill-sharing between chaplaincies;
 - providing placements for acute chaplains into mental health care units;
 - inviting guided reading from Care Trusts for acute chaplains;
 - sharing developmental and/or training opportunities (e.g. reflective practice);
 - encouraging attendance at appropriate training days, workshops, etc.;
 - considering cross-Trust chaplaincy employments in future recruitments.

Engaging with patients with acute mental health distress requires particular approaches. It probably isn't for every chaplain and we are only one of the 'helps' available to mental health service users while in acute hospitals. But our scope to contribute is significant and possibly greater than we are realizing.

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Further Reading

Bentall RP (2004). *Madness Explained: Psychosis and human nature*. London: Penguin Psychology.

Cobb (2008). *Mental Health Strategy for Sheffield Teaching Hospitals* (March). Sheffield Teaching Hospitals NHS Foundation Trust.

Cornah D (2006). *The Impact of Spirituality on Mental Health*. London: Mental Health Foundation.

Deegan P (1996). Recovery as a journey of the heart. *Psychiatric Rehabilitation Journal* **19**(3): 91–7.

Lindridge A *et al.* (2007). *Keeping the Faith: Spirituality and recovery from mental health problems*. London: Mental Health Foundation.

Sainsbury Centre for Mental Health. 'Ten Top Tips' for recovery oriented practice. At: www.scmh.org.uk.

Sen D (2006). *The World is Full of Laughter*. London: Chipmunkpublishing.

Sheffield Mental Health Partnership Board. *Sheffield Strategy for Mental Health and Wellbeing*. At: www.dh.gov.uk/en/Healthcare/Mentalhealth/NewHorizons.

Shneidman ES (1996). *The Suicidal Mind*. Oxford: Oxford University Press.

Swinton J (2000). *Resurrecting the Person*. Nashville, TN: Abingdon Press.

Report by the Mission and Public Affairs Council of the Church of England. *Continuing Issues in Mental Health*. GS1678. London: Church House Publishing.

Royal College of Psychiatry (2006). *Spirituality and Mental Health*. At: www.repsych.ac.uk/mentalhealthinfo/treatments/spirituality.aspx.

Tidyman M and Seymour L (2004). *Promoting Mental Health: A resource for spiritual and pastoral care* (October). NHS/Archbishops' Council of the Church of England and National Institute for Mental Health in England.

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Separating Religion and Spirituality

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Abstract

The scientific study of religion and spirituality is less than half a century old. They have traditionally been viewed as overlapping aspects of the one construct. 'I'm spiritual but not religious' is a common phrase. This article examines the various definitions of spirituality and argues that, as research in this area develops, differences are emerging. Thus equating spirituality with religiousness is likely to lead to a misunderstanding of their respective roles in building mental health resilience and will not enable scientists to answer questions such as 'Is religion good for your mental health?' Questionnaires that measure these separate domains are described.

Key Words

Religiousness; Spirituality; Definition; Questionnaires

Main Article

Introduction

The scientific study of religion and the impact it has on people's lives is relatively new. In 1972 George Comstock, an epidemiologist at Johns Hopkins Medical School, published a paper examining the link between mortality and church attendance in the general population. Now, more than two-thirds of the 126 medical schools in the USA run modules on religion and healing, up from three in 1992, and the first textbook of religion and health was published in 2001 (Koenig *et al.* 2001), with a second edition due in 2012.

Recently the *American Journal of Psychiatry* ran an editorial on the topic (Curlin *et al.* 2007) suggesting that the long-standing lack of interest among psychiatrists concerning the religious beliefs of patients may be passing. The American Psychiatric Association (1990) and General Medical Council of Britain (2008) have issued their own guidelines on approaching religious beliefs among patients.

Notwithstanding the possible increasing recognition by psychiatrists that religion may for some patients be an important aspect of their lives and also a contributor to their ultimate outcome, those in the general public increasingly describe themselves as spiritual but not religious. What is meant by spirituality in this instance is often unclear. For most it implies some type of reflection about life itself or aspects of life. This may range from examining the role of God or a supernatural force in our lives to considering the state of the world at present. For many it is clearly distinct from religion, as the comment 'I'm spiritual but not religious' implies. It is not tied to any institutional practices or (for the most part) traditions, nor are there any prescribed codes of conduct underpinning it in the generality of cases. That the construct known as spirituality is variable is demonstrated in a study by Bibby (1995) in which Canadian adults were interviewed and 52 per cent expressed their spiritual needs in conventional religious terms such as belief in God, attending church and so on, while 48 per cent expressed these in more abstract terms, e.g. wholeness, reflection, etc.

This separation was not always present and for centuries spirituality was seen as central to and part of religiousness. Indeed religion was the all-encompassing parameter within which religion was subsumed. Those who were spiritual were seen as especially devout and engaging in practices that not only included church attendance and prayer but also contemplative exercises such as meditation, fasting, study of sacred texts and eremitic monastic practices. Gradually this balance changed and spirituality superseded religiousness as a more widely embracing domain. Nevertheless, spirituality was still trained on the supernatural, that may have included a personal God or, if not, then on a power greater than oneself.

With the reaction against institutional religion in the 1960s alongside the growth in secularism, the concept of spirituality began to encompass those who were secular and for whom spirituality did not relate to any concept of the Divine or of the supernatural.

Does It Matter?

Some may believe that questioning the overlap or separation between religion and spirituality is an exercise in hair-splitting that is irrelevant in clinical and pastoral settings. This is only partially true. In arenas such as pastoral counselling the difference is not relevant since all counsellors, pastors and therapists should work within the framework of the person's world view whether it be a largely religious one, a spiritual one without any religious connotations, neither, or a combination of both. All should be offered hope and meaning whatever their perspective.

However, if we wish to answer questions that examine the relationship between spirituality/religion and health then it becomes more relevant. Problems relating to measures of spirituality and to the failure to separate religiousness from spirituality have been powerfully articulated by Koenig (2008) and my consideration of this has been influenced by the writing of Koenig.

There is a populist view that participating in a church or in some other institutional form of religion is unimportant since individuals find their own meaning without any formal religious beliefs, or indeed with none. This is what many refer to as a spiritual outlook. Others believe that religious practice *per se* is crucial, while some see spirituality as the more reflective element in religiousness. It is clear that the word 'spiritual' holds different meanings for different people and therein lies the problem with much research – the nuance of the term is not acknowledged. We must have a means of evaluating this, rather than assuming that spirituality and religion are identical and that they contribute equally to health. With this perspective in mind, one is able to ask questions such as 'Do religious beliefs and spirituality contribute equally to recovery from depressive illness?' or 'Are suicidal thoughts more or less common in those with spiritual beliefs as compared to those who engage in religious practices?'

Having found some answers to these questions, it is then important to ascertain the mechanism by which this influence is exerted. Take the question of longevity – it has been shown that those who actively engage in public religious practices live longer than those who describe themselves as spiritual (McCullough *et al.* 2000). It is obviously important to understand how this effect comes about. Is the beneficial effect due to the moderate lifestyle of those engaged in religious practice? Is it that those who are healthy are better

able to attend church? Are the benefits the result of having a social outlet or social supports? Is there something over and above these obvious variables that influences longevity? Indeed, the social aspects of religion are recognized by atheists as being of importance, hence their claims that being in a football team or a book club would have the same effect. These are important questions to examine if we are to holistically understand protective and risk factors and those attributes that influence health outcomes.

These research questions can be summarized as follows:

- Are religiousness and spirituality important measures in health research?
- Are both equally important?
- Do spirituality and religiousness influence different domains of outcome?
- How do they exert their benefits, e.g. social support, prayer, meaning, hope, lifestyle, moral injunctions?

Delineating the Groups

The spiritual but not religious group is a relatively new category that was identified by Roof (2001) as emerging from the baby boom generation. Born to postwar parents, they spawned the social revolution of the 1960s and shifted the focus away from the institution of religion to the 'search' of the individual and defined their own gods. One study (Zinnbauer *et al.* 1997) shows that this group tend to view religiousness in a negative light and are less likely to engage in traditional forms of worship as compared to those who describe themselves as religious. They are, however, more likely to be more independent of others, to hold 'New Age' beliefs and to have mystical experiences. They also view spirituality and religion as non-overlapping constructs and are described in table 1 (*see p.42*).

The new group (spiritual but not religious) clearly demonstrates that 'spirituality' is a broad construct and that it spans several groupings. Table 2 (*see p.42*) shows four possible categories comprising religiousness and spirituality and clearly demonstrates that regarding both of these as synonymous is an oversimplification.

That these groups self-identify was exemplified by one study (King *et al.* 2006), which found that 17.7 per cent identified themselves as neither religious nor spiritual, 13.1 per cent described themselves as spiritual but not

Table 1. Religion vs. spirituality

Authoritarian	From within
Denominational	Personal
Linked to community	Autonomous
Ritualistic	Not hidebound
Stipulates behaviours and rituals	Morality individualized
Personal God or Supernatural	Supernatural not necessary
Beliefs	Experiential

Source: Zinnbauer *et al.* (1997).

Table 2. Classification of spiritual, religious and secular persons

1 Spiritual and religious	This classification represents the traditional view of the relationship of one to the other
2 Spiritual but not religious	This is the newest group
3 Neither religious nor spiritual	This is the secular group
4 Religious but not spiritual	This group has received little or no attention but might represent the group with an extrinsic religious orientation

Source: Allport and Ross (1967).

religious, while 69.2 per cent described themselves as religious (and spiritual), leading to the conclusion that three of the groups identified in table 2 do exist. They should form an important comparison group against which to compare the benefits or harm of religiousness or spirituality.

For research into spirituality and religion to continue, it is important to delineate these various categories. While the first and third in table 2 are clearly identifiable and the fourth in all probability is rare, probably being those who engage in religious practice by compulsion or habit but without internalizing its message, the second group is relatively common and is distinct from the religious group. The third group however, the secular group, who are neither religious nor spiritual, face extinction as the concept of spirituality broadens to incorporate personal beliefs or feelings into the

definition. By default they may merge with the spiritual but not religious group (see Definitions, below).

Definitions

Religiousness is easily defined as participating in a set of beliefs, practices and rituals related to the sacred. The sacred is defined as ‘that which relates to the numinous (mystical, supernatural) or God, and in Eastern religious traditions, to Ultimate Truth or Reality. Religion may also involve beliefs about spirits, angels, or demons’ (Koenig 2009).

On the other hand, spirituality is more difficult to define, although it is a more popular term now than is religion. It is more personal, less associated with rules, institutions and the restrictions of religion. One definition that is widely accepted is that of Ellison (1983):

Spirituality is universal, yet unique to every person ... [spirituality] enables and motivates us to search for meaning and purpose in life. It is the spirit which synthesises the total personality and provides some sense of energising direction and order. The spiritual dimension does not exist in isolation from the psyche and the soma. It affects and is affected by our physical state, feelings, thoughts and relationships.

