Understanding Mental Health and Spirituality

Peter Gilbert

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The chapter was chosen as illustrative of Peter's inimitable style as well as of his key interests, many of which are discussed in John Swinton's tribute article, 'Peter Gilbert: In Memory of a Life Lived Well', in this issue of *JSS*.

Spirituality and mental illness

'Siddra' was born into a second generation Pakistani family who were Muslim. Her parents adhered to the Five Pillars of Islam (the profession of faith; the five daily prayers; almsgiving; fasting; pilgrimage to Mecca) and were also keen that their children should integrate themselves into UK society, be as well educated as possible, and gain rewarding careers.

'Siddra' went to university, got a good degree and went into medicine. As a third year medical student she became stressed, anxious and then depressed. In her turmoil she questioned herself about her illness. Was it:

- purely biological
- a result of a stressful environment
- abandonment by Allah (God)
- an identity crisis; was she caught between two cultures, and was her scientific training a help or a hindrance in this crisis?

A sympathetic and skilled GP, an Imam trained in mental health, and her family supported 'Siddra', and she eventually recovered and qualified as a doctor.

In *The Dark Threads*, Jean Davison writes of her existential crisis as a teenager from a Christian family in the 1970s:

'As a teenager I wanted badly to find a meaning, a purpose, a pattern, a God. To think as I started doing then, that there might be none of these things, was hard for me to take. Over the years I have learnt to live with ambiguities, uncertainty, a possibility of never knowing. But it seems that "something" of my leanings towards spirituality never left me' (Davison, 2009).

Davison sought advice from a GP who was unsympathetic; and then from a psychiatrist who she felt would offer her listening time, but instead admitted her to High Royds psychiatric hospital near Bradford. There, she received a diagnosis of schizophrenia (which appears then, and in retrospect, to be inappropriate), as well as major tranquilisers and electroconvulsive therapy. Eventually she moved out of the system and created a fulfilling career for herself in working with those also experiencing mental distress.

Her yearnings for a spiritual dimension never left Davison and towards the end of the book she quotes a poem by Benjamin Franklin:

> 'Not 'til the loom is silent
> And the shuttles cease to fly,
> Will God unroll a canvas
> And explain the reason why
> The dark threads are as needful
> In the Weaver's skilful hand
> As the threads of gold and silver
> In the pattern He (sic) has planned' (In: Davison, 2009).

One doesn't need a specific religious faith to feel that we have an 'inner spirit' and value, a motivating force and life meaning, and purpose which shapes our lives (see Gilbert *et al*, 2010, chapter 9).

Reflection exercise
What do you feel gives your life meaning and purpose?
How do you see your identity? Who do you think you are?

Definitions of mental health

The World Health Organization states clearly that *'there is no health without mental health'* (see Friedli, 2009). The connection between mental and physical health is increasingly recognised, as is the sense that in a knowledge-based society, mental well-being is essential for economic prosperity as well as social cohesion.

One way of looking at mental health is as follows:

'Essentially about how we think and feel about ourselves and about others and how we interpret the world around us ... it also affects our capacity to cope with change and transitions such as life events ... Mental health may be central to all health and well-being.' (Rankin, 2005)

A whole person approach

To work with people in an effective and cost-effective way we need to connect with the whole person in the context of their whole life. This includes their family, social groups, community, housing, employment and leisure time etc (see Gilbert, 2010). Figure 1 illustrates the aspects which should be considered when working with someone with mental health problems.

Understanding hopes, fears and aspirations

Cognitive		Psychological
Physical		Spiritual
Emotional		Creative

Understanding the past

Social environment

FIGURE 1   Looking at the whole person.

Reflection exercise

When you experience mental distress, what elements from figures 1 and 2 do you feel are most relevant to your experience?

What are your hopes for the future?

What approaches do you take to ensure your well-being?

Models of mental illness

Andrew McCulloch summarises a number of possible models of mental illness (McCulloch, 2006).

- Biological models that are concerned with the biological and chemical basis of mental illness – this is fundamentally what we refer to as the 'medical model', although many doctors use a more integrative approach.
- Social or psychological models that are concerned with life events, family dynamics and belief systems or thinking style. This also encapsulates social models of disability that focus on how society reacts to the disabled individual.
- Intuitive or spiritual explanations that see the mind as a battleground for conflicting forces: the conscious versus the unconscious, good versus evil, etc.
- Existential belief, which views mental illness as another valid form of human existence – this is rare.

