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# Psychiatric and Mental Health Nursing

The craft of caring

Second edition

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## CHAPTER 73

# Spirituality, nursing and mental health

Stephen G. Wright\*

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### INTRODUCTION

I was 10 years old and playing football in the street; snotty nosed kids in dirty T-shirts and worn old shorts. Brian stood on the pavement alone, just watching with a lonely, longing look on his face. Nobody spoke to him, and he spoke to no one. He had come from a few streets away and wandered into our patch, an odd thing to do in those days – kids kept pretty much to the streets near home. He might just as well have wandered over from a foreign country. He went to the same school as me, but was in a different year. One of my teammates called out his name together with a dirty word and told him to ‘Get lost’.

They put me in goal, the place where the least useful player could be safely stored, there being no skill required but to stand around a lot and (hopefully) block the ball anyway you could if it came your way.

I was always useless at football, and so I learned an early lesson about exclusion in my working class childhood – always being the last to be picked for a team. I remember feeling some sympathy for Brian, for I too had the feeling for much of my childhood of being left out, not wanted. I can see him now as I write this as clearly as I could see him then, his grey pullover with a hole at the elbow, his dull brown hair all spiky and unkempt, his muddy shoes with socks rolled down to his ankles. The

backdrop, of red brick council houses and ranks of factory chimneys pushing into the blue summer sky, frames the picture memory of him I keep.

I was bored in goal and all the action seemed to be taking place at the far end. I sat down on the pile of clothes that marked one goalpost and the next thing I knew Brian was beside me offering a stick of chewing gum. ‘Ta’, I said, and smelled the spearmint as I took it from the silver wrapper. He was about to speak when I caught an expression of alarm on his face. He was looking at something behind me but before I could turn I felt the slap across the back of my head. I whirled round in pain and tears to find my older brother reaching over me and shouting ‘Get inside!’ It was only a few yards to our front door, but by then the salt water had created long lines through the dirt on my cheeks and my cries of protest. He banged the door behind us, ‘Mam told you to stay away from him.’

When I looked out the window everyone had gone, except Brian leaning by himself against the lamppost.

I never quite understood then why I was supposed to avoid him. The words used by grown-ups to express disapproval were assumed to mean something to me, but they did not. Brian lived alone with his mother, who had ‘gone mental’. Whatever that was it was clearly a serious thing, and obviously worse than measles or mumps because I knew when I had had these things you were

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not allowed to play with anybody. So I thought maybe 'mental' was something you could catch. As far as I knew, Brian was a perfectly 'normal' kid like me, but, whatever it was his mother had got, then it seems there was a risk that he could have it too and could even pass it on to me.

I never saw him again. Older neighbours muttered words like 'fostered' and 'nervous breakdown' and somehow these seemed to be linked to his disappearance. Perhaps they were something to do with death, for I knew that when Mr Haworth up the street died he went away and I never saw him again either. But I did not dwell too much on these mysteries; there were long summer days to enjoy before it was back to school.

Decades later I sat in nursing school where I was introduced to the sociological concepts of 'stigma' and 'disabling the normal' and I remembered Brian and how his mother's mental illness not only stigmatized her but spread out across the family. I was left with uncomfortable feelings about just what it was to be 'normal' – who or what had defined the parameters. Caught up in the tendency towards binary opposition in our culture where *good–bad*, *sane–mad* seemed so clear-cut I was in conflict. The *mad–sane* paradigm came to be meaningless in my progress through nursing as I met the disturbed souls fitting no diagnostic label (much as we, with breathtaking certainty, made sure they had them!). Most disturbed people seemed to me to be having a perfectly understandable response to the madness of their situation; a reflection of the horror of their reality. Faced with all this existential angst, why not go crazy, get drunk, take drugs or shop till they dropped? Maybe I was the insane one because I could not see what was wrong with life?

