In Every One: a psychiatrist's reflections on spirituality.

Susan Mitchell

INTRODUCTION

Victor Frankl, psychotherapist and survivor of Auschwitz, in 1973 wrote:

Man lives in three dimensions: the somatic, the mental and the spiritual.

To put it another way: Each one of us has biological, physical (the somatic), social and psychological (the mental) and spiritual attributes - for a healthy life it is best if these are in balance. We are social beings with complex relationships within families, groups, culture and environment; all of these are interrelated and I believe traversed by the human spirit. Whatever we believe its substance to be, the spirit energises, connects and searches for meaning and purpose in life. Spirituality is the expression of that energy - the inner workings of the spirit.

Frankl went on to say:

The spiritual dimension cannot be ignored, for it is what makes us human.

If health care is to be holistic then it must acknowledge the spiritual dimension as well as the biological, social and psychological ones. Attention to one aspect alone cannot lead to full recovery. Psychiatry as a medical discipline is sometimes pejoratively regarded as hostage to a *medical model*. This *medical model* is one that regards all

illness as somatic, due at some level to bodily malfunction and it gives pre-eminence to biological remedies especially drugs.

In trying to understand spirituality and mental illness, such categorical explanatory models can be misleading as they tend either to ignore the spiritual or to see it as an addition to the other aspects. Although within psychiatry a more balanced and holistic bio-psycho-social approach has evolved, this may still leave little place for the spiritual and indeed can itself be hard to uphold; in 2005 the president of the American Association of Psychiatrists reflected that "we have allowed the biopsychosocial model to become the bio-bio-bio model". Johan Cullberg, one of an increasing number of humane and enlightened psychiatrists, argues cogently in his book 'Psychoses' that a humanistic view is compatible with biological understanding. There is now an increasing acknowledgement of the role of trauma, environmental factors and social isolation – the kinds of things that may adversely affect the spirit – both in the etiology and in the management of mental disorders.

I would like to consider the links between these dimensions in all of us – not just the spiritual, that of *God* in everyone – but that of the somatic and especially the mental in *everyone*. When I was a young medical student one of my psychiatrist uncles (yes psychiatry can be a hereditary condition) explained that all of the symptoms of mental disorder (depression, anxiety, paranoia, hallucinations etc.) could be experienced in ordinary situations such as danger, loss, sleep deprivation or dreams. This made a big impression on me at the time; today it would probably be called 'normalisation'. Later when I learned about stress vulnerability models of mental disorder I came to understand that we also *all* have vulnerabilities, we all have points at which we may

crack under the stress and strain of life, but we also have protective factors and resilience and many of these have a spiritual dimension. I think that this way of making sense of mental illness helps us to understand it as an experience that we all at times share, it also helps us to keep the connection with the spiritual.

OUTLINE

I'm going to start by talking a bit more about the relationship between stress and vulnerability and how I believe stress vulnerability models of disorder incorporate a spiritual dimension; what that spiritual dimension is and something of what the benefits are of attending to this in mental health care. Then I'd like to give you some examples of what I believe is the importance of a humane, 'spiritually attentive' approach for both patients and staff. This will lead me on to talk about The Retreat in the development of humane care and its importance in current practice. Finally I will say a bit about how we might ensure that all mental health staff have a better understanding of meeting spiritual needs.

But first, why me?

I am a practical clinician and for the last six and a half years of my paid employment I worked at The Retreat with people with severe psychosis in what is now called the complex mental health recovery unit. If anywhere in Britain has a claim on some tradition in understanding the importance of the spiritual dimension in the lives of those with mental disorders and of the practical expression of this, it is The Retreat York and I would like to be part of ensuring that this tradition both continues and extends beyond the confines of that organisation.

I have no claim to any special expertise or knowledge in this area other than my own interest, awareness and observation over the past 35 years, and a belief in the importance of having as honest and open a relationship with my patients as possible. Although, that said, I am now the co author of a chapter on Psychosis in Spirituality and Psychiatry, published last month by the Royal College of Psychiatrists.

A number of years before moving to the Retreat I became increasingly aware that there could sometimes be a barrier between my patients and me. I was not addressing all their needs, in particular spiritual ones. I knew the things that sustained *me*, like tai chi, mindfulness and mountains (and at times the shared experience of Quaker meeting for worship) yet I was hesitant about discussing these topics, aware that we all have different values and I that should not impose mine on others. And although I had begun to tackle this whilst working in the NHS in Scotland my move to The Retreat gave me the scope to consider this in more depth.