Quite often these models will interact, meaning that a life event may cause a chemical imbalance which requires a range of approaches, including social, spiritual, medical and cognitive. Sometimes there will be a range of different perspectives eg. the voices an individual hears could be seen as a psychotic illness, demonic possession, or as the Hearing Voices Network (see Romme *et al*, 2009 and Jane Taylor in Gilbert *et al*, 2010, p5–8) would argue, another dimension of the human experience (see figure 2).

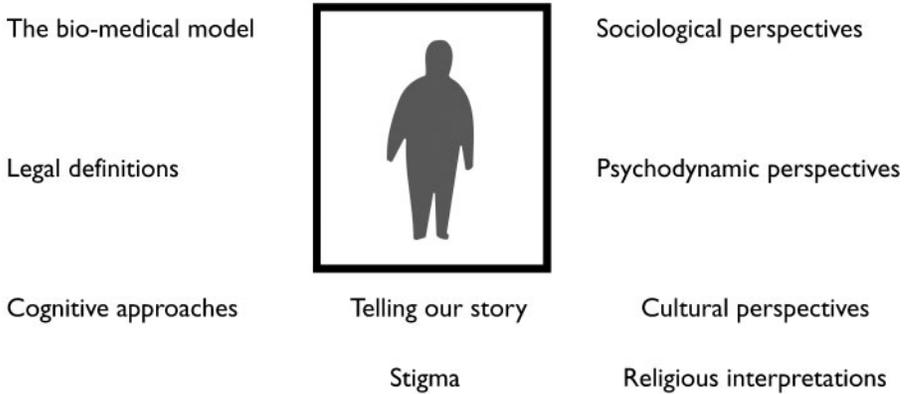| The bio-medical model | | Sociological perspectives |
Legal definitions		Psychodynamic perspectives
Cognitive approaches	Telling our story	Cultural perspectives
	Stigma	Religious interpretations

FIGURE 2   Diverse perspectives of mental well-being and ill-health.
(First published in Gilbert *et al* (2010) *Social Work and Mental Health: The value of everything* (2nd edition) and reproduced with permission from Russell House Publishing)

Stigma and prevalence

Despite the fact that prominent individuals, such as Stephen Fry and Alastair Campbell, and medical practitioners such as Cathy Wield and Liz Miller, have spoken publically about their episodes of mental distress, there is still a great deal of stigma generally, and this may be exacerbated in some cultural communities. The esteemed scientist, Dr Lewis Wolpert, who wrote about his depression in the very moving *Malignant Sadness* (Wolpert, 2006) says that nearly everybody he speaks to has some experience of mental distress, either directly or through a close relative or friend. They talk to him about it, because they know he has been through a similar experience.

It is often said that one in four people experience an episode of mental ill-health at one time in their lives, and issues such as the recession and associated unemployment, demographic change and stigma and discrimination can all have an effect on those experiencing mental ill-health. For instance suicide rates, having dropped steadily over the past 10 years, have seen a rise since the credit crunch and subsequent economic and social disruption (see Gilbert, 2010; The NHS Confederation, 2009).

Discovering the spirit

The idea that human beings have an inner spirit is prevalent in all philosophical and religious traditions. In the West we base a great deal of our scientific and medical advances on the wisdom of the ancient Greeks. The philosopher Plato (circa 428–348 BCE) stated that: '*As you ought not to cure the eyes without the head, or the head without the body; so neither ought you to attempt to cure the body without the soul, because the part can never be well unless the whole be well.*' (Phaedo, quoted in Ross, 1997, p1)

Embryologist, Lewis Wolpert, while describing himself as 'a hard line materialist', uses spiritual and religious language in his description of depression: *'If we had a soul – and as a hard line materialist I do not believe we do – a useful metaphor for depression could be 'soul loss' due to extreme sadness. The body and mind emptied of the soul lose interest in almost everything except themselves. The idea of the wandering soul is widely accepted across numerous cultures, and the adjective 'empty' is viewed across most cultures as negative. The metaphor captures the way in which we experience our own existence. Our 'soul' is our inner essence, something distinctively different from the hard material world in which we live. Lose it and we are depressed – cut-off, alone.'* (Wolpert, 2006)

In the Hindu religion, the Bhagavad Gita talks about *'that which pervades the entire body with consciousness, you should know to be indestructible. No one is able to destroy that imperishable soul'* (BG, 2.17) and *'the soul can never be cut to pieces by any weapon, nor burned by fire, nor moistened by water, nor withered by the wind. This individual soul is unbreakable and insoluble, and can be neither burned nor dried. He (sic) is everlasting.'* (BG, 2.23–25)

Sometimes the words 'spirit' and 'soul' are used interchangeably. In the Jewish faith, however, these are distinct. The soul (nephesh) is God given but a relatively passive entity. The spirit (ru'ach), however, means both breath and spirit and denotes not just life, but invigorated life. Rabbi Dove uses the analogy of the craftsman making glass through blowing into the molten liquid so that gradually the form takes shape through the action of the maker's breath (see Gilbert and Kalaga, 2007). For Muslims, Allah is said in the Qur'an to breathe Allah's ruh into each human being. The Oxford English Dictionary defines spirit as our 'animating or life-giving force' and it is evident that mental health services which don't work with an individual's animating or life-giving force cannot really be either effective, or indeed cost-effective.