This definition is difficult to conceptualize and apply to the scientific study of the issue.

Another, by Hill *et al.* (2000), defines spirituality as ‘the feelings, thoughts, experiences and behaviours that arise from a search for the sacred. The term “search” refers to attempts to identify, articulate, maintain or transform. The term “sacred” refers to a divine being, divine object, Ultimate Reality or Ultimate Truth as perceived by the individual.’ This clearly places spirituality in the space of the supernatural or sacred and it is more akin to that of the traditional view of spirituality.

The World Health Organization has developed the World Health Organization Quality of Life measure (WHOQOL) (WHOQOL Group 1998) with a subscale that measures spirituality, religion and personal beliefs (WHOQOL-SRPB). While describing eight dimensions (connectedness to a spiritual being/force, awe, meaning of life, wholeness/integration, spiritual strength, inner peace/serenity/ harmony, hope/optimism and faith) that might capture

religiousness and spirituality, the instructions for completing the questionnaire remove any meaning linked to religiousness and instead broaden the definition of spirituality beyond recognition to include the possibility that belief in aliens constitutes a spiritual dimension.

The following questions ask about your spiritual, personal or religious beliefs. These questions are designed to be applicable to people coming from many different cultures and holding a variety of spiritual, religious or personal beliefs ... Alternatively you may have no belief in a higher, spiritual entity but you may have strong personal beliefs or followings such as beliefs in a scientific theory, a personal way of life ... While some of these questions will use words such as spirituality, please answer them in terms of your own personal belief system, whether it be religious, spiritual or personal.

One of the results of this broad definition was shown in a study of the relationship between quality of life and spiritual, religious and personal beliefs (WHOQOL Group 2006). Using the WHO questionnaire and interviewing 5,089 people from 18 countries, it found that in the analysis the measure of spirituality/religiousness explained 65 per cent of the variance in the quality of life score. A contribution of this size is implausible and is almost certainly due to the broadness of the definition and the fact that feelings of well-being (such as hope and optimism) were included as measures of spirituality and also as measures of quality of life. This is known as confounding. If this approach was widely accepted, then those who see themselves as neither religious nor spiritual (see table 2) would be included with the spiritual group, a position that they may wish to eschew.

For further discussion of the problems of other commonly used rating scales for spirituality the reader is referred to Koenig (2008).

Questionnaires for Measuring Religiousness and Spirituality as Separate Constructs

Those engaged in the science of religion, interested in evaluating the differential effects or otherwise of religiousness and spirituality, are going to be challenged in a number of respects unless the measures chosen for this are carefully selected. The first and most significant is that questionnaires which

distinguish one from the other are scarce. Indeed, most studies have used simple statements from subjects about religious and spiritual practices in combination. There are, however, now some schedules available that either focus on one aspect or that facilitate this by allowing for subscale measures to differentiate these.

The measure of religiousness which is the most simple to use, has been validated and meets the criteria delineated above, is that by Koenig *et al.* (1997). This is a five-item measure for use in health outcome studies (known as the Duke University Religion Index – DUREL) and consists of five questions. The first relates to church attendance or other religious meetings, the second to private religious activity such as prayer, meditation or bible study and the final three to the impact of these on one's life and approach to life. The directions on the questionnaire were to 'answer the following questions about your religious beliefs and/or involvement. Please indicate your answer with a checkmark.'

The questions can be summarized as follows:

- 1 How often do you attend church or other religious meetings? (rated on 6-point scale)
- 2 How often do you spend time in private religious activities, such as prayer, meditation or Bible study? (rated on 6-point scale)
- 3 In my life, I experience the presence of the Divine (i.e. God). (rated on 5-point scale)
- 4 My religious beliefs are what really lie behind my whole approach to life. (rated on 5-point scale)
- 5 I try hard to carry my religion over into all other dealings in life. (rated on 5-point scale)

A measure of spirituality/religiousness with clear definitions of the various groups (religious, spiritual but not religious, etc.) was developed by King *et al.* (2001). The questions are not contaminated by any measure of psychological well-being and the focus is clearly on the supernatural or on powers greater than oneself. Both of these tools thus allow for the separation and independent evaluation of these dimensions in research.

For a comprehensive list of tools to measure religion and spirituality, the reader is directed to Koenig *et al.* (2001).

Is There Any Evidence that Religiousness and Spirituality Have Different Influences?

This question has not received a lot of attention due to the inclusion of religion and spirituality into a single measure in most studies. A few have separated them and the results, while tentative, suggest that there may be value in exploring this in greater depth than has hitherto been the case.

A Canadian study (Baetz *et al.* 2004), arguably the largest of its kind, examined over 70,000 adults as part of a multi-wave longitudinal study. Its aim was to identify the relationship of spiritual or religious self-perception and religious worship to depressive symptoms. Background confounders that might cloud the picture were controlled; these included socio-economic, demographic (e.g. age) and health variables. Those who attended church more frequently had significantly fewer depressive symptoms, while those who stated that spiritual or religious values were important to them, or perceived themselves to be spiritual or religious, but who were not involved in religious institutions, had higher levels of depressive symptoms. Clearly, the relationship between spirituality and religiousness is complex, but the findings suggest that formal involvement in worship carries benefits that are not obviously evident among those with more diffuse attitudes (such as merely perceiving or stating themselves to be spiritual or religious).

King *et al.* (2006) examined six ethnic groups in Britain. Comparing the combined religious/spiritual group with those who are neither, no difference in the prevalence of common mental disorders (CMDs) was found. However, when the spiritual group who did not practise religion were compared with those who did engage in religious practice, CMDs were twice as common in the former. A more recent study on suicidal behaviour (Rasic *et al.* 2009) found that self-harm behaviour such as overdosing and cutting was lower in a group who were religiously practising in comparison to those who identified as spiritual, after controlling for social supports.

Among Canadian adolescents (Barna Research Group 1999 2000), religiousness (defined as church attendance) as opposed to spirituality (defined as personal belief in God or a higher power) was associated with a greater positive impact on psychosocial adjustment.

These studies lend weight to the view that greater attention needs to be paid to studies that investigate religiousness and spirituality as separate, but sometimes overlapping, entities, in emotions, behaviour and functioning.

Recommendations

Few studies have examined spirituality and religiousness separately and so the majority that combine both should be read with caution. The fact that a study may state that religion is an important factor in determining a particular illness outcome may be more complex than is implied when spirituality and religion are combined into a single measure. If they were constantly overlapping constructs this problem would not arise, but as the two have diverged in practice in recent years, the theory of assuming unity is flawed and may lead to a misunderstanding of the results.

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References

Allport GW and Ross JM (1967). Personal religious orientation and prejudice. *Journal of Personality and Social Psychology* 5(4): 432–43.

American Psychiatric Association (1990). Guidelines regarding possible conflict between psychiatrists' religious commitment and psychiatric practice. *American Journal of Psychiatry* 147(4): 542.

Baetz M, Griffin R, Bowen R *et al.* (2004). The association between spiritual and religious involvement and depressive symptoms in a Canadian population. *Journal of Nervous and Mental Disease* 192(12): 818–22.

Barna Research Group 1999 (2000). Barna Research online: teenagers. At: www.barna.org.

Bibby RW (1995). Beyond headlines, hype and hope: shedding some light on spirituality. Paper presented at the meeting of the Society for the Scientific Study of Religion. St Louis, Missouri.

Curlin FA, Lawrence RE, Odell S *et al.* (2007). Religion, spirituality and medicine: psychiatrists' and other physicians' differing observations, interpretations and clinical approaches. *American Journal of Psychiatry* 164: 1825–31.

Ellison CW (1983). Spiritual well-being: conceptualisation and measurement. *Journal of Psychology and Theology* **11**: 330–40.

General Medical Council (2008). *Personal Beliefs and Medical Practice*. London: GMC.

Hill PC, Pargament KI, Wood RW *et al.* (2000). Conceptualising religion and spirituality: points of commonality, points of departure. *Journal of the Theory of Social Behaviour* **30**(1): 51–77.

King M, Speck P and Thomas A (2001). The Royal Free Interview for Spiritual and Religious Beliefs: development of validation of a self-report version. *Psychological Medicine* **31**(6): 1015–23.

King M, Weich S, Nazroo J *et al.* (2006). Religion, mental health and ethnicity: EMPIRIC – a national survey of England. *Journal of Mental Health* **51**(2): 153–62.

Koenig HG (2008). Concerns about measuring ‘spirituality’ in research. *Journal of Nervous Mental Disease* **196**: 349–55.

Koenig H (2009). Research on religion, spirituality and mental health: a review. *Canadian Journal of Psychiatry* **54**(5): 283–91.

Koenig HG, Meador K and Parkerson G (1997). Religion Index for Psychiatric Research: a 5-item measure for use in health outcome studies. *American Journal of Psychiatry* **154**: 885–6.

Koenig H, McCullough M and Larsen D (2001). *Handbook of Religion and Health*. New York: Oxford University Press.

McCullough ME, Larson DB, Hoyt WT *et al.* (2000). Religious involvement and mortality: a meta-analytic review. *Health Psychology* **19**(3): 211–22

Rasic DT, Belik SL, Elias B *et al.* (2009). Spirituality, religion and suicidal behaviour in a nationally representative sample. *Journal of Affective Disorders* **114**: 32–40.

Roof WC (2001). *Spiritual Marketplace: Baby boomers and the remaking of American religion*. Princeton, NJ: Princeton University Press.

WHOQOL Group (1998). The World Health Organization Quality of Life

Assessment (WHOQOL): development and general psychometric properties. *Social Science and Medicine* **46**: 1585–96.

WHOQOL Group (2006). A cross-cultural study of spirituality, religion and personal beliefs as components of quality of life. *Social Science in Medicine* **62**: 1486–97.

Zinnbauer BJ, Pargament KL, Cole BC *et al.* (1997). Religion and spirituality: unfuzzifying the fuzzy. *Journal for the Scientific Study of Religion* **36**: 549–64.

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Assessing Spiritual Strengths and Needs

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Abstract

Spirituality may hold the clue to more humane services but its relationship with other models is complex, as this article demonstrates using Venn diagrams. Nevertheless, spirituality sheds light on something that appears to be increasingly vital as our services face an uncertain future. A preferred definition of spirituality is offered and the lived experience of faith is engaged with before moving on to consider the concept of spiritual strengths. This is followed by some very pragmatic comments on issues underlying the assessment of spiritual strengths and needs. A distinction is drawn between initial and ongoing assessments. Consideration is given to what we are trying to achieve in assessment. Finally, the importance of supporting staff and building trust is emphasized as the only way to earn respect and be effective. It is hoped that the reader of this article will find it full of practical ideas that are grounded in a robust theoretical framework.