## VANITY, BADNESS AND THE FAMILIAR

In Durham Cathedral a line of black stones is inlaid across the aisle stretching from one wall to the other. In the Middle Ages this was the limits to which women could proceed. Beyond that, it was men only; women were unworthy of drawing close to the holy of holies. In some schools of thought they still are deficient in some way, not quite up to the 'normal'; a standard set by men and, some believe, by God too. Where has the line been drawn in mental health, and what happens when we cross it? Currently, psychobiological models of what is normal mental health prevail. When the line is crossed – when we cannot function or relate 'normally' to others – a diagnosis rapidly follows, often serving in some way to keep you forever beyond the line.

A spell working in a secure unit for profoundly disturbed women led me to encounter the deepest and darkest shadows of the human psyche. All 16 women had committed terrible crimes of violence, including murder, and were judged to be not just bad but mad. All had been

abused as children; all had histories of deprivation, drug and alcohol abuse, criminality and violence (towards themselves and others). I was both fearful and awestruck by these women. In the face of their reality, or what they had been told or learned *was* reality, they had kept it together and stayed behind the line for so long. Under the sorrow and hurt of their years, they had sometimes found happiness and joy. Yet, they had crossed this line of normality drawn by forces beyond their control and were forever condemned. When their reality crossed into the reality of the normal, catastrophe was the only outcome.

These two worlds vie for authority, and at the fluctuating boundary is the grist for the mill of modern mental health care. The line between is rarely clear, although we invest huge legal, financial, personal and organizational energy in making it otherwise. Nurses and patients meet on this messy frontier in the giving and receiving of effort to hold the imaginary line, for here we find the unfolding and infinite crisis of meaning; here, people struggle to make sense of themselves and the world.

The prophet wails at the transitory emptiness of life. 'Vanity of vanities! All is vanity' (Ecclesiastes), for in Hebrew vanity is *hevel* – meaning vapour, wind, things transient and impermanent. The passing nature of ordinary reality has led many in all spiritual traditions into the quest for the possibility of a non-ordinary reality (arguably the 'real' reality), the landscape of the soul, the absolute, *God*. The writer of Ecclesiastes seems to have been a mystic; having looked through the doors of perception beyond material reality, he saw another reality. Such shifts in boundaries, such spiritual emergence, from our established way of seeing the world can produce a profound transformation in the way we live our lives. We can become more fully human, or we can crash into mental chaos.

There is much scholarly discussion on the line between madness and mysticism, but for nurses in the field of psychiatry this is no mere theoretical debate. We are pushed into engaging with our own inner struggle over the rights and wrongs of the approaches and treatments on offer. Some manage this conflict by accepting the status quo, others seek to work from within but try to change things, and others escape the profession (coping strategies, defined decades ago in Marlene Kramer's<sup>1</sup> seminal nursing study). A fourth way has unfolded in my experience – that of nurses *internalizing* the conflict and becoming sick. The commonest form of that sickness is *burnout*, when the energy invested in shoring up the defences against conflict fails, and we collapse into an inability to function.<sup>2,3</sup> Such a crisis is spiritual.

## SPIRITUALITY, RELIGION AND HEALTH

There is growing evidence that a major cultural shift towards matters spiritual is under way,<sup>4</sup> and a knock-on

effect is found in the expectations of patients seeking spiritual support from nurses. Yet the evidence suggests that there is still much confusion, among nurses especially, over what spirituality and religion are and what relevance if any they have to health care.<sup>5</sup>

Everybody seeks meaning, purpose, direction and connection in life. We all at some point, perhaps continually, seek answers to all those great existential questions such as 'Who am I?', 'Why am I here?', 'Where am I going?' and 'How do I get there?' We all pursue love, joy, relationships, work and activities that nurture and feel 'right' to us, and this pursuit may or may not be God centred. This is spirituality, and it lies at the very roots of our being. Religion can be seen as the ritual, liturgy, doctrines and practices that we collectively bring to our spiritual life, to codify and unify it with others, and which may provide answers to those existential questions. Everybody is spiritual but only some are religious.