As the UK becomes more multicultural, and many people live their lives across several cultures (see Gilbert *et al*, 2010, p119–120), understanding varied and perhaps interlocking modes of spirituality will become increasingly important (see Coyte *et al*, 2007; Fung *et al*, 2009).

One way of looking at the interaction of mind, body and spirit, through various philosophical and religious traditions, is detailed in figure 3. It is important to note that again all philosophical traditions, whether religious or not, have a strong sense of social responsibility, so that the citizen has responsibilities as well as rights, and a duty to minister to the needs of those less fortunate than themselves.

Some commentators have asserted that the word 'spirituality' is relatively recent. Ursula King (2009) on the other hand traces it back to the early part of the fifth century CE, and it gradually developed in its use as a counterpoint to 'materiality', and so continues to this day as a counterpoint to the obsession with material goods and consumerism (see Coyte *et al*, 2007).

The Royal College of Psychiatrists defines spirituality as: *'Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective awareness of individuals and within communities, social groups and traditions. It may be experienced as relationship with that which is intimately "inner", immanent and personal, within the self and*
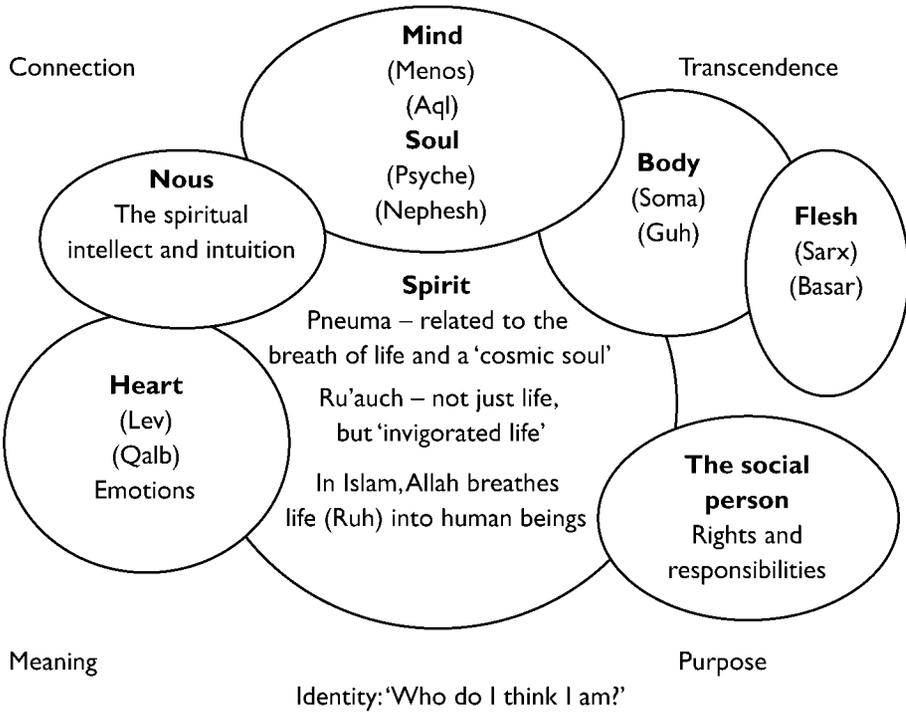
Connection

Mind
(Menos)
(Aql)
Soul
(Psyche)
(Nephesh)

Transcendence

Nous
The spiritual
intellect and intuition

Body
(Soma)
(Guh)

Flesh
(Sarx)
(Basar)

Spirit
Pneuma – related to the
breath of life and a 'cosmic soul'

Ru'auch – not just life,
but 'invigorated life'

In Islam, Allah breathes
life (Ruh) into human beings

Heart
(Lev)
(Qalb)
Emotions

**The social
person**
Rights and
responsibilities

Meaning

Purpose

Identity: 'Who do I think I am?'

FIGURE 3   The whole person.

others, and/or as a relationship with that which is wholly "other", transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with matters of meaning and purpose in life, truth and values.' (Cook *et al*, 2009, p4)

Religious belief

As the UK becomes a society of many cultures, religious faith is likely to become increasingly important.

