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Report

Nurturing a new discourse: mental health and spirituality

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Abstract

On the 1 November 2006, Staffordshire University, in partnership with the National Institute for Mental Health in England and the National Spirituality and Mental Health Forum, organized a multi-faith symposium on perspectives in mental health involving all nine of the major faiths and the Humanists, with a strong user voice. It is planned that a series of symposia on related topics will be held on an annual or biannual basis.

Key words: faith, mental health, multiculturalism, spirituality, community

No safe harbour?

The Roman sage, Seneca, is reputed to have said that: 'if you do not know which port you are sailing to, no wind is favourable'! In Britain today, it is often unclear where society is going, and even what the main strands of discourse are.

There are, of course, the issues of multiculturalism (Modood, 2007; Sacks, 2007; Sniderman and Hagendoorn, 2007), but even more fundamental perhaps is the identity crisis around whether we are a society based on the individualized economic liberalism of the USA, or the more communitarian values of the rest of Western Europe. In foreign policy, we have followed the USA into the long-term ethical, political, economic and humanitarian quagmire of Iraq (Steele, 2008), but at home also, we are unsure whether we want a health service that is based on social insurance or a privatized one, or something which is a mixture of both (Toynbee, 2007). These tensions are interestingly being played out between the devolved Scottish Parliament and its English counterpart around free care for elderly people, prescription charges, student fees, etc.

In many cities, the shabby 1960s and 1970s office blocks are being torn down, liberating fine Victorian buildings with their coloured stone and brick facades. In Bradford,

for example, a city of many cultures, the secular edifices mingle with Victorian churches and mosques, temples and gurdwaras. Of course, the Victorian era speaks of a colonial past, with its very mixed heritage (Brendon, 2007). We are not sure what part of our history to be proud of, and, in a secular age, we are surprised to find ourselves living in a society where religion is now a major discourse again (see Bunting, 2006; Coyte et al., 2007). It is not only Richard Dawkins who is surprised at that! In fact, commentators, such as Grace Davie, have pointed out that Europe, in its attitude to religious belief, might not be so much the norm as an outlier (see Davie, 2002).

Because we inherit, as human beings, an allegiance to individuality and also to tribalism, we would prefer to have a known port to sail to: a safe haven, a secure anchor – our quest for certainty in 'an uncertain world' (Bauman, 2007). Maurice Keen, the noted historian of the Middle Ages, describes them as a remarkably homogeneous era (Keen, 1968). Identity then tended to be unproblematic. People knew where they were, and were usually rooted in communities where the same families had been for generations and family nomenclature was area based. Of course, migrations have always been a part of life, and for my own part, my patrilineal heritage is Anglo-Saxon, whereas my matrilineal link stems from a clan mother ('Jasmine') who goes back to ancient Mesopotamia. Brian Sykes, the Oxford geneticist, considers 'Jasmine' (Sykes, 2006) to be a clan that moved along the Mediterranean coast, thus giving rise to my Portuguese, Roman Catholic maternal grandmother, who married a Scottish Presbyterian international rugby player, creating a microcosm of religious, cultural and ethnic diversity all of its own! Chief Rabbi Jonathan Sacks has recently argued that a laissez-faire multiculturalism has already failed and that we now need to '. . . reinvigorate the concept of the common good. Society is where we come together to achieve collectively what none of us can do alone' (Sacks, 2007, p. 5).

'[T]he perennial problem of civilisation', Sacks continues, 'given new depth and pathos in our time, is how to manage our separateness and togetherness, our differences and our interdependencies. *If we were completely different we could not communicate. If we were exactly alike we would have nothing to say.* Politics is the art of living with difference, and how we deal with it shapes much else in our world' (Sacks, 2007, p. 12, his emphasis).

Is everybody happy?

The American constitution enshrines the Jeffersonian injunction towards: 'life, liberty and the pursuit of happiness'. And, indeed, happiness has become a pursuit for twenty-first century-Britain, but one that we do not apparently think we need to work for!