Vulnerability and stress

Models of vulnerability and stress suggest that we all have vulnerabilities of one kind or another; the fact that my aunt had a bipolar disorder and that my great aunt committed suicide implies that I might have some (possibly biological) vulnerability to depression but that it might require a stressful event for me to actually experience depression. Models of stress vulnerability also suggest that if a stressful event is severe enough it could precipitate a psychological disorder even if there are no predisposing individual psychological or biological characteristics; the link between an adverse social environment and the onset of depression has long been recognized. The majority of research in this area consistently finds a relationship between the experience of stressful life events and the onset of depression, with some studies suggesting that approximately 50% of individuals diagnosed with depression have experienced severe stress before the onset. The relationship between stress and vulnerability is complex. Not all vulnerability is 'biological'; some forms of 'stress', for example childhood sexual abuse or the experience of torture, generate vulnerabilities. There is now a better understanding of the interplay between 'biological' genetic, neuro-developmental and traumatic events as *vulnerability factors* on the one hand, and social and spiritual supports –including work or occupation and a sense of cohesion- as *protective factors* on the other, with 'stress' acting as a *trigger.* So if a person has a vulnerability and they experience stress their resilience or protective factors may determine whether or not they will experience any psychological disturbance.

So what is the spiritual dimension?

It is difficult to put into words the ineffable quality of spirituality; indeed the immanent nature of spirituality is such that you may not notice it unless you first allow for the possibility that it exists. It is also difficult to talk about and if we do there can be the danger of turning it into something else – spirituality with a capital 'S'. But there is, I believe, in all of us something (a spiritual quality) that goes beyond what we can measure or define - an aspect that is an awareness of the transcendental or of the 'divine'. For many people spirituality is reflected in their religious practice, for others it may be in something else such as music, poetry, nature, exercise, art or indeed their work.

Spirituality is often confused with other things, with fairies, spirits, spiritualism or especially religion. But spirituality need not be the preserve of religion. My understanding is that the spiritual – the sense of the totality - is pre-eminent and inclusive and that the guiding purpose of all religions is to connect us to the spiritual (Remen, 1993). Some of us find a 'spiritual home' in organised religion. For others organised religion is oppressive, and may have a negative connotation or be linked with abusive experiences. Even for those committed to religion it may have negative as well as positive aspects; the person may feel guilt that they need something more than their faith to sustain them or may experience their religious group as stigmatising or rejecting.

Can we define spirituality then? A definition by Professor Chris Cook (2004), a psychiatrist in the department of Theology and Religion at Durham University, for me gets close to what we are considering:

> 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 others, and/or as relationship with that which is '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.

This definition reflects all of the five elements that have been identified as spiritual needs by Swinton, another mental health professional turned theologian this time from the University of Aberdeen.

1. **Values/structures of meaning** Hope, faith, purpose, dealing with guilt and initiating forgiveness, courage, freedom, patience and tolerance
2. **Relationships** therapeutic presence, possibility of intimacy
3. **Transcendence** creativity, reaching god, dimensions beyond self
4. **Affective feeling** comfort, peace, happiness, reassurance
5. **Communication** telling stories, listening and being listened to, language, healing stories

These spiritual elements are important to healing and recovery (the resilience and protective factors that I referred to earlier) and it is important that we find ways to nurture and sustain them. Of these **keeping hope alive** is particularly important. Perhaps Emily Dickinson, herself no stranger to mental distress, puts it best:

"Hope" is the thing with feathers —

That perches in the soul

And sings the tune without the words

And never stops – at all -

And sweetest – in the Gale – is heard -

And sore must be the storm -

That could abash the little Bird

That kept so many warm -

I've heard it in the chillest land -

And on the strangest Sea –

Yet, never, in Extremity,

It asked a crumb – of Me. Emily Dickinson c.1861

For Pat Deegan, North American psychologist, campaigner and former service user, the 'chillest land' was a desolate friendless mental institution, but here she realised that hope was "not just a nice sounding euphemism. It is a matter of life or death" and she talks of the importance of relationships in keeping hope alive; Rachel Perkins, a psychologist in the UK who has suffered from mental illness, also acknowledges the importance of relationships and that: "hope does not exist in a vacuum".