Key Words

Spiritual strengths; Spiritual needs

Main Article

Introduction

To some scientifically minded purists, the very idea of spirituality and spiritual care is something of a chimera, a monster, a fantasy, something that doesn't quite fit the data; something that one might wish didn't exist. Yet McSherry (2000: 11) comments that 'one cannot escape the fact that nursing takes a great deal from the individual's emotional and spiritual

reserves even if one does not see nursing as a vocation'. Spirituality may not fit easily into our outcome-driven NHS, yet the phrase continues to be used by many who aspire to more humane and more effective services, whether service users, carers, or staff. Others use similar terms like hope (Basset and Repper 2005), recovery (Deegan 1988), dignity (Fitzharris 2007), but what they all have in common is an awareness that all too often something vital is missing from psychiatric care. This has long been recognized by writers like Goffman (1970) and Szasz (1970) and popularized by Kesey (1973). But, before we sign up enthusiastically to the anti-psychiatry movement, it's worth noting that the spirituality section of the Royal College of Psychiatrists is their fastest growing, and the website contains much valuable material.

We need to recognize that debates for and against spirituality take place in a political context, especially at a time when the choice of a particular model may result in the favoured advocates retaining their job and the vanquished seeking work outside the NHS. It is vital that we appreciate the significance of 'such a time as this' (Esther 4:14, NIV) in terms of both its threats and its opportunities if we are not to find ourselves as pawns in others' game plans.

Spirituality and Other Models

Many chaplaincies like the one I lead have quite intentionally repositioned themselves in their Trusts by renaming themselves 'Chaplaincy and Spiritual Care Department' or simply 'Spiritual Care Department'. We have every reason to claim expertise in the broader area and have a perfectly valid right to stand against the National Secular Society (BBC News 2009) who portray us as purely sacramental ministers (although sacramental ministry is of profound importance in its own right). If you have changed the name of your department but not considered ensuring that your budget heading is similarly renamed, may I suggest that you consider doing so. Public scrutiny of budgets entitled 'Chaplaincy' risks unexpected consequences of ill-informed decisions!

Such renamings do, however, generally suggest that faith and religion are subsets of a more all-encompassing entity called 'spirituality', but, from the perspective of the Equality Act 2010, it would appear that 'spirituality' is a subset of 'religion or belief'. The NHS publication *Religion or Belief* (Department of Health/EHRG 2009: 33) seems to understand that one can

be religious but not spiritual, religious and spiritual, or spiritual but not religious! Thus, in Venn diagram terms, they are seen as intersecting sets and could be represented as in figure 1.

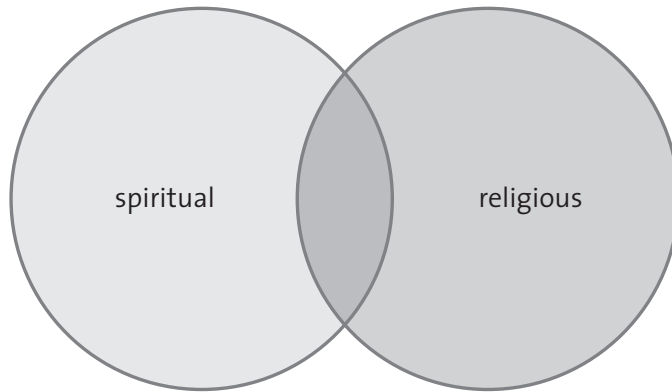


Figure 1

The question we need to ask ourselves is ‘to whose advantage is it to portray things in this way?’ Pettigrew and Whipp (1993: 114) consider in detail how in an industrial setting those in authority have a vested interest in defining how concepts are demarcated. Their work, though from a different sector, makes for interesting reading and sheds much light on what chaplains and others experience in the NHS. They observe that:

Firms seldom collect ‘clean’ data on the environment; it has to be perceived, constructed. How that is done will be affected by the values of those concerned and the pre-existing norms which structure their thought.

Perhaps those who have named themselves ‘Chaplaincy and Spiritual Care Department’ have claimed the greatest ground? Whether or not that is in fact the case, Venn diagrams offer us a simple heuristic or way of thinking about how spirituality relates to other concepts currently in use within the NHS. I will explore these broadly before offering a working definition of spirituality.

Spirituality, Recovery, Dignity, Diversity

If we think of religion or belief/faith as a subset of spirituality, then we end up with something looking a bit like a poached egg (see figure 2).

Everyone, unless they are dead, may be assumed (rightly or wrongly) to be spiritual! Some choose to express their spirituality through (but not exclusively through) religion or belief/faith. So far so good, but let's now introduce another concept: recovery and the recovery approach.

Those of us who see spirituality as 'the reason we get up in the morning' would propose that recovery is a subset (or aspect or function) of spirituality and might represent it as in figure 3.

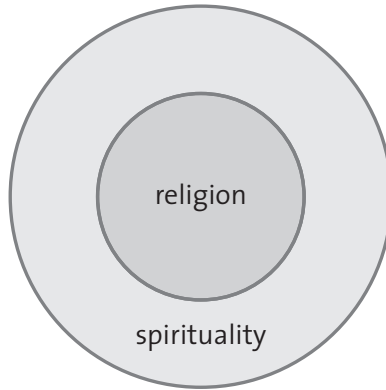


Figure 2

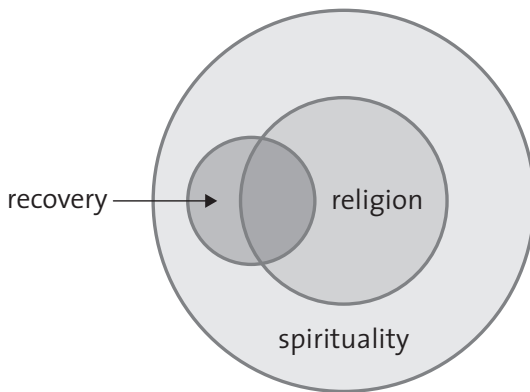


Figure 3

Looked at this way, everyone is 'spiritual' and some spiritual people are 'in recovery'. Of these, some are 'religious' and some people who are 'religious' will be in recovery! But, in the Trust where I work, all service users admitted to the acute inpatient wards are to be given a 'Recovery Folder' which contains a section on 'spirituality'. If spirituality is an aspect of recovery then we get something looking very different (figure 4).

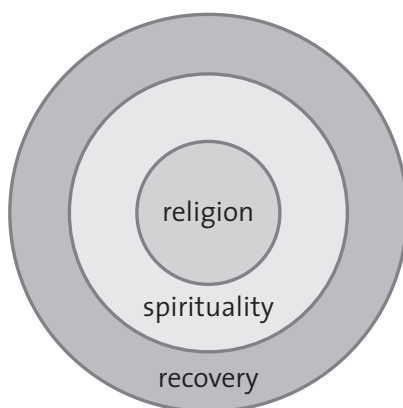


Figure 4

Religion or faith/belief is seen as a subset of spirituality which, at least in terms of the logic of our Recovery Folder, is a subset of the all-encompassing concept of recovery. I'm perfectly happy to go along with this for the purposes of having spirituality, faith and religion taken seriously by the inpatient service, at least in terms of the Recovery Folder, but struggle somewhat if this is to be understood at a philosophical level! (From an evangelical Christian perspective, this may feel one step too far. From that standpoint, spirituality is a subset of Christianity as evidenced, for instance, by the Engel Scale (Engel and Norton 1975) and recovery has to fall in line as a therapeutic tool, nothing more, nothing less.

But, let's have even more fun and introduce another concept, like dignity. Without trying to overstretch the graphic capabilities of my software, it should be evident that we could end up with 3-D Venn diagrams. More importantly, we raise the question of what is to be subordinated to what! In case you are wondering why I am taking you on this almost metaphysical journey, the reason is that, if we haven't considered these matters and how

they play out in the political context of the NHS, any attempts that we may make in assessing spirituality are likely to be, at best, superficial.

That this is not simply an ideological debate is evidenced by the number of organizational groups and committees you will typically find in any NHS Trust that are tripping over each other trying to advance one approach or other, just as in the wider community you find several churches or several mosques of differing opinion, each seeking to proclaim sometimes quite similar messages.

If, for the moment, we leave to one side a Christocentric or Islamocentric perspective, and apply the Pareto Principle, or 80–20 rule, to many of the concepts clamouring for our attention in the NHS, we may find that 80 per cent of each is covering common ground and that only 20 per cent of each is distinctive. The diagram would then potentially look like figure 5, where the common ground is represented by everything inside the larger circle.

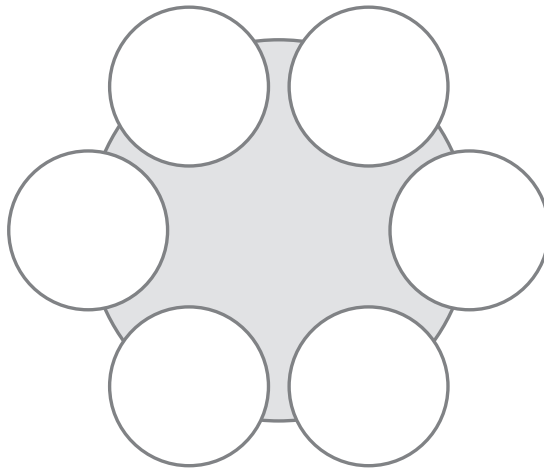


Figure 5

If this is right, then, at least from a theoretical perspective, we would do well to form a single group which would advocate for best practice and have on its membership people who could represent the distinctive aspect of each model. Organized in this way, we could deliver a far more streamlined service and avoid bombarding frontline staff with complexity. Sensitive and mutually respectful members of the group could share in the delivery of training and more time would be released to spend with service users on wards.

The Life Application Bible Commentary (1991: 1815) describes the man left by the roadside in the Parable of the Good Samaritan (Luke 10:25–37) in the following terms:

- To the expert in the law, the wounded man was a subject to discuss.
- To the robbers, the wounded man was someone to use and exploit.
- To the religious men, the wounded man was a problem to be avoided.
- To the innkeeper, the wounded man was a customer to serve for a fee.
- To the Samaritan, the wounded man was a human being worth being cared for and loved.
- To Jesus, all of them and all of us were worth dying for.

And much the same is true with regards to health-care professionals and the service user. What the Bible commentators omit to mention is the wounded man's take on the situation. Barker and Buchanan-Barker (2009: 56) offer an interesting and invaluable perspective on this particular matter with their concept of the 'centre of narrative gravity'. All too often, they argue, the story told is from the clinicians' perspective as if the service user is someone to be commented on, whose hopes and fears are almost irrelevant to their recovery. So, as we seek to consider how we might assess spiritual strengths and needs, let us keep in mind the wider picture of a person who cannot be fully described by any model, approach or framework.

Definition of Spirituality

You might be thinking: this is all very well, all very inclusive, but please give me a definition of spirituality. Let me offer you my favourite, which I have chosen partly due to the fact that it comes from a nursing background. I have found that it is readily accepted by frontline staff:

In every human being there seems to be a spiritual dimension, a quality that goes beyond religious affiliation that strives for inspiration, reverence, awe, meaning and purpose ...