In his *Nicomachaen Ethics*, Aristotle wrote that: 'happiness is the meaning and purpose of life, the whole aim and end of human existence,, but as Richard Schoch points out in his recent work, *The Secrets of Happiness* (Schoch, 2007):

> *Unhappy is the story of happiness. More than two thousand years ago, when the ancient Greeks first thought about what constitutes 'the good life', happiness was a civic virtue that demanded a lifetime's cultivation. Now it's everybody's birthright . . . We have lost contact with the old and rich traditions of happiness, and we have lost the ability to understand their essentially moral nature. Deaf to the wisdom of ages, we deny ourselves the chance of finding a happiness that is meaningful . . . somewhere between Plato and Prozac, happiness stopped being a lofty achievement and became an entitlement. (p. 1)*

Modern malaise, postmodern portent

It would sometimes feel easier if one could think of one age coming to an end and another beginning. It is confusing that the Age of Empires has aspects of feudalism, that the Enlightenment rulers often reverted to feudal practice, and that today, modernism laps upon the shores of what some call late modernity, others second modernity or postmodernity, and Zygmunt Bauman, in a resonant phrase: *liquid modernity* (Bauman, 2000). Bauman (2007) describes the current times as:

> *The new individualism, the fading of human bonds and a wilting of solidarity are engraved on one side of the coin whose other side shows the misty, contours of 'negative globalisation'. In its present purely negative form, globalisation is a parasitic and predatory process, feeding on the potency sucked out of the bodies of nation-states and their subjects. (p. 24)*

And we might add that, for many people, it is an age of attempting to seek certainty in uncertain times, as Bauman's title suggests.

Charles Taylor, in his *Ethics of Authenticity*, speaks of three main marked changes as characterising the current age: an individualism that sees many people no longer placing themselves within a 'great chain of being', the 'primacy of instrumental reason', whereby aspects of life are reduced to impersonal mechanisms, and we often find ourselves placed within Weber's 'iron cage', and the withdrawal from a society into a form of life which Alexis de Toqueville presciently forsaw, where individuals are 'enclosed in their own hearts' (Taylor, 1991, pp. 2–10).

The National Health Service (NHS) exemplifies an attempt to combine the modernist and collective approach with an attempt towards a more postmodern element off personalization through the recent White Paper for Adult Services and Commissioning Guidance (Department of Health, 2006b, 2007). The accent is quite rightly now on a greater personalization of care: 'A shift towards services that are personal, sensitive to individual need and that maintain independence and dignity' (Department of Health, 2007, p. 10).

But we do have to be wary of an Americanized approach, which basically says: 'it is your individual responsibility – over to you'! Simon Hoggart in *The Guardian* remarked cynically that: 'We must know enough to treat ourselves where necessary. That way we will earn the right to take charge of our own medical destiny!' (Hoggart, 2008). More sociologically, Bauman speaks of: 'Once competition replaces solidarity, individuals find themselves abandoned to their own – pitifully meagre and evidently inadequate – resources' (Bauman, 2007, p. 68).

A number of faith communities will place the accent in health and well-being more on the family and community than on the individual (see Okasha in Cox et al., 2007 and Patel, 2006). As the Mercia Group put it:

> *(the) focus on religion has been driven both by major international events, which have highlighted the political demands associated with religious movements, and by an increasing recognition by academics, policy-makers and service providers of the importance of religion in defining identity, particularly among minority communities. In addition, minority communities are increasingly seeking to press for the accommodation of their religious customs and practices within the legal and economic system of the UK. (Beckford et al., 2006, p. 11; see also Vulliamy, 2006)*

The NIMHE Project

The National Institute for Mental Health in England (NIMHE) Spirituality and Mental Health Project was set up in September 2001 by Professor Antony Sheehan, then leading the core group to set up the National Institute, and Peter Gilbert became the Project Lead. The Project focuses on two main issues:

- Spirituality as an expression of an individual's essential humanity, and the wellsprings of how she/he live their lives and deal with the crises that can leave us drowning rather than waving. It is, therefore, an essential element in assessment, support and recovery for users and carers in a whole person approach. It is also vital in work with staff, in the creation of person-centred organizations.
- The establishment of positive relations with the major organizad religions and faith-based organizations at a time when a harmonious construct between statutory agencies and faith communities is essential (see CIC, 2007). This is especially so in an age of global communications, where the international, the national and the local are continuously interacting with each other (see Coyte et al., 2007; Cox et al., 2007).

The Project has a number of elements to it.