Yet the spiritual elements – values, meaning, relationships, communication - are the very things which may become fractured or disturbed by what we call 'mental illness' in particular matters of meaning and purpose in life, truth and values are the very elements that are at the core of the psychotic experience. Psychosis often arises in

adolescence or early adult life, when the individual is developing a sense of self (schizophrenia has been called the 'sickness of the self'), questioning established certainties, myths and beliefs; exploring or experimenting with new ones and seeking their own sense of purpose and meaning; grappling with the conflicting demands of external expectations and opportunities while at the same time trying to fathom their internal world. Psychosis is also found disproportionally in both first and second generation migrants whose situation is often characterised by a new and challenging external reality in terms of language, culture and social support. And it can have a devastating effect on the family as well as the sufferer.

Creativity is an essential aspect of spirituality; the experience of transcendence and the need to explore dimensions beyond the self. It has long been recognised as a dynamic force through which our lives have meaning and purpose that also involves communication, relationships and affective feeling. It is important not to neglect this as Vincent van Gogh was aware when he wrote to his brother Theo in 1888

"I can very well do without God both in my life and in my painting, but I cannot, ill as I am, do without something which is greater than I, which is my life – the power to create".

For a patient recently at The Retreat the opportunity to be creative was very important. She writes: 'Prior to coming to the Retreat I had not done any art for 25 years. Being here unlocked a joyous creativity for me. During my stay I was captivated by the beauty of the grounds and sought to capture some of that beauty in my paintings and photographs. '

Peter Chadwick, himself a psychologist, refers to the spiritual dimension of his illness as reinvigorating and enriching of creative and emotional life and states that "The recognition of the spiritual side of my illness and the taking of it seriously by clinicians and social workers were extremely important in my recovery" (Chadwick 2001).

Being listened to, gaining new understanding in the process of telling and listening are important in the process of recovery. Through this meaning and coherence can be regained. Yet it can often be difficult to maintain this kind of collaboration when a person is in the confusion of their psychotic reality and in the pressurized 'unreal' setting of a psychiatric ward. It may be difficult then to have any sense of the person's whole psychological reality, and only too easy to fall back on a checklist style of interviewing and not *really* listening (Jackson & Williams, 1994). Fear may make it difficult to communicate; (both for the doctor and the patient) there may be aspects of the experience for which there are no words (or for which it is difficult to find words). Hence we may need other "languages", drama, art, literature [especially poetry] and music; some way, as Chadwick puts it, for the person to turn their pathology round 'in a productive and creative direction' and to 'give oneself over to something bigger and more important than oneself'.

What happens if we attend to spiritual needs?

People who have experienced mental illness have identified a number of benefits of both meeting spiritual needs and of improving the training and understanding of mental health staff. The benefits include

- improved self-control, self-esteem and confidence;
- faster and easier recovery, e.g. achieved through both promoting the healthy grieving of loss and maximising personal potential;
- improved relationships – with self, others and with God/creation/nature;
- a new sense of meaning, resulting in reawakening of hope and peace of mind, enabling people to accept and live with problems not yet resolved.

A recent study by researchers in Northampton (Kohls & Walach 2007) has shown that spiritual practice can buffer mental distress and that lack of spiritual practice (both religious and secular) can be a risk factor for mental distress. Other studies support the benefits to mental health of belonging to a faith or spiritual community and of holding religious or spiritual beliefs.

What is spirituality when it comes to mental health care?

What I call **practical spirituality** is as much way of *being* as a way of *acting.* It is both being and doing; the ability to journey with someone involves doing as well as being. It is meeting on equal terms as people, offering acceptance, being in the present moment in all that we do. Every form of therapy has the potential to be spiritual: 'Spirituality' is not a special form of treatment, there are no technical routines that are inherently spiritual – it is the way in which the work is carried out that imparts the spiritual quality and therapeutic approaches that enhance creativity, connection, and communication for the individual have been shown to improve self-esteem and wellbeing.

Let me explain what I mean by practical spirituality

Many of the people who are referred to the Retreat have spent long years in other hospitals and have been deemed to have complex, intractable and unresponsive conditions and we can be asked to offer long-term care. This is not always what the individual concerned wants and it is sometimes possible to turn the situation round and for the person to return home. In one such instance a member of the referring team said:

'I don't know what you're doing but I'd like to bottle it'.

'Well' I thought, 'maybe some of it doesn't go into a bottle'.