While spirituality for most people embraces some form of deity or transcendent realm, this is not universal. What matters is that we *believe* in something and that we feel we *belong* to something, not least because there are direct health benefits.<sup>6</sup> On balance, those committed to spiritual practice and/or religious connection are more likely to live longer, healthier and happier lives than those who do not. There is no evidence that one belief system is superior to any other and there may be downsides; for example, some ill people can get worse because they think God has deserted or is punishing them.<sup>7</sup> Curiously, the healthiest and happiest people in one study were not those *getting* support from their religious community, but those who felt they were *giving* most.<sup>8</sup> What seems to be going on is that the spiritual-religious paradigm offers people a sense of centre, of focus, of meaning in an often meaningless and chaotic world.<sup>9</sup> Without this, the distress may not only cause physical ailments<sup>10</sup> but also project us into all manner of mental disturbance from depression to psychosis. Spirituality, until recently largely ignored by the field of psychiatry, seems to be a connecting factor as it directly affects our well-being – both patients and staff.<sup>11,12</sup>

Religion can be seen as the conduit through which we channel and express our 'way of seeing'. This 'seeing' can also change as we encounter beliefs and experiences that challenge our status quo – sudden insight, trauma or the presence and parables of great spiritual beings, such as the Buddha or Jesus, can change our way of seeing joyfully but can also leave us feeling chaotic and confused. Transformational experiences – or intimations of the absolute – can easily be dismissed as madness or delusion,<sup>13–17</sup> and when linked to God can be dismissed as the need for an 'opium' to dull the pain of an unjust world and an instrument to keep people under control (Marx), a sign of neurosis arising from the need for a father figure (Freud), or consolation in the sorrow of the world (Feuerbach). Others, such as Sartre, put the desire

for God down to our own desire to *be* God and find our own meaning in the world.

Recent studies suggest our brains are 'wired' for God,<sup>18</sup> or that we may be genetically programmed to connect with the divine<sup>19</sup> – the outcome of an evolutionary process that advantaged a religious tendency because it helped people survive and find meaning in a distressing world. Physiologists place the mystic, ineffable experience as an effect of an outpouring of serotonin or endorphins, or a product of electrical discharges in temporal lobe epilepsy, whereas others have shown that it can be drug induced.<sup>20</sup> Is religiosity therefore just some kind of mental illness or deficiency, which with the right treatment we can cure or with the right education grow out of? Or maybe it is just good health insurance?

## MAD OR MYSTICAL?

Underhill's<sup>21</sup> classic text on mysticism describes five distinct stages, moving from the purgation of old ways of seeing to union with the divine. Many people report such mystical union, and it is probably far more common than is generally believed as indicated by the work of the Alister Hardy Trust.<sup>22</sup> Modern research<sup>23</sup> is increasingly supporting what many spiritual traditions have always claimed – that consciousness is more than the product of the brain and that the absolute is not a delusion but reality. Is the madman drowning in these boundless waters in which the mystic swims? Is our mental health system packed with people whose underlying distress is spiritual but not recognized as such?

The pain of the mystical/spiritual crisis or emergence may be confused with psychosis, but 'emergence' (if nurtured rightly) changes us positively – we tend to be more whole, more loving, more forgiving, more functional in the world and not less. Our compassion extends to ourselves and others, reducing the risks. We become more accepting, inclusive and embracing of others and ourselves, more discerning rather than judgemental. We are also more likely to be more trusting and able to work collaboratively with others, fostering a sense of humility and the possibility that we are not always right, that we do not always have to be in control. Through all these 'mores' – which are all about 'becoming' – a spiritual experience ultimately enhances rather than diminishes our humanity. And mystics eventually learn who it is safe to talk to so that they do not get branded insane!