The word 'religion' derives from a Latin word meaning 'binding obligation', and this demonstrates how much it is to do with a sense of community and social cohesion. It stems back to a time when it was vital that people knew who you were and what to expect from you, and the sense of social solidarity and obligation.

Religion encompasses most, if not all, of the aspects described in definitions of spirituality, usually in the context of belief in, and possibly a personal relationship with, a transcendent being or beings, and with a meta-narrative which seeks to explain origins of the world and those living in it, and the questions which face human beings around life, suffering, death, and re-awakening in this world or another.

Religion can provide a 'world view', which is acted out in narrative, doctrine, symbols, rites, rituals, sacraments and gatherings; and the promotion of ties of

mutual obligation. It creates a framework within which people seek to understand and interpret and make sense of themselves, their lives and daily experiences.

Faith communities can be welcoming, integrative and supportive; while some others can be exclusive and stigmatising of people experiencing mental ill-health.

The benefits and disadvantages of spirituality and religion

As we have seen, spirituality relates to a person's inner spirit, and therefore intensely to their experience of being human, their meaning and purpose in life; their human quest; what makes them tick; what keeps us well when life throws its challenges at us. It may also be related to a belief in a personal god, a cosmic life force, and/or an organised religious grouping. A Sikh, Christian, Muslim, Jew, Hindu etc. may feel as close to God while walking in the hills as worshipping in their gurdwara, church, mosque, synagogue or temple.

Case study 1

Anna is a practising Roman Catholic, married to David, who was brought up in the Jewish faith but hasn't practised for some time. Despite the different cultural traditions, the mutual respect between the religious traditions has been helpful to both Anna and David as the marriage progressed. When David developed a bipolar condition, however, his behaviour in relationships with his wife and children, and in his handling of money, became unpredictable.

The community team offers the family positive support, but now there is an increasing range of spiritual and cultural issues as both their two teenage children struggle to respond to the pressures they face of growing up, and coping with their father's illness, and their mother's anxiety.

David is giving indications that this mental health crisis is also a spiritual one for him, and that he may need to re-explore aspects of his original faith.

Question

How can the cultural and spiritual aspects of this family best be attended to?

(Taken from Gilbert (2008) *Guidelines on Spirituality for Staff in Acute Care Services*)

The downside of being in a society which is increasingly individualised, atomistic and consumerist can be that individuals are often locked within the confines of their own hearts, not reaching out to others in compassion (suffering with) and social solidarity. It can all be about 'me'.

The advantages of belonging to an organised religion are:

- feeling that a benevolent and more powerful entity is looking after you
- a sense of 'divine empathy'
- the provision of specific coping resources, not least through the signs, symbols, rituals and narratives which faith communities provide to give a framework for life
- the generation of positive emotions, eg. love and forgiveness, which fit strongly with the Foresight research into mental well-being, which shows that

altruism or giving is a major element in a person's mental well-being (Foresight, 2008)
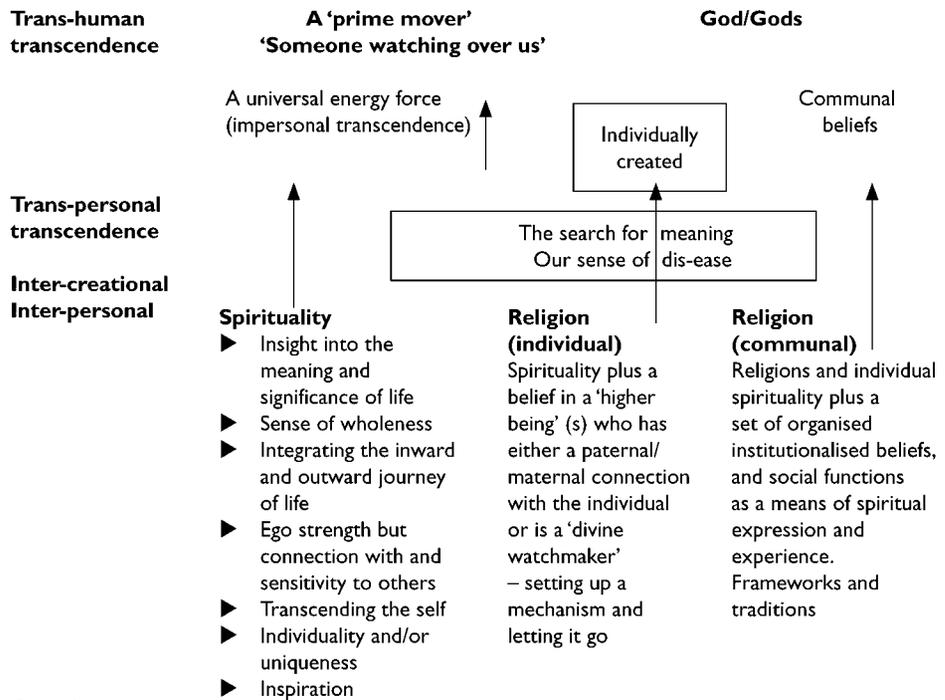- a sense of belonging
- trust in God and in the faith community.