Although I would not claim that this is unique to The Retreat, what I think we were (and are) doing differently was (and is) attending to key elements of the spiritual dimension, developing trusting relationships, listening, really listening so that the

person feels heard, sharing in and bearing some of the pain and loss with both the patient and their family - being open and meeting on equal terms as human beings.

Most of these key elements relate to what can be recognised as central features of spirituality; purpose and meaning, relationships, trust, coming to terms with bereavements, creative needs, understanding meaning in madness, journeying through pain, telling stories. An acceptance of the validity of an individual's experience, belief or aspiration, a willingness to help them make some sense of it and an acknowledgement of the spiritual in the real ordinariness of life. Awareness, language and approach are crucial in how this is done.

But what happens if there is a lack of spiritual awareness?

What had happened in the team referring a person for long term care that they have effectively 'given up'? David Kennard (2007) has recently described how in 'the day-to-day work in mental health units, pressured from many directions, staff may adopt self-protective defences such as emotional detachment, reductive labelling, them-and-us blaming, and retreat to the paperwork.' They may need to recover the 'sense of meaning and fulfilment in their work, the humanity and compassion that first brought them into the field'. Despair as well as hope is contagious. Psychiatrists (physicians of the psyche) need to be able to develop the capacity to witness and endure the distress of those with mental disorders, to travel the sometimes long and complex road to recovery with them, while sustaining an attitude of hope.

Too often staff may 'give up' when a person who has a recurrent illness, fails to respond quickly to conventional treatment or when ECT also fails. In this case the

person may try to kill themselves if they believe this is a treatment of last resort. Or there may be a particular difficulty for staff 'connecting' with a person who is more able intellectually than they are, teachers, doctors and lawyers come to mind. What is needed here is not 'relabelling' the person as untreatable or psychopathic, as can happen, but really listening to them, finding out about their doubts and fears, understanding their meanings through a trusting relationship. Then things can often begin to change when the person feels understood and accepted by the process of simple listening and acceptance not 'goal orientated' therapy. The lack of ability of members of a team to 'tune in' to such a person's "larger meanings" might well cost him his life.

Sadly, unless we pay attention this will continue to happen.

I like many of my colleagues have learnt more from those with mental illness than from text books. I have recently been looking at the old hospital notes of my aunt, who taught at the College of Art in Dublin and was herself an accomplished artist. She died in her 85th year after a life long battle with mental illness (and with psychiatrists). What was most moving in the records were her many letters. In one of these she objected to being given what she called 'mechanical treatments'. In 1955 she wrote: "I have my intelligence and everything in me revolts against the mechanical treatments. I am quite different. An artist is not mechanically minded at all." This was after a long admission during which she had had 60 treatments with insulin induced coma which her doctors thought had helped her – for her what helped most was probably the fact that she was given some clay and was able to create a

sculpture of St Francis and that she had some interested people to talk to who I hope connected with her meanings, as she said "Human encouragement every time!"

Much of the current interest in spirituality in mental health relates to the benefit that attention to spiritual matters can bring but there is also considerable interest in more extreme spiritual experiences or spiritual crises. Clinical practice brings us into contact with people who are distressed by their disorders and for whom spiritual experiences are not positive - the certainties of the psychotic world may be ruled by devils and evil spirits. The person with depression can be seen as 'dispirited' with associated delusional beliefs and perceptual disturbance and the person with elevated mood may have excessive spiritual energy, to the exclusion of all else when what is needed for health is a balance; enough spirit to be alive but not an overload. How do we listen and how can we support and travel the road with people who are spiritually distressed. If we accept that the religious or spiritual sense is the 'sense of the totality' that is a sense that may be unbearable for anything but a short time. As this beautiful quatrain by Rumi puts it:

The mystic dances in the sun,
hearing music others don't.
"Insanity," they say, those others.
If so, it's a very gentle,
nourishing sort. Translated C Barks

But what if the spiritual experience does not feel nourishing to the person? If the greater part of your experience is 'the beauty of the universe' you will be exhilarated

but the awe inspiring may become terrifying and you will then suffer terribly. In this situation the distinction between spiritual experience and mental disorder can become blurred – a line from the wonderful poem by Patrick Galvin 'The madwoman of Cork' captures this for me,

'*I am the madwoman of Cork, my mind fills me'*.