## SOUL AND SPIRIT

The notion that we might have *souls* – that we are not so much human beings having a spiritual journey as *spiritual beings* having a human journey (de Chardin<sup>24</sup>) – runs



against the grain of much of modern scientific health care. Reduced to our ego/personhoods, 'Who I am' becomes the plaything of multiple attachments to countless roles and identities and functions. A spiritual emergence may shift us out of this limited way of seeing, but we can find ourselves being seen as crazy in some quarters. Into this unknown landscape the soul now emerges, for a spiritual emergence is all about the birthing of the soul. Our culture is now deeply rooted in the possibility that human beings can be happy and healthy with ever more scientific advances, material comforts and designer bodies and babies. The pain of that birthing happens when the soul punches through these limited perceptions. Much of our healthcare system strains with this perspective. In studious efforts to keep religion and spirituality and their downsides and uncertainties out of health, a whole swathe of the human spiritual experience has been sidelined, restricting the possibility of helping patients draw upon their spiritual and soul resources in time of need.

A full exploration of the concept of *soul* here is beyond the scope of this chapter, and many would deny that such a thing exists. This material view of human beings prevails in our healthcare system. But briefly, known as the real, true or highest Self, soul, that 'of God' in everyone, the Essence – it suggests a quality of consciousness, presence and being that is in but not of the ordinary or 'false' self as the Hindu tradition describes it. The personhood, or ego – that conglomeration of ways in which we find our place in the world – is a very useful thing to have for getting around, relating, separating, connecting but according to these world views (held by the great majority of people in the world) it is not all that we are.<sup>25</sup> In the soul, in our essence, which is both personal and transpersonal, found in all things yet contained by none, we not only find our individuality, we also find unity, with all that is.

In his poem *The Waste Land* TS Eliot<sup>26</sup> captures the disjointed conversations, the disconnected relationships, the sterility of language and the dark and dull existence of community, the purposelessness, nihilism and *ennui* in a landscape without soul. Three great unconscious forces – the fears of death, separation and meaningless – govern much of human existence. The possibility of Essence may help us overcome these. Our unwillingness or inability to deal with these dark fearful forces in ourselves may spill over into neglect or abuse of ourselves or others. The impact of unresolved unconscious stuff among healthcare staff is harmful to them and those they care for, which is well summarized in Obholzer and Roberts'<sup>27</sup> survey.

However, calls for change in the dominant materialist paradigm in mental health care are getting louder, from both patients and professionals.<sup>28,29</sup> The reduction of human beings to biological processes where who *we are* is relegated to the outcome of a bunch of neurones and

neurochemicals is being challenged. The idea that, when we break down, we can be 'fixed', by tweaking with the right chemical or psychotherapeutic spanners, is increasingly seen as simplistic.

In the play *Equus*<sup>30</sup> we see despair and spiritual pain writ large when the psychiatrist must confront honestly, in himself and his profession, the terrible limitations to his understanding of the complexity and intricacy of the human psyche, and his (in)ability to help. One 'case' finally breaks through his efforts to convince himself that as a psychiatrist he knew what he was doing. He comes to recognize that sometimes in his treatments he may not be helping but dulling and deadening the life force in his patients:

... passion, you see, can be destroyed by a doctor.  
It cannot be created ...

and later he cries in despair

In an ultimate sense I cannot know what I do in this place – yet I do ultimate things. Essentially I cannot know what to do – yet I do essential things. Irreversible, terminal things. I stand in the dark with a pick in my hand, striking at heads! ... I need ... a way of seeing in the dark. What way is this? What dark is this? I cannot call it ordained of God; I can't get that far.

## KNOW YOURSELF

If nurses are to revitalize the care of people with mental health problems and refresh it with the integration of spirituality, what about the spirituality of the nurses themselves? Studies suggest that nurses are reticent about spirituality, not just because they are unsure what it is but also because they are unsure of their own spirituality.<sup>5</sup>

It is relatively easy to learn the instrumental things of nursing – the practical and theoretical know-how of problem-solving. It is a much tougher call to know oneself and others so that we can relate more fully, more meaningfully – for such expressive skills touch the very depths of us and what it is to be human. Our effectiveness, or otherwise, falls upon our willingness and ability to connect with others, and that in turn is dependent on our knowing of ourselves. Thoreau<sup>31</sup> wrote:

It is something to be able to paint a picture, or carve a statue, and so to make a few objects beautiful. But it is far more glorious to carve or paint the atmosphere in which we work, to affect the quality of the day – this is the highest of arts.