(see Swinton, 2001 and Sims, 2009, and chapter 2 of this book)

The downside of religion again stems from its original meaning. Organised religion can be:

- over-controlling, and a straightjacket rather than a framework
- overly paternalistic, repressive and homophobic
- some of the earliest religions seem to have been female-led, but the priesthoods we know today tend to be male-dominated
- overly concerned with the needs of the organisation and not the individual or group.

(see figure 4)

Trans-human transcendence   **A 'prime mover'**   **God/Gods**
                                       'Someone watching over us'

A universal energy force (impersonal transcendence)   Communal beliefs

Individually created

Trans-personal transcendence

The search for meaning
Our sense of dis-ease

Inter-creational Inter-personal

Spirituality
▶ Insight into the meaning and significance of life
▶ Sense of wholeness
▶ Integrating the inward and outward journey of life
▶ Ego strength but connection with and sensitivity to others
▶ Transcending the self
▶ Individuality and/or uniqueness
▶ Inspiration

Religion (individual)
Spirituality plus a belief in a 'higher being' (s) who has either a paternal/maternal connection with the individual or is a 'divine watchmaker' – setting up a mechanism and letting it go

Religion (communal)
Religions and individual spirituality plus a set of organised institutionalised beliefs, and social functions as a means of spiritual expression and experience. Frameworks and traditions

Questions
Is spirituality and religion a selfish and individualistic pursuit, or are they outward-looking and connection to the 'common good'? Can independence and interdependence co-exist? Are the rituals of organised religion helpful or unhelpful? How prevalent is love and acceptance as opposed to hate (self and others), guilt and non-acceptance of diversity?

FIGURE 4   Spirituality and religion.

Some of the saddest people are those who adhere to all the religious rituals, but seem to have no inner spirit, and very little ability to walk in the shoes of the original founder of the religion or philosophy. The efficacy of religion depends on the degree in which it is well integrated into people's lives, and on the manner in which people extend that belief system and framework into all aspects of their lives to the benefit of others.

Dignity in care

The scandal at Mid Staffordshire Hospital, detailed in the Healthcare Commission report of March 2009 and the subsequent Robert Francis QC enquiry of February 2010, highlighted the tragedy of unnecessary deaths and an underlying routine lack of care.

'In the trusts' drive to become a foundation trust, it appears to have lost sight of its real priorities … and did not properly consider the effect of reductions in staff on the quality of care.' (Healthcare Commission, 2009, p11)

'The care of patients was unacceptable.' (Healthcare Commission, 2009, p6)

'The trust did not have an open culture where concerns were welcomed'. (Healthcare Commission, 2009, p9)

Both reports demonstrate that when a healthcare organisation loses its way and concentrates on an inappropriate business model, while neglecting its primary function of treatment and care, people suffer.

To create and sustain a service which centres on:

- people's personal, family and group needs
- an individual's 'animating and life-giving force'
- people's dignity
- the underlying culture and identity of each individual.

Leadership with integrity of spirit needs to be developed at all levels. Leadership is all about setting a value-based direction, with others, towards a better future; creating the right culture; bringing the necessary resources to bear to meet the goals; and developing people (Gilbert, 2005a; Goffee & Jones, 2006; Gilbert & Fulford, 2010).