A practical spirituality task is to try to make the unbearable bearable through the ordinary, so the beauty of the universe can be seen calmly again as through the eyes of a gardener. In a spiritual intervention or in a clinical intervention that acknowledges the spiritual we aim for balance. Helping the person see that there is more to their life than just the overtly spiritual so that they 'attend' to their bodily needs and personal care. Through an apparently simple matter of getting the person out working in a garden or riding a bicycle in the spring sunshine; they are getting more than physical exercise.

The language that we use is important in creating a sense of balance, openness and acceptance no matter how strange or bizarre the experience of the other seems. Mindfulness and other 'grounding' techniques can be used to help the person reconnect with consensual reality. It is notable that in the early days of The Retreat there was recognition of the importance of work or occupation in recovery, in particular working in the garden.

And so to The Retreat

This audience perhaps needs little introduction to the history of The Retreat a synopsis of which is in the information packs.

In 1790 Hannah Mills, a Leeds Friend was admitted to the York Asylum where she was refused visits from the local Quakers and died shortly afterwards. These events appear to have been the catalyst for the idea of creating a place where Quakers could be cared for according to their beliefs and by their own people. This element of common values of patients and therapists – a continuity of spiritual dimension – may well have been one of the important factors that created this unique and successful form of moral therapy.

William Tuke, described as a man of *'an uncommon degree of firmness of mind'* founded the Retreat 1792 based on humanity and kindness with particular attention to the comfort of the patients. Moral treatment emphasized kindness and order within an attractive environment. Pleasant pastimes, a sense of domesticity, a surrogate home and family, and occupational therapy were innovations at York, whereTuke created an environment where people could:

- take responsibility for their own emotions and conduct;
- gain a clearer sense of their own personal truth and their responsibility towards others and
- develop trusting relationships.

He rejected the use of fear as a means to control behaviour, encouraged a mild tone of voice and calm use of authority and the desire for the esteem of strangers as an inducement to self-restraint. He said: "The patient, on all occasions should be spoken to and treated as much in the manner of a rational being as the state of his mind will possibly allow. By this means, the spark of reason will be cherished."

This connection with the non-psychotic 'sane' aspect of a person when their way of presenting themselves is unfathomable or unacceptable is a key issue in rehabilitation

psychiatry and in recovery today. It has its roots firmly at the Retreat and in the Quaker belief that there is 'that of God' in everyone despite their loss of reason .The emphasis on the 'Inner Light', that positive, spiritual, life-affirming experience at the core of every individual regardless of race, gender, age, religion, belief or status, is still the guiding principle of The Retreat today. The early Retreat has been described as a "lay experiment caring for distressed people, a small therapeutic community based on an extended family model, in which attendants and residents lived, worked and dined together."

The first superintendent of The Retreat, George Jepson, appears to have been appointed more for his Quakerly spiritual qualities than for his experience in caring for the mentally ill [he was a self taught apothecary and weaver]. Before he came to York he had been held in considerable esteem by the country folk around Knaresborough, 17 miles west of York. Many travelled to see him because of their belief in his healing powers. He was, in my view, the person who was largely responsible for the form of 'moral treatment' described by Samuel Tuke (William's grandson) in 1813 in the '*Description of The Retreat, an institution for insane persons of the Society of Friends'* as follows: The moral treatment of the insane, seems to divide itself into three parts; and under these, the practices of The Retreat may be arranged.

We shall therefore inquire:

- *By what means the power of the patient to control the disorder, is strengthened and assisted.*
- *What modes of coercion are employed, when restraint is absolutely necessary.*
- *By what means the general comfort of the insane is promoted.*

The first of these has strong resonance with modern forms of collaborative psychotherapy now used at The Retreat – CBT, DBT for example and also with the idea of resilience and the enhancing of protective factors that I mentioned earlier.

George Jepson seems to have been a remarkable man who began work at The Retreat at the age of 53 and remained there until he was 80 - the year that William Tuke died. Daniel Hack Tuke, William's great grandson wrote: 'George Jepson devoted himself to the work in the same spirit as William Tuke'; Anne Digby in her scholarly account of The Retreat, *Madness, Morality and Medicine,* describes Jepson as a spiritual healer and she wonders if this was the elusive element that led to the success of The Retreat:

"*…if The Retreat's moral therapy did indeed contain a hidden kernel that was spiritual healing, it helps to explain why the treatment was so successful at York and much less so in other institutions that attempted to copy it*."