How nurses affect the quality of the patient's day – how they imbue it with meaning, purpose, direction, wholeness, relationship – is the very stuff of spirituality

and of spiritual care. Spiritual care is not just about that delivered by the 'expert' chaplain, but is integral to nursing care. Every time we 'come alongside' another, listen deeply and open our hearts to the suffering of the other so that he or she may find a way through it is spiritual care and I will explore some of these concepts in more detail later. While the maturing nurse moves along the trajectory from novice to expert, as Benner<sup>32</sup> in her classic study so richly illuminated, there may be yet another level beyond excellence. It is the level of *art form (or craft)*, when there is a synthesis of knowledge and experience, of inner and outer connection, of seeing patterns beyond conscious thought that transcends reduction by rational analysis. Such a way of caring costs no less than the presence of our whole, aware and healed self to the healing opportunity of the other. It is the 'manifestation of the nurse's fundamental self and source of being through the mastery of acts of caring.'<sup>33</sup>

There is much talk in therapeutic circles of the 'wounded healer'.<sup>34,35</sup> We come into nursing with all the personal baggage of our wider world experience and need to explore more deeply what this baggage, usually in our unconscious, is like so that we can become healed ourselves and not risk projecting this onto others or causing further suffering to ourselves.

'Know yourself' was inscribed in the forecourt of the temple at Delphi. To know ourselves we must plunge deep into the unknown realms of our interior castle, as Theresa of Avila called it. And it seems we have two choices. We can go there willingly, that is consciously, to explore and become more whole, or we can bumble along through life hoping and trusting that somehow we will get it all together and learn to be a better person and nurse. Through approaches such as counselling, psychotherapy, retreat time, insight tools such as the Enneagram and so on, those of us drawn to this strange and wonderful world of nursing can consciously seek insight – *In-sight* – to inform and understand, to clarify and to heal (and *none* of us is unwounded) so that we may transform from wounded healers into the healed. There is a way up to a higher level of being as a person and a nurse – more whole, more loving, more aware, more compassionate, more at ease with the world with more equanimity. These 'mores' and others like them are the very stuff of becoming a fulfilled human being. To get this high we must also descend lower, to unpick the ties that bind and restrict us, our fears and angers and resentments and hatreds, many of which are lurking away in our unconscious, limiting us from being more at ease with the world, catching us in ping-pong reactions over which we seem to have no control and which hurt ourselves and others.

For some the possibility of infinite exploration is thrilling and inspiring, to others it is profoundly scary. Yet, if nurses and nursing might well profit from a more explicit and conscious attention to the being of nurses as

well as our doing, how can we do this safely? I suggest four key principles for safe spiritual awakening. These may be applied to both patients and nurses.<sup>36</sup>

- 1 *Soul friends*. In the Celtic Christian tradition this is the *Anam Cara*. This is not a safe journey if undertaken alone. What is needed is the support of one or more wise spiritual counsellors or mentors to whom we can turn for guidance. These gurus, therapists, teachers, mentors, guides are people who have walked the path before us and know how to support us in times of need.
- 2 *Soul communities*. Groups of people with whom we feel at home and who lovingly nourish our ongoing spiritual awakening. It might be a fellow group of meditators, a church group and so on; there are many possibilities. The community adds to the checks and balances that can keep us safe in the almost crazy time when one way of seeing ourselves is replaced by another.
- 3 *Soul foods*. Sources of inspiration that refresh, renew and revitalize us. Everything from, literally, good food that nourishes our body or therapies that nurture it, to the arts, scripture, being in environments of peace and beauty, listening to words and music that have heart and meaning for us.
- 4 *Soul works*. Developing spiritual practices which keep us on track and take care of us and foster deepening insight – meditation, prayer, yoga, retreat time, sacred dance, ta'i chi, exploring our Enneagram, labyrinth walking – there is an enormous range of possibilities.