If those managing an organisation are inauthentic and robotic, and don't develop and nurture their staff, then it is unlikely that those staff, in their turn, will be able to work with service users and carers to empower them and provide dignity in care.
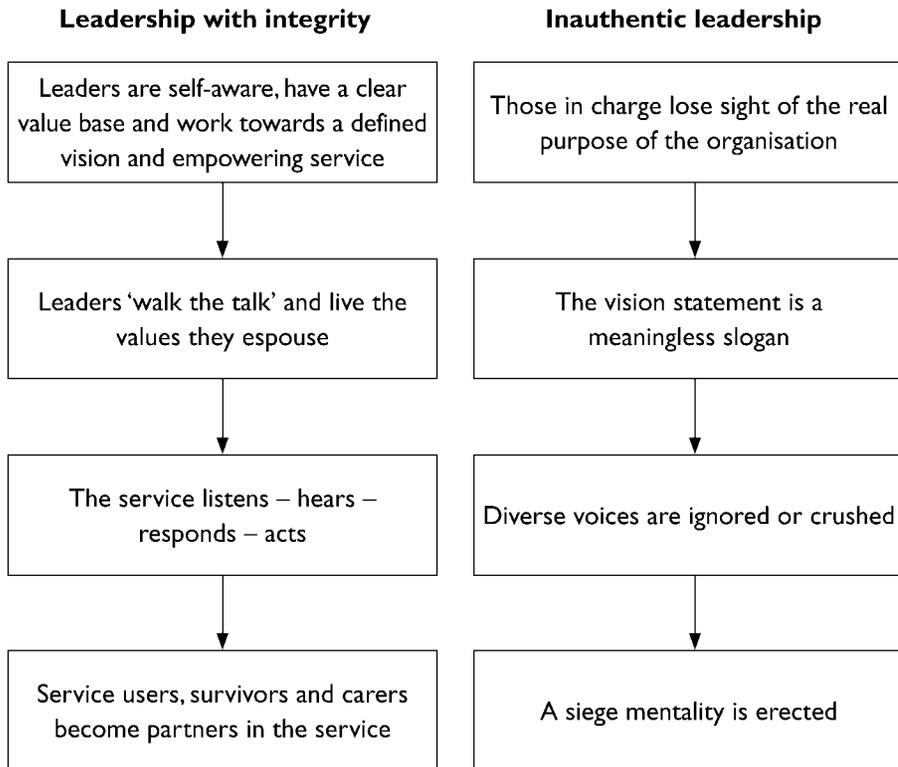
Leadership with integrity	Inauthentic leadership
Leaders are self-aware, have a clear value base and work towards a defined vision and empowering service	Those in charge lose sight of the real purpose of the organisation
Leaders 'walk the talk' and live the values they espouse	The vision statement is a meaningless slogan
The service listens – hears – responds – acts	Diverse voices are ignored or crushed
Service users, survivors and carers become partners in the service	A siege mentality is erected

FIGURE 5   Leadership with integrity.
(Gilbert & Fulford, 2010)

Who am I? Who are you?

Professor Kamlesh Patel, former Chair of the Mental Health Act Commission, spoke clearly about identity: *'If you don't know who I am, how are you going to provide a package of care for me to deliver something? When you do not know how important my religion is to me, what language I speak, where I am coming from, how are you going to help me cope with my mental illness? And that is what I am trying to get over to people; the first step is about identity. It is absolutely fundamental to the package of care we offer an individual'* (Mulholland, 2005, p5).

We never entirely know who someone is, or indeed perhaps even who we are. People will often say to me that they have had a particular experience, either positive or negative, or have undertaken some further awareness training: the Myers-Briggs type indicator, the Enneagram, a meditation course etc, and it has told them things about themselves that they didn't fully realise. For my own part, I found a residential course on the Enneagram (Hampson, 2005) extremely enlightening about a number of facets of my character and how I operate under pressure. Some of my characteristics are in many ways quite contradictory eg. the obsessive push for outcomes and achievement, with a desire to care and look after people. Sometimes they conflict – quite markedly!

It is one of the strange dimensions of mental health services that so many people operating in a professional capacity seem to have real difficulty in acknowledging that they have experienced mental distress, or perhaps a diagnosed mental illness. This is in

some ways in contrast with when I was teaching nursing students working in the field of learning disability, who would quite often mention that they had a sibling with a learning disability, or had contact with people with learning disabilities at an early age and that this had formed part of their motivation to undertake this professional caring role. The Director of the National Mental Health Development Unit, Dr Ian McPherson, interviewed in the *Society Guardian*, spoke about his experience of depression, and being an inpatient at a child and adolescent unit '*within a large Victorian psychiatric hospital on the outskirts of Glasgow*' (O'Hara, 2009). He recalls that '*being in hospital was a strange experience – not particularly bad, but nor was it remotely therapeutic*' (O'Hara, 2009).

When he came into mental health services as a practising psychologist, then as a manager and subsequently also as a trainer, he thought: '*probably slightly naively, that having had experience (of depression), it would actually be something I could bring with me as well as my training. I quickly got the message – subtly and less subtly – that even in what is a fairly liberal profession there was an implicit distinction between people who are patients and people who are professionals*' (O'Hara, 2009).

McPherson now believes that things are changing, and that people are more prepared to disclose elements of their experience, and stand on 'common ground' with those who use the service and their carers. While saying that his own illness '*gives no unique insight*' into mental health conditions in general, McPherson feels that what it has done is '*allow me to understand what it feels like*' to be seen as separate or '*that person over there with a mental illness*' (O'Hara, 2009).