The spiritual dimension tries to be in harmony with the universe, strives for answers about the infinite, and comes especially into focus at

times of emotional stress, physical [and mental] illness, loss, bereavement and death. (Murray and Zentner 1989: 259)

This fits in nicely with the opening quote from McSherry (2000: 11) and has an interestingly positivist evidence base to it. If you don't like it, ask yourself why you don't and/or type the phrase 'definition of spirituality' into a web search engine and you may find one you prefer.

Beyond Religion Lists

Though it is entirely reasonable and often helpful to ascertain a service user's religious affiliation (if applicable) on admission, this information can be just as unhelpful as helpful in the wrong hands. Only a few weeks ago I heard the story of a Somali inpatient who couldn't understand why he was being served curry at every meal. The nursing team had correctly identified that he was a Muslim and required a Halal diet. They had erroneously equated Muslim with Pakistani and therefore served him food from a country some 1,000 miles distant and quite literally an ocean away. Such misunderstandings are almost inevitable when non-believers subject believers to monolithic stereotypes. Lists of how to treat service users from a particular world religion suggest that adherence is all about following a rigid set of observances and fail to engage with the experience of believers as they navigate their way through complex choices and work out what for them are the key issues within their faith.

Perhaps the hardest thing for staff to grasp is that, in these matters at least, it is often the service users who are the experts. They are likely to have thought about the issues involved far more deeply than the member of staff. Obviously, basic hospitality requires us to provide a prayer room with mats or access to a chaplain but these things are only the foothills of a potentially fruitful encounter of mutual understanding, friendship and respect. Andrew Powell, a psychiatrist, argues (2009: xviii):

Doctor and patient are in complementary roles – both need the other. Indeed, at heart we are far more alike than we are different, and as we meet on the path of life, there is one medicine constantly at our disposal that even comes free. This is the power of love, lending hope, giving comfort and helping bring peace to the troubled mind.

The doctor, nurse or health-care worker who runs away from religious patients (or airbrushes out that aspect of their care) is every bit as blinkered as their counterpart who, from a faith perspective, refuses to engage with the spirituality of an agnostic or atheist. Both are somehow deficient in their humanity. Each will have limited the range of fruitful therapeutic relationships they are likely to have with clients. At the heart of what I am advocating here is 'listen to the patient'. By all means have a look at a reputable website like the BBC religions pages (www.bbc.co.uk/religion/) but simply in order to show a willingness to engage, to ask some informed, tentative questions. Only a fool imagines that they can retain an encyclopaedic knowledge of the world faiths in their head, and why bother anyway! A friendly enquiry will almost certainly be met with real enthusiasm and interest as the service user discovers that you respect them as an individual. Who, after all, doesn't enjoy a platform to talk about the things that are important to them!

Spiritual Strengths

Many frontline staff I meet still see their role as confined to providing for religious needs and fail to understand that, for many, their religious belief or participation in a faith community is a real source of resilience, enabling them to withstand, even if only to a degree, the ravages of psychosis or the depths of depression. There is increasingly incontrovertible evidence that people who belong to such communities have better mental health and recover more rapidly from illness than those who don't. The psychiatrist Victor Frankl (2004) was one of the first to identify this when, in 1946, he first described his experiences of Auschwitz and made the observation that, if someone had a reason to live, they were more likely to survive than those who didn't. More recently Koenig (1998, a more academic treatment; 2007, a more approachable book) has been a tireless advocate for the inclusion of spirituality within mainstream psychiatry. We will inevitably encounter nursing staff and others who think purely in terms of religious 'needs'. Whenever I find myself in such a conversation, I seek to encourage them gently and respectfully to consider the other side of the coin as well. Sometimes I draw an analogy with going to the gym. Is going to the gym invariably good? Well, usually but not always! We can take anything to excess. In the same way, most expressions of spirituality, religious or otherwise, are likely to have both healthy and pathological elements to them. In

my experience, frontline staff greatly value this insight and we run a training module on the subject. The best source material I have found on the topic is to be found in chapter 13 of Cook *et al.* (2009). So much, though, for facets of spirituality; let's now consider what to assess when.

Initial Assessment

When first admitted, a service user may be paranoid, hypomanic, or under the influence of drugs. What's most important is to welcome them and help them to settle down. Unless they're being admitted to casualty, they're not likely to die, and so questions modelled around the needs of intensive care units may well be irrelevant in a psychiatric setting. Anyone with a prison history might expect to be seen by the chaplain as a matter of routine, and it may be important for them to be offered this opportunity. From my observations thus far, I would advocate a few simple questions:

- 1 Is there anything else around the issue of spirituality or faith that will be important to you during your time here?
- 2 Are you a member of a faith or religious group?
- 3 Would you like us to take this into account as part of your care?
- 4 Would you like to see a chaplain? (To be asked regardless of the answers to the previous questions.)

The third question helps to distinguish between nominal and practising members of faith groups. Where opportunity arises, the skilled nurse or worker will know when to expand on this question rather than elicit a yes/no response. We don't ask if someone would prefer not to see a chaplain as chaplains often 'patrol' wards and engage people informally, so it would be hard to ensure that this wish would be respected. Finally, the first question has the potential to capture religious strengths as well as needs.

It may be that the service user's record includes an 'Advance Statement', or that they have brought one with them. (An Advance Statement is a document that is prepared when the service user is well, that informs staff how they wish to be treated when unwell.) If an Advance Statement is to hand, all that may be needed is to ask if what is in the Statement is still accurate and if they would wish to add to it in any way.

Ongoing Assessment

Some questions are better asked when the service user is a bit more settled and a relationship of trust has started to develop with the staff. Ideally, the worker with whom they get on best would ask the questions. At this stage, any questions left unanswered as part of the initial assessment should be revisited. Where a service user is receiving care over a number of weeks and months, ongoing assessment should be thought of more as part of a process than as a one-off event. Indeed, when someone's treatment lasts several months or years, then it is vital that it be reviewed periodically or at the request of the service user. People change religion, lose hope, find hope, turn to prayer, get confused, or gain fresh insights. Spirituality is dynamic and can be very fluid in people with severe mental ill health. What suits them one week may not the next. I recall one service user who has a Christian and a Muslim parent. He seeks solace in both faiths and is sometimes confused as to which way to turn. Both the Muslim Chaplain and I (a Christian) support him and let him know that we are happy for him to ask either of us to see the other. He feels treated with respect and knows that he is in control (of this matter at least).

There are a number of assessment tools readily available and generally the free-standing ones on spirituality are the most helpful. The more comprehensive assessment tools rarely seem to demonstrate any real grasp of spirituality and, sadly, a number of them (such as the STAR Assessment Tool) omit the subject altogether.

Perhaps the best of the readily available assessment tools is the HOPE tool (Anandarajah and Hight 2001), whose greatest strength lies in the ease with which it can be used on a busy assessment ward. The acronym HOPE stands a chance of being remembered and a skilled clinician should be able to perform the assessment in the course of a natural and easy-flowing conversation, leaving the service user with a sense of being valued and listened to. The acronym HOPE stands for:

H: sources of hope, meaning, comfort, strength, peace, love and connection

O: organized religion

P: personal spirituality and practices

E: effects on medical care and end-of-life issues

But, if you take a closer look at the article, you may be concerned to see that it was published in the *American Family Physician* rather than a psychiatric journal. Further, there is only one reference in the bibliography to an author in the field of psychiatry. This tool, it would appear, has not been validated in psychiatry and so caution may be required before we start using it with every client group under the sun. Having said that, other tools are generally more complex and thus likely to tempt the health-care worker to place their clipboard or laptop between them and the client: not necessarily the best way of getting someone to share at a deep and personal level!

Perhaps, if we take inspiration from Barker and Buchanan-Barker (2009), we may consider it more appropriate to involve service users proactively from the design stage of any assessment tool that we may use. After all, if the tool is about auditing or taking stock of their strengths and needs, then they may be the experts and not we, not even a couple of American paediatricians, however competent.

If you would like to read a recent and fairly exhaustive analysis of spiritual assessment (albeit generally from an acute hospital setting), I would strongly commend *Spiritual Assessment in Healthcare Practice* (McSherry and Ross 2010), which was published after this article was written.

Assessment or Outcomes

A profound question is: why we are gathering information in the first place? Surely it is to effect a change in how our care impacts on the service user's experience or likelihood of recovery. Ideally, I would suggest, we want to ask only pertinent questions and as few of them as possible. Data Protection Principle 4 of the Data Protection Act 1998 states: 'Personal data shall be adequate, relevant and not excessive in relation to the purpose or purposes for which they are processed'. Similar principles applied to assessment should avoid invasive or irrelevant questions. Enquiries should also explore realistic possibilities. Alternatively, senior management should be informed of deficiencies and resources targeted. In terms of the nursing process (Ross 1998) involving assessment, planning and intervention, and evaluation, it makes little sense to undertake the first step in the cycle without completing the process.

Engaging with Others

Time spent with ward managers, senior practitioners and others is vital if we are to open up opportunities on the wards. I have written elsewhere (Raffay 2010) about this in more depth and plan to publish further material on this subject. I will also be happy to respond to anyone who is interested.

Summary

In this article, I have explored issues surrounding the assessment of spiritual strengths and needs. Some of the material has been philosophical and some extremely practical. I hope that I have offered some helpful insights and provided some useful pointers towards effective outcomes. If you are interested in pursuing the field further, you may like to read the books listed in the references.

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References

- Anandarajah G and Hight E (2001). Spirituality and medical practice: using the HOPE questions as a practical tool for spiritual assessment. *American Family Physician*. **63**(1): 81–9.
- Barker P and Buchanan-Barker P (2009). *The Tidal Model: A Guide for Mental Health Professionals*. London: Routledge.
- Basset T and Repper J (2005). Travelling hopefully. *Mental Health Today*. November: 16–18.
- BBC News (2009). Church should fund NHS chaplains. At: <http://news.bbc.co.uk/1/hi/health/7988476.stm> (accessed 8 August 2009).
- Cook CCH, Powell A and Sims A (2009). *Spirituality and Psychiatry*. London: Royal College of Psychiatrists. (A really significant contribution. It includes a chapter on assessing spirituality needs, pathological spirituality and religion and religious experiences.)