No mention, however, is made of 'spiritual healing' in the *Description*.
The social historian Roy Porter also alludes to the unique qualities of The Retreat when discussing the shortcomings of the subsequent asylum movement that paid…..:

"*… too little regard for the highly exceptional conditions attending to The Retreat itself – its small size, its extraordinarily homogeneous community of Quakers, patients and staff; its support network of local Friends who ran informal halfway houses and paid visits, etc. The nineteenth century put its faith in the asylum but*

failed to pay attention to the unique conditions under which the asylum might actually repay such faith."

In the early accounts of The Retreat there is recognition of the importance of a spiritual strength because of the stressful nature of the work with the mentally ill. Anne Digby quotes from the journal of William Waller an attendant there from 1843 -1856:

"*…. my trials have been great while engaged as attendant on the afflicted in body and mind, and I feel I need the grace of patience, and also humility to enable me to act and think aright, and to walk as becometh the gospel*."

July 1847

There are echoes here of the Old Testament verse from the Book of Micah "to act justly, love mercy and walk humbly with your God" which remains pertinent still. Today our professional training focuses on valuable technical knowledge, skills and experience, all of which are essential if we are to think clearly about how to help our patients; ('act justly') but we must also have the care and compassion ('love mercy and walk humbly').

In the early years of the Retreat many people came to visit especially following the publication of the Description. Between 1815 and 1834, 703 visitors came to The Retreat including the Grand Duke Nicholas of Russia and seven Senecan Indians from North America along with many from Europe.

The Retreat continues to attract visitors, often from the USA and Europe and there has been a renewed interest in moral treatment in recent years both here and in the USA.

Links with the USA have been renewed in the past few years and the Retreat has been invited to join The Ivy League Psychiatric Hospital Group. This is a consortium of seven hospitals in the North East USA sharing a history of the origins in the Moral Treatment movement inspired by The Retreat that has been meeting for over a hundred years. The group has focused its attention on disseminating information on advances and best practice methodology in the area of mental health and on learning from one another's successes and failures in the area of practice. This year I was invited to the inauguration of the new Bloomfield Care Centre in Dublin, incorporating the original Bloomfield Retreat, founded in 1807 by Irish Friends and based closely on the Retreat York. Unfortunately I was not able to attend but we look forward to building on this link. The Retreat has been involved in some international outreach too. After a number of visits to and from colleagues in Moscow who are keen to develop a similar model of service for psychosis and we now have regular video conference supervision with them. In February this year Annie Borthwick visited Zomba Hospital in Malawi and has now developed a support link with the Occupational Therapist there, who is trying hard to involve service users in learning new and practical skills, to educate families and to start a day service so that people can be rehabilitated gradually. In March I was invited by some visitors from France and subsequently spoke to a UNAFAM (Union Nationale des Amis et Familles de Malades Psychiques) group in Avignon about the work of the Complex Mental Health Recovery Services.

These continuing visitors and the interest in The Retreat are testament to the power of the idea, realised by William Tuke, nurtured by George Jepson and publicised by Samuel Tuke that the subsequent generations of those working there have kept alive.

The Retreat began by putting humanity and spiritual concerns first; it was run by lay therapists with a pragmatic not a theoretical approach. Although doctors were always employed as visiting physicians, it was not until 1838 that John Thurman became the first resident medical officer. His appointment broke the tradition of resident lay therapists and visiting doctors. The Retreat along with the Bicêtre under Pinel in Paris employed ex-patients as attendants as they believed that they often had a deeper understanding of the nature of the work. Have we now come round full circle with our recognition of the contribution that 'service user consultants' or 'experts by experience' can make?

In the 21st century the Retreat has once again found its pioneering spirit and a reconnection with its founding principles. Staff strive to uphold these principles and constantly question how well this is achieved. Any organisation with a somewhat idealised past needs to do this. Although bigger than the original, it is still small enough to feel like a community (275 staff and 95 beds) and is once again an innovative place where new approaches to complex and intractable problems can be tried. There has been a growing interest in our work as we have tried to combine the Retreat's original principles with modern evidence based treatments. At The Retreat there is now constant attention to improvement in practice, which includes service user involvement with former patients acting on appointments and other committees, constant attention to the physical environment which includes a new learning resource centre and a newly created 'Quiet Space'. This room is a simple and peaceful environment designated for service users and staff of any faith or none. It is a space in which to pray, meditate, worship, or just quietly *be*, away from the hustle and

busyness of the day-to-day hospital routine. The room may also be used for small-group religious activity, for Quaker Meetings, Holy Communion, Roman Catholic Mass, and as a regular prayer space for those of Islamic or Jewish faiths.