The strengths and needs of service users and carers, and assessment are topics covered in chapters 4, 5 and 10.

Exploring your own spirituality

To really engage with other people's spirituality we need to engage further with our own. This isn't always easy, as it is not something we are used to doing. Recently, an Antarctic explorer spoke about how in the first week of her trip she tended to think about things at home that she had left undone; in the second week her thoughts became more orientated to serious issues; and in the third week she began to engage with issues such as the meaning of life.

At Staffordshire University, we invited social work students across the three years to join together in a small seminar group to explore the issues of spirituality, and asked them to bring in an item which had spiritual importance. One person brought a small statue of the Buddha which they had purchased in Thailand; another brought a picture of herself, her husband and her child, her husband had died suddenly at an early age, leaving her a single mum so this was a particularly moving image; another spoke of her husband who was currently serving in a war zone; another with a religious affiliation brought a copy of their scripture; and another brought pictures of his voluntary work.

Some items had a very deep emotional impact, others less so, but they were all important to the person bringing them, and were all treated with immense respect by the other participants. This safe environment enabled people to really explore their spirituality and listen to other people's with respect. Organisations need to create opportunities where people can use exercises, such as the reflection exercises in this chapter, to explore experience, identity and spirituality.

Please use figure 6 to consider aspects of your identity and spirituality.
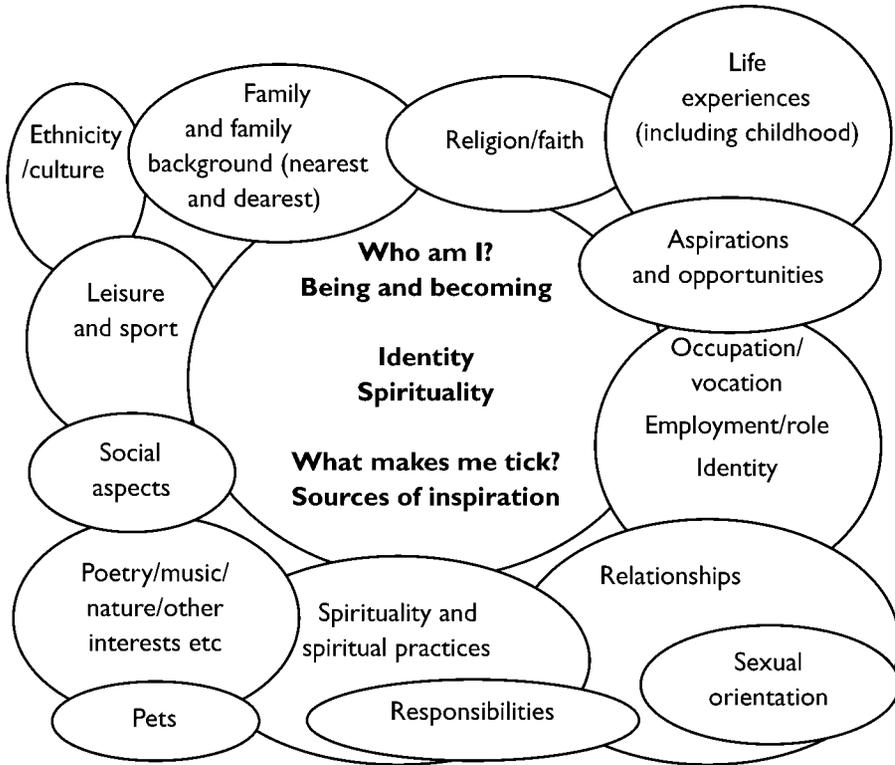
FIGURE 6 Identity and spirituality.
(Adapted from Gilbert (2008) *Guidelines on Spirituality for Staff in Acute Care Services*, p9.)

Creating space isn't easy in a busy environment, but is absolutely necessary to allow staff to engage with their own humanity, those of others, and with the human spirit of the whole organisation (see Aris and Gilbert, 2007).

Speaking from experience

When I experienced an episode of life-threatening depression 10 years ago, I drew on a range of spiritual, physical, medical and communal approaches to survive and recover (see Gilbert, 2010). My inner spirit has much to do with 'connection' and I found that depression disconnected or 'unplugged' me from myself, other people and God. I found the following helped me to 'reconnect' with my inner spirit.

- A GP who really listened attentively, gave me a measure of control over how I dealt with my illness, and prescribed the right medication for me.
- A friend who absorbed my extreme anger and sadness. As a society we are not very good at coping with and responding positively to strong feelings.
- My running club where I received communal support and the physical and spiritual benefits of running (Gilbert, 2005b).