To address issues around providers recognising and relating to people's spiritual and religious needs, Pilot Sites were set up in 2005 around a specific framework (see Aris and Gilbert, 2007), and a National Symposium for the Pilot Sites took place at Lincoln University in May 2005. The Pilots are not driven by performance indicators, but by the impetus within the Pilots themselves – usually impelled by a combination of users, professionals and voluntary organizations (some of which may be specifically faith based).

To assist in the commissioning process, commissioning guidance is currently in preparation.

Liaison with faith communities has taken place through the national Inter-Faith Network, and also through the national Spirituality and Mental Health Forum (Chair: Martin Aaron), in liaison with the national Group for Mental Health Chaplains, and keeping in close touch with the Department of Health.

It has been important to bring the professions on board. Strong links have been created between the Project and the Royal College of Psychiatrists Special Interest Group (www.rcpsych.ac.uk/college/sig/spirit/index.asp), with the British Psychological Society and the Royal College of Nursing. Work with the social work profession has been more complex, as each qualification course for social workers is effectively independent, but liaison has taken place with the General Social Care Council. In nursing, spirituality now features in the Chief Nurse's review of mental health nursing: *Values into Action* (Department of Health, 2006a).

Other aspects are: working with a growing number of centres for spirituality in universities (see Swinton, 2007), to build up a UK-wide body for the study of the subject and research to be launched in 2008, working on commissioning guidance, keeping up links with the Scottish Executive and the Welsh Assembly Government, and putting out publications that are designed to appeal to a wide range of audiences.

One of the central values of NIMHE was to create an effective and positive partnership between local, regional and central policy and practice initiatives.

Unfortunately, this may shortly be lost, as increasing regionalization is taking place without an awareness of the need to retain a national vision.

The Symposium concept

Because of the increasing research base on the interaction between faith and mental health, views from service users and survivors about the positive benefits, but also the problems associated with organized religion, and the work that took place in 2004 with the Church of England over the production of a Parish Resource Pack (NIMHE/Church of England Archbishops' Council, 2004), it was decided to set up a Multi-Faith Symposium at Staffordshire University on 1 November 2006. The aims of the day were quite ambitious (see Box 1).

Box 1. The aims of the Symposium

- Gather together a theologian/philosopher plus a mental health practitioner, from each of the nine faiths currently consulted by central government and the Humanists, with a strong user voice.
- Consider, in a respectful and reflective setting, how each religious belief/philosophical tradition views mental health in both positive and negative terms.
- Look at how different religious groups and the Humanist tradition work with people to prevent mental ill-health, to help those who are ill and to assist in the process of their recovery.
- Ascertain what service users find helpful and unhelpful from faith communities (led by Mary Ellen Coyte).
- Chart thematic issues, e.g. the relevance of ritual, nourishment, prayer/meditation, etc. within the different traditions.
- Consider ways of working cooperatively together to promote an inspirited service ethos and greater inter-faith harmony.
- Consider questions of research and other future work.

The outcomes that we hoped for were around: greater understanding of the relevance of belief systems to mental well-being, the mapping of synergies between various belief systems, promoting good understanding and positive working relations between faith communities and mental health Services, the strengthening of networks between partnership organizations, a plan for future partnership work in regard to research, publications, inter and intra-faith symposia, etc., and a record of the day.

The nine faiths invited were: Baha'i, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Sikhism and Zoroastrianism. The Humanist Society was invited and well represented, and there was a specific service user/survivor voice.

At least one person from each faith and the Humanists were represented. It was not always easy to gain a theologian from some of the faiths which are still small in numbers. We had hoped to gain user representation from each faith/belief/tradition, but this proved too

much, even with a long lead-in process. Nevertheless, the user voice was very strong, both in the spoken and the written word (see Gilbert and Kalaga, 2007), and a better spread of user involvement across belief systems is something to be aimed for in the future.

As Project Lead, Peter was questioned as to why *nine* faiths, and not, for example, Paganism, which is of increasing interest, Scientology, Rastafarianism, etc. Peter's view was that there needed to be a rationale for this first symposium, and that the consultation method used by the Department of Health was as good as any at this time. The nine faiths were the ones liaised with over the production of guidance around chaplaincy services in 2003. In the future, especially in regional events, depending perhaps on the faith make-up of a particular population, this could become wider. Links with a pagan representative, working with an NHS trust, have been made.