- Deegan PE (1988). Recovery, the lived experience of rehabilitation. *Psychosocial Rehabilitation Journal*. **11**: 4.
- Department of Health/EHRG (2009). *Religion or Belief: A practical guide for the NHS*. London: Department of Health.
- Engel J and Norton W (1975). *What's Gone Wrong With the Harvest? A communication strategy for the Church and world evangelization*. Grand Rapids: Zondervan.
- Fitzharris R (2007). Address to Dignity conference. Keepmoat Stadium, Doncaster, 9 October.
- Frankl V (2004). *Man's Search for Meaning: The classic tribute to hope from the Holocaust*. London: Rider.
- Goffman I (1970). *Stigma: Notes on the management of spoiled identity*. Harmondsworth: Penguin.
- Kesey K (1973). *One Flew over the Cuckoo's Nest*. London: Picador Pan Books.
- Koenig H (ed.) (1998). *Handbook of Religion and Mental Health*. San Diego: Academic Press.
- Koenig H (2007). *Spirituality in Patient Care*. West Conshohocken: Templeton Foundation.
- McSherry W (2000). *Making Sense of Spirituality in Nursing Practice*. London: Churchill Livingstone.
- McSherry W and Ross L (eds.) (2010). *Spiritual Assessment in Healthcare Practice*. Keswick: M&K.
- Murray R and Zentner J (1989). *Nursing Concepts for Health Promotion*. London: Prentice Hall.
- Pettigrew A and Whipp R (1993). *Managing Change for Competitive Success*. Malden, MA: Blackwell.
- Powell A (2009). The spirituality and psychiatry special interest group at the Royal College of Psychiatrists. In Cook *et al.* (eds.) *Spirituality and Psychiatry*. London: Royal College of Psychiatrists.
- Raffay J (2010). Training the workforce in spiritual care. *Mental Health, Religion and Culture*. **13**(6): 605–14.

Ross L (1998). The nurse's role in spiritual care (adapted). In Cobb M. *The Spiritual Challenge of Health Care*. Edinburgh: Churchill Livingstone.

Szasz T (1970). *The Manufacture of Madness: A comparative study of inquisition and the Mental Health Movement*. San Francisco: Harper and Row.

The Holy Bible: New International Version (1984). Logos Research Systems (1996, electronic edition). London: Hodder and Stoughton.

The Life Application Bible New International Version (1991). Eastbourne: Kingsway Publications.

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Who Cares? An Exploration of Our Understanding of 'Self'

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Abstract

The idea of 'self as tool' is discussed with reference to cultivating awareness. The fairy tale 'Red Riding Hood' is used to help explore the health-care chaplain's working with 'self as tool' with reference to some Jungian notions of the psyche.

Key Words

Self; Awareness; Encounter; Relationship; Persona; Shadow

Main Article

Introduction

In what follows I have tried to write up the content of my presentation at the CHCC Annual Conference 2010, which took place on the first afternoon over two sessions. The presentation was made speaking to images rather than given as a lecture and it was interactive, giving the conference delegates a number of opportunities to discuss questions in small groups.

It fell broadly in two parts; in the first I attempted to give a context to the whole idea of self as tool, broadly arguing that the practice of awareness is the primary way to knowing self, how we find self in relationship and how we as human selves find ourselves as conscious, self-reflective beings in this vast universe (I have omitted the latter from this write-up, as without the Hubble telescope images it is hard to recapture what I was trying to present). In the second part I invited the delegates to interpret the fairy tale 'Little Red Riding Hood', as a way into understanding the complexities of self using a Jungian

psychological model. I have tried to capture the atmosphere of presentation rather than produce an academic paper. Particularly in the discussion of the fairy tale, the reader will find many questions that were put to the delegates and could be used in a team reflective practice session.

As chaplains we spend our days offering care. I have been asked to address the question ‘who is the carer?’ and more specifically, in a conference with the theme of ‘Self as Tool’, my question is, what do we mean by ‘self’? Who is this self that we rely upon as our primary tool within the care-encounter? I want to address this question from the perspectives of spirituality and depth psychology; there are other angles, other viewpoints on this question which focus on what is central to our personhood, for example there are important philosophical lines of enquiry, but time is limited and I hope what I have to say will urge further questions and further exploration.

Discovering Self: The Practice of Awareness

My starting point is our experience of our self. The spiritual traditions that I know of all promote spiritual practices that fall under the broad heading of meditation. Fundamentally, this is the practice of learning to be aware, of learning to be and remain present and attentive; aware, for example, of the torrent of thoughts streaming through the mind and of the momentary gaps between the thoughts; aware of the sensations experienced in the body, of the emotions held within the heart and aware of something that all traditions prefer to say is ineffable, being both beyond and near, a presence and an absence, known and yet ultimately unknown. In the Western Christian monastic tradition this practice is most often referred to as *meditatio*, which can lead to contemplation (McGuinn 1994); in the Christian East it is known as *watchfulness* and is found particularly in the *hesychast* tradition of monastic Eastern Orthodoxy (Palmer *et al.* 1995); Buddhism teaches the meditation practices of *samatha* (now made popular under the name ‘mindfulness’ [Kabat-Zinn 1996]) and *vipassana* (Dhiravamsa 1975; Hanh 1987); the Chinese have the moving meditation practice of T’ai Chi (as well as other meditation practices); Japanese Buddhism has given us Zen; India has given us the many forms of yoga, each being a way of exploring self; Sufism, the mystical branch of Islam, promotes awareness through the rhythmic movement of the dervish dances. Being inwardly still (even if using body movement to

achieve this), paying attention to our inner processes, I want to suggest, is our primary research tool for understanding self.

Awareness of Self in Chaplaincy

Self-awareness and wisdom

Individual wisdom comes about from sustained attending to our inner processes plus reflection on the life events that our inner processes react to. There is no wisdom without the necessary attention and appropriate reflection. James Hillman, writing of how the soul learns, suggests there is a way of deep reflection (which is soul work) that ‘changes events into experiences’ (Hillman 1991). We could say that wisdom (the wise soul) is acquired by way of nurturing our exploration and understanding of self. As chaplains we can also draw upon the collective wisdom found in our religious and spiritual traditions, which is largely a collection of writings from down the ages by people who have been investing time in wisdom – the exploration of self in all its relating (see below). As chaplains we need to find a confidence in being wisdom-centred.

Self as relational

Our sense of self is formed in and through encounter and relationship. In health-care chaplaincy we work with at least four dimensions of self-in-encounter:

- intra-personal: awareness of the inner processes of body, mind, heart and soul;
- inter-personal: awareness of the processes in our relationships and encounters with others;
- eco-personal: awareness of our relationship with the places we inhabit, locally and globally;
- trans-personal: awareness of our relationship to God, to the Divine, the Tao, Buddha-nature, to Allah, Brahman, to the cosmos and the wonders of the universe(s) – to give a few names to the nameless.

What we experience as our self – our sense of being a distinct human being alive now – is shaped through encounter with each of these dimensions. By

sustaining our awareness of our self within each of these dimensions of encounter we bring a dynamic sense of wholeness into our work.

Self: meaning and symbol

To be attendant to self in this way nurtures the chaplain's capacity to be attendant upon meaning. The search for meaning is central to the spiritual quest and we recognize that meaning most often finds expression in symbol and metaphor, in image, poetry and music (Hillman 1975). So as chaplains we train our listening to the symbolic to become attuned to the emergence of meaning. This might be seen as somewhat subversive in the reductive, positivistic approach of evidence-based medicine. But both are necessary if we want to be really caring of the whole person; our approach complements rather than competes.

Higher Self

In spiritual care we recognize a Higher Self, the transpersonal dimension of our self's relating, which calls forth an attitude of surrender within our self. Religious language names this Higher Self as God, Christ, Allah, Brahman, Bodhicitta. Paradoxically, in that attitude of surrender we become more truly our selves as we relate to a Higher Self which is reflected in our self (Edinger 1972). The chaplain brings the awareness of the transpersonal dimension into care-encounters and can be fluent with the symbolic language and images that a patient might use to describe their encounter with a Higher Self.

Self in Depth Psychology

Carl Jung once said that if we think we are masters of our own house we deceive ourselves. He considered what is unconscious to be more powerful and determining in our lives than our conscious ego. The ego is like the tip of the iceberg, with the rest of the psyche submerged under the ocean. What lies 'under' ego consciousness Jung termed the *personal unconscious*, which, within the human psyche, is the 'place' of split-off affect, feelings that are too painful to be held in consciousness; for example, those moments of intense guilt, shame, desire, the emotional damage of early trauma. From his years of clinical work, particularly working with dreams – his own and those of his patients – Jung developed the theory of the *collective unconscious*, which is a

deeper layer of the psyche that supplies non-personal imagery in dreams and imagination. Here in the depths of the human psyche Jung explored the *archetypes* of the collective unconscious – universal images that convey great energy, which fuel every life in the form of instinctual drives. Arguably, Jung’s greatest contribution to understanding the human psyche was his concept of *Self*, by which he named the central archetype of the collective unconscious (Jung 1959). For Jung the Self is the archetype of order that seeks wholeness and, most importantly for our discussion, is both within, yet greater than, the individual human psyche.

As an empirical concept, the self designates the whole range of psychic phenomena in man. It expresses the unity of the personality as a whole.

(Jung 1923)

Jungian psychology, I believe, has much to offer spiritual care as Jung gives a map and a language by which people of differing traditions can speak of their experiences. To illustrate this and to further our reflection upon, and our understanding of, self that is the tool in our work, I am going to turn to a well-known fairy tale which I think is a good story for us chaplains to ponder and which will help us explore different elements of the totality we call self. Jung considered fairy tales, along with myth and religious texts, to be expressive of aspects of the collective unconscious. Fairy tales, he felt, were closer to consciousness than myth and he would use fairy tale to amplify dream material (Von Franz 1987).

Little Red Riding Hood: A Tale for Chaplains

This tale, from the collection by the Grimm brothers (Grimm 1975), is well known through children’s books and pantomime. However, it also gives us excellent images by which to explore our understanding of self.

The tale starts out with a young girl who was loved by everyone but most of all by her grandmother. The tale narrates how the girl was asked by her mother to take some cake and wine to her grandmother when she was sick. So it is a story of someone visiting a sick person in service of someone else. This is why it has such resonance for chaplains – we all find ourselves being a Red Riding Hood when we get a referral, or the pager goes, or we make a routine ward visit. The tale immediately poses a question to us: who do we consider we are serving when we go about our visiting? The Trust that pays

our salary? The religious organization we belong to? God? The patients? The staff? Our own needs?

Persona

We are told in the tale that the girl gets her name from the red cap her grandmother made for her and which she always wore. This opens up the dimension of the personality Jung referred to as the *persona* (Stein 1998). This in effect is a mask or a number of masks the ego can utilize in enabling the personality to relate to the outer world. In terms of our discussion, the *persona* is the manifestation of self to the outer world. Versatility in use of the *persona* is important for healthy adaptation to our changing environments. We run into problems when the persona becomes fixed and we bring one face or attitude to every situation. So Little Red Riding Hood became identified with the red cap made by her grandmother. She wore this wherever she went, the tale narrates. If we can read this symbolically, the red cap represents a fixed attitude dominated by the rather overwhelming attitude of the grandmother, such that the child is stuck in a performance of pleasing grandmother. So the tale poses a powerful question to chaplains: what *persona* or *personae* do we use in our role as chaplain? Do we feel there is an image that our working context demands us to project? How different is our mask when we are with colleagues and when with patients? Is there a particular mask or attitude that we feel is rather fixed? The problem of the fixed persona is that it becomes a defence, aiming to protect some other aspects of the personality from being expressed or related to.