- A friend who had been through a similar experience and offered wise counsel and support.
- Counselling to help me understand how past and present experiences were impacting on me.
- A place of spiritual 'asylum', the Benedictine Abbey at Worth in Sussex, where I didn't have to 'do' anything. I could sit in the choir stalls and the monastic community uplifted me through their prayers.
- Valued friends and colleagues who offered me employment, and valued me through their expressed faith in me.

Real 'recovery' took some time – about a year later I was off medication and back in work. Running along a beach next to Bamburgh castle in Northumbria, and looking across to the Holy Island of Lindisfarne, I experienced an epiphany which gave me confidence of moving forward in a sense of positive discovery and recovery.

Languages of love

Talking to a service user before the multi-faith conference in 2006, he remarked that what service users want from professionals and services is 'love'. The Royal College of Psychiatrists' recent book echoes this theme when the authors say:

  '*… 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*' (Powell in Cook, Powell and Sims, 2009 (Eds), pXVIII)

Love isn't an easy word to unpack, but inspection reports, surveys and feedback from user groups across a range of care situations, state that people desire loving attention to their humanity, identity, dignity as individuals, cultural context and practices, and innate spirituality. It is sometimes particularly difficult to demonstrate love to those who have been in a professional caring role, and then need care themselves (see case study 2).

Case study 2

Jenny had worked as a mental health nurse in both community and acute residential settings for 12 years, before she experienced an episode of acute mental disorder, following a period of stress at work.

Although in a mental health setting, and in a trust which spoke of the importance of 'experts by experience', and sharing experience, Jenny had noticed that, in a recent survey within the trust, very few people had felt able to indicate experience of mental ill health; and the prevailing culture was to: 'grin and bear it'. Trying to hide her symptoms, Jenny became increasingly manic, creating problems for herself, her family, her colleagues and service users, and eventually arrived at her GP's surgery in such a state, that she needed to access secondary care services – which caused her distress and the feeling of being stigmatised. For Jenny, being a mental health nurse had become a way of life, believing passionately in the need to care for others in distress, so when she became ill it was as though her whole life and identity was falling apart.

Now back at work, Jenny has found supportive colleagues and managers. She has been able to accept this experience and see it as valuable, and she has integrated the experience into her working life.

Questions
Does this sound like an experience you recognise?
How accepting is your organisation of the experience of mental ill health among staff?
How could Jenny have been supported initially?
Do you feel able to speak about your negative as well as your positive experiences?

Language

The method of human communication, either spoken or written, consisting of the use of words in an agreed way.

It is said that there are five languages of love:

▶ time

▶ words

▶ touch

▶ gifts

▶ acts of service.

However, language is sometimes difficult, country to country, or even the use and understanding of language from region to region within the same country.

What is precious, valuable, acceptable; difficult to appreciate or accept in one language might be quite different in another.

Many people find it hard to accept verbal compliments, but may find a small gift an affirmation which they can accept without a problem.

Some professions may use different languages eg. nurses, especially in physical care, may be using a great deal of touch. Social workers and psychiatrists may be using words more often. Care workers, acts of service.

How do we understand and use these different languages?

FIGURE 7   The five languages of love.
(Taken from Gilbert (2008) *Guidelines on Spirituality for Staff in Acute Care Service*, p18–19.)

For different people, love and care will be expressed, acceptable and accepted in different ways. For some, a few appreciative words may have profound meaning; but for others it will be very difficult to accept any measure of appreciation, as they feel they don't deserve it. For others, touch is very reassuring, and this is often the feedback we receive from people who are dying and feel isolated, alone and afraid; but for others touch is invasive or culturally unacceptable. An expression of empathy can be very subtle, sometimes the sharing of the feeling through a look or

even mutual tears (see Gilbert, 2010) may establish a common bond of humanity which pulls us through the crisis.

Recently I went to my GP, who was professional, a good listener, human, humorous and gave me a sense of hope. As she had made me feel better I sent her a card expressing my thanks. Neither her care nor my thanks was very complicated, nor did it take much time, and if she had been less human and less effective then it would have probably taken just as much surgery time. So why is it that we find being human so hard to do? It's not that difficult – is it?

Conclusion

Spirituality, in whatever form it takes, is a vital dimension of our humanity. As disillusionment with robotic and mechanistic forms of care has set in, and our society has become more multifaceted and multicultural, spirituality is becoming of increasing importance in health and social care.

The subsequent chapters will explore this in a range of ways which are intended to be helpful for those who use services, informal carers, frontline staff, managers and policy makers.

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