There were other questions around representation intra-faith. For example, the Christians were represented by two speakers from the Church of England, including the Archbishop of Canterbury's main advisor at Church House. Again, the organizers felt that it would be impossible to represent every strand of any particular faith, and so, while specifically inviting some members of Black Pentecostal churches from within the Pilot Sites, the richness and diversity of intra-faith perspectives might be better worked through in a specific symposium devoted to that issue.

The organizers went to a recognized national inter-faith body for advice, again, specifically to try and gain an authoritative view of a particular faith/belief system. We were fortunate that Judaism, for example, produced Rabbi Jonathan Dove as the Chief Rabbi's personal representative, to speak on mental health, the British Humanist Society appointed a spokesperson to talk from a philosophical point of view, and the organizers invited the National Social Work Lead, Jane Shears, to speak as the Humanist practitioner, the Council of Imams and Mosques sent their Executive Director, Mr. Raza, whose mental health service partner was Selina Ullah, who had worked in one of the Pilot Sites (Bradford) and was Race Equality Lead in the North East.

It would be a mistake to couple faith and ethnicity too closely together. The members of the Muslim faith in this country come from a wide range of areas with different traditions: e.g. the Indian subcontinent, the Middle East and Africa, to name but a few. The Hindu representatives were a Hindu priest, with Caucasian ethnicity, and a psychiatrist from the Indian subcontinent. The faith tradition and culture of an individual or group may be very different, depending on the part of the world they originate from, but also the type of immigrant experience that they have felt. African Muslims often speak of coming from a Sufi tradition within Islam. Conversions to different faiths are also a major factor. Assumptions around spirituality and religion are far too easily made. In fact, the excellent guides to belief systems, which a number of NHS Trusts have produced can, ironically, persuade staff that if they have read the paragraph on Jainism, then they know all about that belief system without realizing that there may be many stages and subsets of belief, and the ethos of a faith may differ depending on the cultural origin of the individual or group.

The case studies, on which the multi-faith discussions were based, proved fascinating areas for dialogue. Again, many presuppositions were challenged around issues of possession, for example (see Box 2). Responsible faith communities are not prone to rush to look for spirit possession, and, indeed, some faiths believe only in the Divine Spirit and not in spirits loose in the world.

Box 2. One of the case studies discussed at the conference

Mr. X, a man in his mid-30 s, had been brought up in a family with very strong religious observance. He had, at one time, attended a faith school and always been to his place of worship regularly.

A serious-minded man, Mr. X worked hard, and in his mid-20 s, married and had two children. Working in a high-pressured area of financial services, however, led to increasing stress on Mr. X in his early 30 s, and his behaviour became increasingly unpredictable, with episodes of hyperactivity, which started off being within the bounds which were containable by his family, but were increasingly bizarre and led to him spending money on articles that had no relevance to the family and which they could not afford. He also experienced episodes of depression, when he could hardly get out of bed, and his employers were becoming increasingly irate with his absences.

Eventually, Mr. X went to his GP, who referred him to a psychiatrist, who, in turn, diagnosed Mr. X as having bipolar disorder. Mr. X was not always willing to take medication regularly, and within a year was experiencing the hearing of voices emanating at or around his place of worship, urging him to accept a more aesthetic lifestyle. Some of his friends and neighbours thought Mr. X might be 'possessed'.

The community psychiatric nurse assigned to him felt that it would be helpful to involve a 'minister' from Mr. X's particular faith, but Mr. X was wary of this and this raised issues around confidentiality for the community psychiatric nurse (CPN), who felt ever-more strongly that some form of involvement from the faith community would be helpful.

In the meantime, Mr. X's increasingly volatile behaviour was alienating his wife and his children.

Box 3. The practicalities

There were, perhaps, a number of other issues involved in producing, what we believe, is the first-ever symposium where all nine faiths and the Humanists have been brought together to discuss mental health. Indeed, it may be a world first!