But above all what I believe the Retreat offers to all who use its services are consistent humane relationships. This has been borne out recently during an evaluation by the service users of the complex mental health recovery unit were having hope and being valued as an individual were recognised as important, especially by those who had moved on, and that having a clear model of care delivery, in this case psychosocial interventions, may be important in allowing the staff to remain hopeful and compassionate.

The importance of relationships and connectedness is also captured in a letter I received last year from a patient I had looked after years earlier in Scotland:

……it's just what's needed when a person has been through tough times. The professional relationships we form help to ease us back into more normal and natural kind of relationships with our family and acquaintances that we perhaps once had and that helps to set a good basis for a sustained recovery……

A better understanding of meeting spiritual needs

Too often training misses the spiritual dimension nor is it an integral part of our assessments. 'Assessment' in this context really means having an awareness of and enquiring about the spiritual concerns and needs of the individual and if appropriate

attending to them. Perhaps 'appreciation' is a more appropriate term than assessment as we cannot measure or quantify the spiritual.

This should not be a matter of an impersonal check list of questions but more a case of arriving at a shared understanding of what is important for the person in a way and at a time that is comfortable for them. In order to do this sensitively, healthcare workers should have an awareness and understanding of their own spiritual dimension. It is also helpful if they know something of religious beliefs and practices and are able to distinguish between spiritual experiences and spiritual practices.

Spiritual strengths for healthcare workers include: being balanced reflective and honest; remaining focussed in the present, alert, unhurried and attentive; having the ability to create and convey to others a calm state of mind; showing empathy and compassion; having the courage to witness and endure distress while sustaining an attitude of hope; developing discernment about when to speak and when to remain silent; learning how to give –and to be sustained as well as drained; being able to grieve and let go (Powell 2002).

It is important to be able to know when to ask for help too. An experienced nurse said to the consultant that he was finding it extremely difficult to look after one of his patients. 'I can't go there with her.' What he meant was that the degree of this woman's depression was so profound, so palpable in its pain and distress that it touched on his own past periods of depression too keenly. He was afraid of being dragged down too. Within the team staff members were each struggling to hold on to hope on behalf of this woman who had lost all her own. They were able to share this sense of hopelessness in the staff support group and in so doing regained some hope for her. When working with a group of patients who have been ill and in hospital for

many years, and who may have given up hope or any sense of agency for themselves long ago, this is not an uncommon situation; trying to make the unbearable bearable and sustain the spirit is a practical task.

How do you help someone to be spiritually aware and to meet the spiritual needs of those in their care? How do we as professionals cope with the dilemma that on the one hand we are urged to do everything that has a strong evidence base, to work in specific teams and on the other to be more person-centred, humane and spiritually aware?

The first step is of course to talk about it. The following are things to consider when assessing the spiritual needs of a person's life or one's own.

- What
  - sustains you
  - gives you strength
  - keeps you going in difficult times
- How do you keep hope alive
- In the past, present and future
- What might help, and how might we help

At the Retreat, through the Spirituality Working group, we are actively looking at what is the best way to help staff feel more at ease with spiritual issues and ways that might help in having such conversations. Annie Borthwick and I have recently held a seminar for staff to explore this which was well received and has led on to further work.

But most important of all we must try to ensure that we adopt a humane and compassionate approach in all we do, a wholeness that includes mutual support amongst all staff, not just the clinicians.

Summary

I hope some of what I have said has been of interest and has perhaps prompted some questions. I hope also that I have conveyed something of the importance of a pragmatic spirituality for us all. For me it is an essential element, not one that is easily measurable but is noticed when it is absent. I think there is much to be learnt from continuing to reflect on the work of the early Retreat and on our own current practice, by listening to what service users and carers are telling us and ensuring that we acknowledge their creative energy, and do not stifle it.

'Creativity is eruptive', wrote Dory Previn. 'It's a blade of grass pushing through concrete. And we poured the concrete.'

Kathleen Jones in her introduction to the facsimile of the *Description* in 1996 states "respect for patients, the emphasis on human rights and the value placed on relationships are as relevant now as they were in 1813"

Rigorous science and compassionate humanity are both needed in a good physician; to ignore the spirit is indeed to miss the humanity.

Susan Mitchell 27 July 2009