Continuing with the tale, the girl's mother gives her a basket containing wine and a piece of freshly baked cake (we note the physical and spiritual nature of what the girl is asked to bring) and tells her to take it to her sick grandmother. At this stage the tale invites us to reflect on what we might be bringing to our care-encounters. What do we bring in our metaphorical basket? What are we asked to bring and by whom? How much of what we bring is our own need? If the latter is to some extent true and we are not sufficiently aware of it, then what we find we are bringing might prove to be quite different from what we might hope to bring.

Shadow

The mother sets the girl on her way with some cautionary advice: 'Set out before it gets hot and when you are going, walk nicely and quietly and do not

run off the path, or you may fall and break the bottle, and then your grandmother will get nothing' (Grimm 1975: 139).

So the little girl takes the path through the woods. In psychological terms the wood is the unconscious. It is a place of limited light, where trees, plants and undergrowth grow untended by people and is inhabited by wild animals. In the wood the little girl soon meets the wolf. The wolf is a very important character in helping us explore our understanding of the self because in the tale the wolf symbolizes the shadow aspect of our self. Jung used the term 'shadow' to refer to those parts of our self that we prefer not to see, so they are placed where there is no light, meaning they are not held in consciousness but repressed or split off from consciousness into the unconscious. Jung says of the shadow that it is 'everything that the subject refuses to acknowledge about himself and yet is always thrusting itself upon him directly or indirectly'. In mental health care we find that people accessing services have suffered early emotional damage which has been too painful for the person to feel and relate to consciously. When the ego is not strong enough it becomes overwhelmed with feeling that the person fears they will never emerge from. As a survival mechanism the ego splits this off from consciousness but that does not mean it is out of harm's way as it presses upon consciousness from its split-off place in the shadow where, to bring in another Jungian concept, it gains energy and forms a *complex* which has its own impact within the personality. So when we are talking about a self it is important that we keep in mind this shadow aspect.

The girl in the tale knew little of the shadow; she represents a stage of development where she needs to confront the shadow. So the story tells us that the wolf suggests she goes off the path into the wood to collect a bunch of flowers for grandma. The girl becomes immersed in this. Going further and further she becomes enchanted by the beauty of flowers she has never seen before. There is much we could unpack here about the discovery of her sensuality and sexuality; suffice to say that when we fall into the shadow we can feel lost, not knowing our way among feelings, thoughts, sensations and intuitions we are not familiar with but which, for growth and for a greater understanding of self, we will do well to find out about.

So what might we find cast in the shadow of a chaplain? It is difficult and often painful territory. We want to keep the *persona* fixed; it is more comfortable not to face what lies behind the masks we wear. But if self is our tool we need to be willing to explore this shadow side of self too. In health care we

are fortunate because the patients we meet will help us get in touch with our shadow material. It can be useful to ask why we find ourselves coming into contact with patients who are presenting similar issues? What are the challenges for us in these issues? Why is it that some of us work with death and dying, some with psychosis and depression, some with maternity units and others with burns and trauma? In reflective practice or supervision we can reflect upon what we have felt and said in our care-encounters, particularly picking up the unexpected interjections, feelings and thoughts: 'What made me say that?' This can lead into the question, 'so what was I caught by in that encounter?' which will inevitably lead into some shadow material.¹

Collective shadow

I referred earlier to Jung's distinguishing between the personal and collective unconscious. It's the same with the shadow. There is personal shadow material, made up of our own experiences, and collective shadow material, which is collectively repressed by a group, organization, or even a nation. It has been interesting and very painful to watch and experience the splits in the world of chaplaincy over the last ten or more years, splits which are hopefully being healed now. The collective shadow of any organization is very powerful and hard to get hold of because it feels so powerful, but for us as chaplains it is important that this is acknowledged as this too is within our self. Here we find issues that have beset faith communities down the ages: the urge for power and the claims to truth and certainty which lead to diminishing others.

Self

When an organization sets out to care, in the collective shadow will be the potential to harm. And so in the tale the shadow wolf eats the grandmother, transforming the figure of maternal love into a devouring monster. The little girl falls into the wolf's trap and is swallowed into the belly of the wolf. This represents a crisis: how is the heroine going to escape from the entrapment of the devouring shadow? How do we find our way out of the labyrinths of our occasions of being lost or devoured by some intense feeling which we find we can't simply shake off? The tale introduces the huntsman. He is one who knows his way around the forest. He is acquainted with the ways of the animals. He is at home in the forest. He is an image representing the *archetype of the Self* (Edinger 1972). Here we are introduced to the Higher Self by way of

an image. This is important as Jung claims the Self is usually mediated by way of images that can be related to by ego consciousness. Many of the spiritual traditions say that the Higher Self is ultimately formless. However, in the human psyche the Self is mediated in the form of images, hence the symbolic imagery found in religious and mythological traditions.

In 'Little Red Riding Hood' the huntsman is one such image of the Self. The huntsman appears from within the wood, as he happens to pass the old woman's cottage. The Self appears and brings to the individual psyche what she needs – to be set free from the grip of the shadow. This cannot be manufactured by the ego. Instead the image of the ego trapped within the belly of the shadow might be understood as an image of the ego's need to surrender to that which is greater. The huntsman frees the captive girl and grandmother by cutting open the wolf's stomach, which the little girl then fills with stones which, like a cairn, mark her encounter with him, with the shadow. Jung says that for the personality to grow into wholeness the ego has to surrender to the Self, so that we become servants of the Higher Self (Edinger 1972). As chaplains we know this from our faith traditions. In Christianity this is presented by St Paul stating in his letter to the Galatians, 'It is not I who live but Christ that lives in me' (it is noteworthy that for Jung the image of Christ was the Self in the Western psyche) and the Christian spiritual tradition is really founded upon the possibility of this relationship with God in Christ by the Holy Spirit. Zen Buddhism sometimes describes this as surrender to Big Mind and is most beautifully portrayed in the ox-herding pictures where the Zen monk is shown searching for the bull (representing the energy of Big Mind or Higher Self) then riding it, and finally letting it go (letting go of attachment to the image) to wander in the world again (Reps 2000).

Practice and the craft of spiritual care

If our primary tool in our work is self, then how far are we able to make space for the archetype of the Self, or the Higher Self, to inform our work? If this is, as I have suggested, perhaps one of our uniquenesses as health-care chaplains, I wonder what enables this and what hinders this in our daily work? It will certainly take courage. It will need safe reflective spaces and will need time away, set apart for our own depth work, where we continue the journey into knowing our self and discovering more about the primary tool of our work. I like to think of our work being a craft (Bushell 2008). Just as the craftsperson has their tools, so we have our developing awareness of

Self informing our self. Richard Sennett, in his study of craftsmanship (2008), suggests that it takes around 10,000 hours of practice for a crafts-person to become proficient, to be able to take up tools and work in a state of flow. Let us continue to practise our craft using self in relation to Self as our primary tool.

Note

- 1 This is the territory of transference and counter-transference, which sounds technical but which goes on in all human relating, but there is not time to explore that here.

References

- Bushell S (2008). The craft of spiritual care. *Journal of Healthcare Chaplaincy* 9: 1/2.
- Dhiravamsa (1975). *The Way of Non-Attachment*. London: Turnstone Books.
- Edinger E (1972). *Ego and Archetype*. New York: Putnam.
- Grimm, Brothers (1975). *The Complete Grimm's Fairy Tales*. London: Routledge and Kegan Paul.
- Hanh, Thich Nhat (1987). *The Miracle of Mindfulness: A manual on meditation*. Boston: Beacon Press.
- Hillman J (1975). *Re-Visioning Psychology*. New York: Harper and Row.
- Hillman J (1991). *A Blue Fire*. New York: Harper Perennial.
- Jung CG (1923). *Collected Works* (vol. 6). London: Routledge and Kegan Paul.
- Jung CG (1959). *Collected Works* (vol. 9, pt. II). London: Routledge and Kegan Paul.
- Kabat-Zinn J (1996). *Full Catastrophe Living: How to cope with stress, pain and illness using mindfulness meditation*. London: Piatkus.
- McGuinn B (1994). *The Presence of God: A History of Western Christian Mysticism*. London: SCM Press (4 vols).
- Palmer GEH, Sherrard P and Ware K (trans. and ed.) (1995). *The Philokalia* (vols 1–4). London: Faber.

Reps P (ed.) (2000). *Zen Flesh Zen Bones*. London: Penguin.

Sennett R (2008). *The Craftsman*. London: Allen Lane.

Stein M (1998). *Jung's Map of the Soul*. Chicago: Open Court.

Von Franz M-L (1987). *The Interpretation of Fairy Tales*. Boston: Shambhala.

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Book Reviews

Creativity, Spirituality, and Mental Health: Exploring Connections

By **KELLEY RAAB MAYO**

Ashgate New Critical Thinking in Religion, Theology and Biblical Studies Series

Ashgate Publishing, Farnham, Surrey, 2009

Hardback, 177 pages. ISBN 978-0754664581. £45.00

This book is accurately subtitled 'Exploring Connections', because this is exactly what Mayo does in her readable but wide-ranging book. Her stated aim is to 'emphasize [*sic*] the integral connections between imagination, creativity and spirituality and their role in healing'. As a professor of psychiatry and an ordained minister, a clinician and an academic, she challenges an exclusively medical model for treating mental health problems and offers instead a consideration of the healing potential to be found in using creative, spiritual and religious resources as part of a holistic approach to treatment.

In her introduction Mayo poses herself some searching questions: Can creative expression and spirituality render mental illness more manageable? Just how far can spirituality and creativity take one on the journey to recovery? Is creativity in and of itself healing? Can creative expression help one live more authentically, and if so, how is this linked with living a spiritual life?

And noting that many artists, musicians and writers frequently suffer from some form of mental illness, she also faces the question whether there may be a relationship between creativity and mental *instability*. Are creative people simply more sensitive and therefore more vulnerable, she asks, or is there a more direct link between the state of mind of an individual in a creative state and one in a manic episode?

It is these and similar questions which Mayo goes on to examine in detail in the remainder of her book.

Following an introduction in which she describes something of her personal journey, and briefly gives a background to the historical relationship between psychiatry and religion, she begins her exploration by

reflect-ing on the work of Marion Milner, a British psychoanalyst who wrote and practised during the middle decades of the twentieth century. Mayo acknowledges the profound influence which Milner's writings have had on her own personal and professional journey in linking mysticism with creativity and their role in psychological health.

In chapter 3 she examines both the theory and practice of spirituality and creativity, and makes links with psychoanalytic concepts. This is the most difficult chapter of the book for readers who are not well versed in psychoanalytic theory. While it is part of Mayo's 'setting out her stall', and interesting for anyone who has a working knowledge of psychoanalysis, for the non-specialist reader, this section can be skipped over. However, there are some helpful cameos from the lives of famous people – Einstein, Hildegard, Frida Kahlo, among others – which bring this chapter to life and help to illustrate the points Mayo is making: that creativity is both a search for the sacred and a search for the self.