- Personal contact – working with relatively small groups, some of which have not been used to being involved as partners, requires a more personal approach than we may be becoming accustomed to in the more impersonal world of emails, etc.! Speaking to people personally is important. 'Relationships, relationships, relationships'!
- Persistence – some groups praised the intent of the conference, but were not able to produce a representative. Although we wish to go through the official, national channels, if at all possible, with one faith group, we came in through a circuitous route, through regional contacts, to produce strong professional (although not particularly theological) representation from that faith.
- Preparation – care is needed around issues such as representation, diet, space for prayer, etc.

We also asked each faith/belief system to produce a preparatory paper, which was produced as a university monograph in 2007 (see Gilbert and Kalaga, 2007).

- Pilots – it was essential to link in as strongly as possible with the Pilot Sites, from whence there was strong representation. There was a representative from each of the CSIP/NIMHE Regional Development Centres.
- Professional groups – again, linking with the professions was most helpful. The Royal College of Psychiatrists' Special Interest Group (Chair: Dr. Sarah Eagger) was particularly well represented.
- Presence – the interaction between individuals and groups on the day, with a warm welcome from Staffordshire University's Vice Chancellor, created a very vibrant and positive atmosphere.
- Partnerships – the building of partnerships was essential before the conference, during it and after. It is notable now that a number of regional events, e.g. that in Essex in late 2007, saw the benefit of relationships built up during the 1 November Symposium.

Looking to the future – implications for practice

In the Project as a whole, there is a need to:

- Influence training and education. Unless practitioners are able and willing to recognize their own strengths and vulnerability, then it is impossible for them to relate appropriately to others. Staffordshire University have been tasked to compile guidance on spirituality for staff in Acute Mental Health services (Acute Care Collaborative(England)/Staffordshire University, 2008, forthcoming).

- The pilot sites are exploring issues such as gaining information on people's religious affiliation, if any (complex in itself), and exploring with them their spiritual strengths and needs (much more complex and time consuming – see Edwards and Gilbert, 2007).
- They are also building up positive relationships with faith communities, despite the pressure on chaplaincy services in the NHS at a time when their importance has never been higher!
- The success of this venture demonstrates what could be done on a local and regional level.

The papers and interactions during the day have now been published as a university monograph (Gilbert and Kalaga, 2007). It is also intended to use the model for forthcoming events, and a symposium was held on end of life issues: *From the Cradle to Beyond the Grave*, on 8 January 2008 (publication and DVD, forthcoming). Links have been made with the work that Professor Bill Fulford is undertaking in conjunction with the Department of Health, the World Psychiatric Association and the World Health Organization around taking people's spiritual needs into account in assessment, treatment and care.

A number of regional events are planned for 2008, taking the issues raised in the Pilot Sites' Conference and the Multi-Faith Symposium into more detail at a regional and local level. It would also be helpful to look at intra-faith issues, e.g. the complexities inherent in the diverse nature of Christianity and Islam in Britain. A conference will be held on 24 June 2008 at the University of Worcester, entitled: *Spirituality, Culture and Identity: An Approach to Care*.

The drivers towards including a spiritual and cultural dimension in health and social care are becoming ever more pressing (see Eagger et al., 2008, forthcoming), as the Mercia Group report for the Department of Communities and Local Government makes clear (Beckford et al., 2006).

Major events in December 2007 in Sheffield, Birmingham, London and Sandwell, demonstrated the huge surge of enthusiasm from service users, carers and staff for creating space for the spirit in services at the frontline of society.

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Notes

NIMHE is the agency tasked with helping mental health services develop. It is now part of the Care Services Improvement Partnership. The National Spirituality and Mental Health Forum works to promote an understanding of spirituality and faith in a mental health context. Staffordshire University set up a Centre for Spirituality in 2004 with the explicit support of the Vice Chancellor, Dr. Christine King to promote spirituality as an essential part of ethical and effective health and social care.

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> *There it is, in its splendour and perfection, 'shining to saints in perpetual bright clearness', as Thomas a Kempis said. Not only the subject matter of religion, but also the cause and goal of everything in human life that points beyond the world – great action, great music, great poetry, great art. Our attention to it, or our neglect of it, makes no difference to that world, but it makes every difference to us. For our lives are not real, not complete, until they are based on certain conscious correspondence with it: until they become that which they are meant to be – tools and channels of the will of God.*
>
> *Evelyn Underhill*