Before turning her attention to specific mental disorders, Mayo discusses the idea of *hope* as that which is lost in mental illness and therefore something to be reclaimed during recovery. She considers hope both as a psychological concept and as a theological one, examining the nature of hope in several of the world's major faith traditions. She places particular emphasis on the healing potential of imagination and story in fostering hope, illustrating this with a personal account of using the stories of the Prodigal Son and the raising of Lazarus in a mental health setting.

This is a particularly helpful chapter for those working in any health-care field, since loss of hope can be an aspect of many illnesses, not just mental disorders. Mayo writes that religious and spiritual traditions can offer hope through

promoting connection with something greater than the individual, promising support by divinity and community, permitting grief and the expression of complex emotions, enabling a ministry of presence, affirming the inherent worth of the [sic] each individual and his/her gifts, reframing obstacles as challenges that can be overcome and looking to the future rather than the past. (p. 79)

This is something which chaplains and ministers can take for their own encouragement.

I was relieved to see, however, that Mayo does not shrink from acknowledging that religion does not always foster hope; that a religious approach that is centred on human depravity and an authoritarian God can cause mental distress rather than alleviate it; and that, on occasion, some patients need to be steered away from an unhelpful religious involvement.

In the remainder of her book, Mayo turns to exploring creativity and spirituality in relation to three specific categories of psychiatric disorders: mood disorders, anxiety and eating disorders. Considering each category systematically, she gives a brief explanation of the disorder and then reflects on whether – and how – spiritual and imaginative approaches may be of benefit to those struggling with these illnesses. She draws widely on research which has been done in this field, offering a balanced argument, and always keeping in mind her initial areas of exploration: *do religious beliefs aid or harm in coping with a severe mental illness?* and *does creativity aggravate or alleviate such disorders?* She illustrates her points with case vignettes drawn from her own experience both as a psychiatrist and as a minister, and these bring the theory to life, making it very accessible to the specialist and non-specialist reader alike.

In her conclusion, Mayo attempts to draw together the threads of the book: threads that are sometimes interwoven and sometimes very separate. I found this vagueness frustrating, and wanted the author to establish at the outset a stronger link between creativity and her understanding of spirituality. There are parts of the book where Mayo apparently sees creativity and imagination as aspects of spirituality, yet in other passages she treats them as separate concepts. In places she slips effortlessly between discussing creativity and imagination on the one hand, and reflecting on religious and spiritual practices on the other – as aids to recovery. Yet in other places she talks about creativity *and* spirituality, as if they are independent of one another: ‘How far can spirituality and creativity take one on the journey to recovery?’ she asks. She cites research in which patients were asked which *spiritual* interventions were most helpful, but then notes without apparent contradiction that the patients listed a number of ‘*creative* means of express-ion’ (italics mine) – art, dance, movement, imagery, music. Perhaps it is inevitable when dealing with such abstract concepts as creativity and spirituality that the boundaries become blurred, and it is not clear whether the overarching concept is spirituality, creativity or even self-expression:

Although creativity ... does not prevent one from developing a mental illness, creative expression can play a healing role in helping one express a more authentic self. Creativity allows unconscious dynamics to surface, facilitates an experience of flow and perhaps of transcendence. One's spiritual life also becomes an avenue for expression of the deep self.

In spite of this slight blurring of boundaries, however, this is an important book – for ministers, especially those working in the field of mental health, and for psychiatrists, who may not have considered the significance of spiritual issues in the recovery of their patients. For those who do not consider themselves religious in the traditional sense, Mayo's exploration shows how the broader aspects of spirituality – imagination, story, creativity, transcendence and mystery – can also be utilized in the healing of those whose lives are blighted by mental distress.

Revd Chrissie Wood
Chaplain, St Andrew's, Nottingham

Easeful Death: Is There a Case for Assisted Dying?

By **MARY WARNOCK** and **ELISABETH MACDONALD**

Oxford University Press, New York, 2008

Hardback, 155 pages. ISBN 978-0199539901. £12.99

The authors try to enable the reader to look at the question 'Is it morally justifiable in some circumstances for a doctor or another person to end someone's life or help them to end it?' Assisted dying is not about 'allowing nature to take its course' but making a deliberate decision, often not of the person's choosing, to end a life.

The book offers a way into an open discussion into a sensitive subject where different voices and opinions are heard. Often the term 'slippery slope' is used in discussions around assisted dying, and the authors attempt to look at what could happen in different scenarios. They examine what is already

happening in places like Oregon in the United States, the Netherlands and Switzerland.

Assisted dying affects not just the person and his or her family but also the medical staff involved in the decision-making process and in carrying out the 'ending of a life'. There is a chapter on methods used in easing death and their effects on staff, which is helpful.

Looking ahead, this is a subject which will rear its head time and again. I would recommend this book as a way into the discussions. It is not always an easy read – nor should it be – but it is informative and challenging.

Revd Edith Dawson

Chaplain, Sherwood Forest Hospitals NHS Foundation Trust

The Law of Religious Organizations: Between Establishment and Secularism

By **JULIAN RIVERS**

Oxford, Oxford University Press, 2010

Hardback, 368 pages. ISBN 978-0199226108. £50.00

This book caught my eye for a chapter it contains entitled 'Chaplaincies'. As Julian Rivers states at the outset, the book is 'a systematic study of English law as it applies to organized religion', and it is encouraging to find that he engages with religion as it is found in public institutions. Legal issues have never been far from all kinds of chaplaincy work in recent years. Whether it concerns equality, human rights, data protection, terms of employment, or freedom of religious practice, the legal dimension is all too often under-addressed. The consequence of this can be uncertainty about the role of the chaplain and the rights of all kinds of people to have reasonable access to the spiritual care they need.

Much of the book gives new perspectives on topics already familiar in other contexts. Rivers's canter through 'The Changing Law of Church and State' at the start of the book is enlightening, particularly about the Reformation. Chapter 2 addresses the human rights of religious associations under

international law (just one aspect of human rights and religion). This chapter gives an insight into the organizations, treaties and laws which seek to enable the peaceful coexistence of people from different faiths. The author shows how English law is bound to relate to these international developments even as it enjoys a character shaped by its own history and unique development. Chapter 3 explores tensions between the constitution of religious bodies and secular law, while the following chapter examines the legal position of ministers of religion. This includes reference to the distinction between an office-holder and an employee, with an illustration of why chaplains are the latter. Having discussed the law and public religion in the UK, then the regulation of rites (fascinating) and the position of chaplaincies are examined in chapter 7.

Rivers finds the greatest volume of legislation relating to chaplaincies around the armed forces and prisons. This is probably due to the restricted nature of access to many of these facilities. Across all sectors the author charts a story of increasing diversification arising from the legal issues of equality and the historic role of the Church of England. At the end of this chapter there is an intriguing discussion entitled 'Chaplaincies and Human Rights'. This touches on several issues pertinent to the public provision of health care. There is an example concerning the vulnerability of hospital chaplains when the formal onus on Trusts is only to ensure access to spiritual care. Citing religious diet, Rivers argues: 'it would not be adequate for them [the management] simply to refrain from preventing prisoners from acquiring such food' (p. 231). Respecting human rights in matters of religion cannot simply be a negative obligation (i.e. not to obstruct). While recognizing that some contexts (such as the armed forces and prisons) may employ chaplains for reasons of security, Rivers nevertheless concludes that in principle the state does not have to fund religious ministry typically provided by believers in the community. As a non-lawyer, this leaves me wondering why Rivers sees the example of an institutionally funded religious diet differently from the need to provide religious counsel where, for a secular patient, some other form of support would be offered.

The book concludes with an examination of faith schools and more general religious involvement with welfare and public discourse. In this regard there is an analysis of the clashes between faith groups and secular law highlighted by issues such as adoption. The nuanced conclusion Rivers draws on the basis of his comprehensive survey affirms the mutual benefits

of a legal connection between church and state. In the future Rivers believes that this may change, for many different reasons, but he argues that the state will not be best served simply by avoiding a legal framework for its relationship with religion. For chaplains working in the context of increasing pluralism and vocal secularism this book provides essential tools to engage with and understand the challenges that lie ahead.

Revd Chris Swift

Head of Chaplaincy Service, Leeds Teaching Hospitals NHS Trust

Letters to the Editor

Dear Editor

I thoroughly enjoyed the new edition of the Journal and in particular Andrew Haig's moving address. In fact it stirred up some thoughts that I would like to inflict on him and your readers, if that is acceptable. There is such a lot written and spoken about what counts in the NHS and particularly what is not easy to count in the way medicine tries to. The same debate goes on in counselling and psychotherapy and their registration, which is being squeezed into a medical model of treatment and care. I can see why we want, or feel we need, to put ourselves firmly in official registration procedures. If we are not there, then how can we hang on to our place in the developing NHS where everyone else is registered? Andrew picks upon that most disputed word 'professional' and makes a very good case for chaplains avoiding it in trying 'get alongside' rather than over and above those in their care. He argues passionately that an incarnate faith requires this of Christian chaplains.

Did I come to that family as some sort of spiritual expert, bristling with knowledge and skills to diagnose their spiritual state and prescribe something to put them right? Of course not. I did not come bringing any sort of expertise. The only thing I had to offer was me. One person coming alongside some others. (JHCC 10(1): 6)

Reading the story of this family I was continually struck by Andrew's expertise and skill in discerning the spiritual resources valuable to this family and, indeed, in having them guide him. First he is 'useless with nothing to say'. Such strong feelings might well push him and us into blurting something out or running away, at least metaphorically. But Andrew has the knowledge and the courage to stay without speaking, hugging and touching instead. He offers a prayer – maybe out of his need to offer something or discerning that they look as though they need something and a prayer might be a helpful

offering, especially as it leads them to talking, and him to listening, about their son James. Andrew dares to tentatively offer more, a blessing or a baptism, but leaves it very open and so allows the family to have their spiritual resources and needs acknowledged and met in different ways. Finally, they entrust James to Andrew while they go outside. He says, and no doubt shows to them ‘what a sacred trust this is’, which others, the nurses, can enter into too. As the hours pass, Andrew recognizes that an incarnation of a kind has happened. ‘You have become incredibly close to this family.’ And the family’s revelation, passion and wonder become the inspiration of a sermon and article so that even more of us are touched by its magic. In its way this is a very ‘professional’ activity in which Andrew is a highly effective professional figure. Not true in the way a doctor or nurse or other health-care professional would be, but in his own way doing what he believes in – the root of the word professional is ‘profess’ – and his hospital, by appointing him, recognizes the validity of his profession in order to complete the service it offers its patients. All professions hold a faith: a faith in the science of medicine, in the skill of nursing and allied professions. Each holds a faith at the core of their being and the faiths are different and only brought together in a highly believing and functioning multidisciplinary team.

There is much being written about the skills and expertise of chaplains and the ‘coming alongside’ activity registers high in that writing. It follows closely in the steps of Jesus’s ministry and finds an echo in the epistle to the Philippians (2:8).

Have that mind among yourselves, which you have in Christ Jesus, who though he was in the form of God, did not account equality with God, a thing to be grasped, but emptied himself, taking the form of a servant, being born in the likeness of men. And being found in human form he humbled himself and became obedient unto death, even death on the cross.

The expertise of a follower of Christ requires the same humility and willingness to suffer the consequences. This is not an easy expertise to gain, especially for clergy, who are lifted up above the people. Think of the famous psychoanalyst who, when he had completed ten years of analysis, said that it took him another ten years to find his humanity again. So, in entering the priesthood or lay chaplaincy we have to learn the expertise and then regain our humanity.

However, the incarnation is only one aspect of the Trinity and at times we will be called upon to share our expertise and skill in ethics committees and multidisciplinary training and work, and from time to time we will be required to represent the Father as well as the Son. I had spent some fifteen minutes endeavouring to get alongside a woman patient when she said with some exasperation, ‘When, Reverend, are you going to pray?’

With my best wishes and thanks for causing these stirrings in my soul.

John Foscett

Email: jfoskett@btinternet.com

Dear Editor

Andrew Haig’s sermon [JHCC 10(1)] requires a response. His assertion that chaplains have to sell themselves is accurate, but his analysis of his own involvement in a particular pastoral care episode is disingenuous.

When an 8-month-old baby died in hospital and he was called out of hours to the family, he describes himself as ‘one person coming alongside others’, and claims that ‘the only thing I had to offer was me’. It sounds plausible, but does not fit with the evidence he himself brings.

He did at least eight things which were possible only because he had sophisticated training and considerable experience in theology, pastoral care, priesthood and chaplaincy.

- 1 He experienced and endured the uncomfortable feeling of uselessness, without hurrying into activity or taking flight or asking someone else to be there as the theatre staff had been. He said the nothing that was required.
- 2 He assessed whether physical contact would be appropriate and offered it tentatively when he deemed it was.
- 3 He asked permission to say a prayer, and presumably did say one.
- 4 He initiated talk about the dead baby, enabling the family to describe and display him.
- 5 He broached the subjects of blessing and baptism. Careful study of the church’s teaching and traditions had given him confidence to offer one

religious rite which not every priest would feel comfortable offering in these circumstances.

- 6 When the family responded positively, he conducted the rite.
- 7 He comforted two nurses using physical contact and allowed himself to cry.
- 8 He assisted the nurses by holding the body as they made things presentable for the parents' return.

'Close'? Yes. 'Intense'? Yes. 'Knowledge and skills'? Yes. 'Expertise'? Of course. 'Diagnose and prescribe'? Of course not, but if he was not acting like a doctor in this encounter, he was also not acting as a private individual. He was invited to enter these people's lives as a priest employed by the hospital. When he met them first, as a stranger, he was already trained and experienced, and carrying their notions, fantasies, expectations and projections of what a priest is, of what the Church stands for, and of who God is. He was emphatically not just 'one person coming alongside some others'. The statement 'Hospital chaplaincy is all about loving people' is an inaccurate generalization which does not serve chaplains well at a time when they are being urged to sell themselves.

If professional registration is the currency used by the NHS, chaplains would do well to 'render unto Caesar the things that are Caesar's'. It would then be legitimate for people to interpret and inhabit the role of chaplain in varying ways, without claiming that chaplains are the only people who 'come alongside' others in hospital.

One imaginative approach to 'coming alongside' in recent years is the 'Sage and Thyme' initiative in South Manchester (Connolly M, Perryman J, McKenna Y *et al.* (2010). Sage & Thyme: A model for training health and social care professionals in patient-focussed support. *Patient Education and Counselling* 79: 87–93). Here NHS staff are taught in a half-day seminar a way of listening and responding to patients and carers where 'approach' is encouraged rather than 'avoidance'. Chaplaincy has been involved with the Palliative Care team in developing and presenting a model which enables staff at all levels to 'come alongside' in sensitive, supportive and responsive ways.

I too was a chaplain in the last century. These days, though, I reluctantly recognize the need for 'selling' what is now called 'religious and spiritual

care' in the NHS. Andrew is right to warn of the dangers of losing touch with our weakness and vulnerability. Seeking recognition is fraught with risk, not least the danger that chaplains find themselves talking when they should be listening. But whoever heard of faith without risk?

Canon John Perryman

Previously Chaplaincy Manager

University Hospital of South Manchester NHS Foundation Trust

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Endpiece

Loitering with Intent

God's already loitering with intent;
Waiting for our arrival,
To accompany Him
Within the world of health and care provision;
Coming to the sick and suffering,
Engaging therapies to aid recovery,
Motivating courage to discover new futures,
Listening to the anxieties of patients and carers,
Bringing care through professional interventions,
Understanding stresses and strains within the service providers,
Acknowledging the rituals of faith practice,
Weeping within the bereavement suites,
Saddened by the disclosure of remembered abuse.
God's already there, waiting for us,
Loitering with intent,
And intervening with compassionate response.

Frances Ballantyne
Chaplain, Leicester Partnership NHS Trust

Instructions for the Submission of Articles

If you wish to discuss an article before submission to the *Journal of Health Care Chaplaincy*, please contact the editor by email (at: meg.burton@gmail.com) or on 07976 597971. We seek to include a balance of subject areas (e.g. palliative care, mental health, professional practice, etc.), as well as a range of styles, from academic/evidence-based work to reflective/experimental articles. Our main articles can be as substantial as 3–4 thousand words, while shorter articles are welcomed between 750 and 1,500 words. Articles will be blind reviewed within or beyond the editorial team, and feedback can be provided on request, whether articles are accepted or not.

- Articles should be attached to an email and sent to the editor. Please attempt to emulate the style you find within the most recent edition, although we may amend to enable consistency.
- Each article should have: a clear title; author or authors with the professional capacity in which the article is presented; the hospital and/or academic institution to which the author(s) is (are) attached and in what capacity. For example:

The Spiritual Nature of Nursing P.V.S. Patients

Revd Jim Dobson is the Chaplain, University of Dovedale, Hodness Hospital, Worcester, UK.

- Contact details should be provided for correspondence, including an email address. These will be published with the final article to encourage discussion. Let us know if you do not wish this.
- Complete articles or extracts may be published in electronic form through the CHCC website. Please indicate clearly at submission if you would not wish your article to be published in this form.
- Main articles should be headed by a short abstract. You may also indicate 'keywords' if you wish, e.g. Personhood; Interdisciplinary; Spirituality; Pastoral Care, etc.
- References should be provided and a (selective) bibliography.

Authors of academic articles should use the **Harvard System** of referencing (if in doubt, consult with the editor).

Help with the Harvard System

- In the text of your article you should give the author's name and then the year of publication in brackets and the page number (if relevant).

e.g. Smith (1997: xxx) suggests that, for most doctors, pain is viewed as a physical problem to be dealt with by physical methods.

- If you are referencing an article that is written by two authors, you include both authors' names in the text, then the year in brackets.

e.g. Mitchell and Jones (1989) comment that in recent years, the special knowledge and abilities of Chaplains have extended into the fields of chronic pain control and the control of pain in labour.

- If you are referencing an article which is written by more than two authors, you write the first author's name and then, in italics, write *et al.* instead of other names, followed by the year in brackets.

e.g. Masterman *et al.* (1997) performed a study to examine the contributions of salient behavioural, contextual and developmental information.

- In such cases you include the authors' names in the reference section, up to three authors, followed by *et al.* if there are four or more authors.
- If you use referenced material to support your comments, the references should appear at the end of the sentence in chronological order.

e.g. A number of authors have suggested that the management of spiritual pain should reflect current researched evidence (Mitchell and Dean 1990; Hadjistavropoulos *et al.* 1997; Jones-Williams 1999).

At the end of the article all the publications cited should be listed alphabetically by surname of first author. The following should be included:

If you are referencing a book, provide:

- the name of the author(s)/editor followed by the initials

- the year of publication (in brackets)
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- the place of publication
- the publisher's name

e.g. Bowling A (1997). *Research Methods in Health: Investigating health and health services*. Buckingham: Open University Press.

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- the relevant page numbers

e.g. Wilson RE (1996). Transcutaneous electrical nerve stimulation. In: M Leflowitz, AH Lebovits, with DJ Wlody and SA Rubin (eds.). *A Practical Approach to Pain Management*. Boston: Little, Brown, pp. 136–41.

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- the title of the article (do not use quote marks)
- the name of the journal (in *italics*)
- volume number (in **bold**), number (if available) and page numbers (separated by a hyphen).

e.g. Notcutt WG (1997). What makes acute pain chronic? *Current Anaesthesia and Critical Care* **8**(2): 55-61.

If you are referencing a thesis or dissertation, include the details of level and the name of awarding institution.

e.g. Name (year). *Title*. Unpublished MSc dissertation, Cardiff, UWCM.

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Articles submitted for consideration should be sent to the editor by 30 January for inclusion in the spring/summer issue and by 30 August for the autumn/winter issue. Late submissions are welcome at the Editor's discretion.

Review Articles

Authors of previously published articles may submit a 'review' article of 750 (maximum) words with details of the original publication, date, page number and number of references.

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If you wish to subscribe, but are not a member of CHCC, please contact:

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*For details of the regional representatives and other appointments,
please see the CHCC website.*

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CHCC/Unite

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Websites

CHCC

www.healthcarechaplains.org

Unite

www.unitetheunion.org

College of Health Care Chaplains' Training & Development Programme 2011

CHCC Introductory Course (Non-residential) – March 8th & 9th

Whole Course Cost: £180.00

Venue: 128 Theobald's Road, London WC1X 8TN

CHCC Healthcare Chaplains' Seminar – May 19th

'Chaplaincy Beyond The Boundaries – Surviving The New NHS'

Cost: £40.00 Members £50.00 Non-members

Venue: 128 Theobald's Road, London WC1X 8TN

CHCC Faiths Resource Group Study Day – June 14th

Venue: Leicester Cost: £40

Mental Health Resource Group Study Day – July 8th

'Using Mindfulness within Spiritual Care'

Venue: Balsall Heath Church Centre, 100 Mary Street, Birmingham B12 9JU

Cost: £45.00

CHCC Annual Study Course – Sept 13–15th

Venue: East Anglia University, Norwich

Cost: £450 members £550 non members (£25 off for early booking)

Mental Health Study Conference – Oct 17–19th

'Dazzling Darkness – Engaging with Complex Emotions in Spiritual Care'

Venue: Hinsley Hall (Leeds)

Cost: £325 members £350 non member (£25 off for early booking)

CHCC Introductory Course (Residential) November 7–10th

Venue: Hinsley Hall (Leeds) Cost: £480.00

Further information and applications for all courses may be obtained by contacting William Sharpe, CHCC Registrar, on

William.Sharpe@unitetheunion.org

Please see CHCC web site for further details of CHCC training and cost.

www.healthcarechaplains.org