These four elements together make for a safer evolution of our consciousness and a safer passage through spiritual crisis, helping us to take care of ourselves, to discern the true from the false and to awaken us to the even grander potential of our humanity in nursing.

## SPIRITUAL CRISIS: A NURSING RESPONSE

Few people I have met have had the sudden, blinding, life-changing awakening to Truth that St Paul experienced on the road to Damascus. For most of us, it is the steady plod up the mountain with many an apparent slip along the way. Often, there is a sudden shake that comes with a great trauma – loss of a loved one, illness, burnout. A patient with cancer I recently met told me that she had learned to love the (terror) of her cancer because 'without it I would have stayed asleep. My cancer was my spiritual awakening'. Thus, plunged into spiritual crisis, the muddy waters of the wasteland are perturbed. We are shaken out of our way of seeing things or some echo within keeps calling us to the surface, through the shadow, to find the light.



Spiritual pain and spiritual crisis are tough experiences, and there are signs that paradigms of help beyond the psychobiological are gaining ground. A recent (2007) search of the Internet revealed over 8.5 million references to *spiritual crisis*. Numerous organizations (e.g. [www.spiritualcrisisnetwork.org.uk](http://www.spiritualcrisisnetwork.org.uk)) and individuals are offering more imaginative approaches than a diagnosis of psychosis. Many of the websites of religious organizations seem more willing to acknowledge its existence, but where they have pulled back the void has been filled by nurses, psychiatrists, counsellors, psychotherapists and numerous new age therapists.

Nursing help has curious parallels with the spiritual help offered by priests. Hearing the person's story (the 'confession') unburdens them; suggesting actions to put things right (penance) and expressions of support and acceptance (forgiveness) often follow to restore well-being. In offering that one-to-one support, we add a further dimension from the section above – the nurse can become a 'soul friend'. This is the principle of *accompaniment* – the one who is well and skilled guiding the person through the interior crisis (the same principle as spiritual direction in religious settings), nourishing them with sound guidance (soul food) and suggesting ways to take better care of themselves (soul works) and offering help in groups (soul communities) even if only temporary ones.

A key skill here in which the mental health nurse helps is with the quality of discernment – helping the patient sort out the true from the untrue, the nourishing from the harmful. The analogy to priestly ministry is not so far fetched, for in helping people make sense of their world, to move through crisis and into a new equilibrium and perhaps making significant life changes in the way they are and the way they see themselves, is this not soul care, is this not spiritual care? And is it not also a crisis of the soul for the nurse (judging by the numbers who burn out) when the inability or lack of opportunity or resources to deliver what we know is needed drags us down? Further parallels can be seen in Guenther's<sup>37</sup> concept of 'spiritual midwifery' in spiritual direction. To midwife is a different way of working from the disease-orientated medical model. The midwife helps something to be born, invariably painfully, something that is already present and seeking naturally to come into the world, something that is not 'ill' but deeply healthy. Is not the most effective psychiatric nurse one who 'midwifes' that state of being which is healed and whole waiting within the person in crisis to come into the world?

Part of this midwifery process in relation to spirituality is finding out what the patient's spiritual needs are. For example, some nurses have developed tools for spiritual assessment, which interestingly we can use for patients as well as ourselves.<sup>38</sup> However, it could be argued that if a tool is needed should we be asking the questions at all? Personally, on this latter subject, I have

noted mature nurses tend to move well away from the questionnaire format and can elicit information about the patient's spiritual needs through sensitive discussion around a number of themes such as identifying the patient's spiritual practices, beliefs, sources of help, traditions and so on.

The discovery process is also dependent upon critical ability to listen to and connect deeply to the other. In the fraught world of modern health care, and restricted by our own limitations of insight and skill, often our capacity to hear and fully be with the other is profoundly limited. In the book of Job in the Old Testament, Job is assailed by just about every imaginable form of suffering. Friends constantly come along to advise and console, telling him that it will be all right – 'Job's comforters'. In exasperation, he tells them to stop, and 'listen to what I am saying' for that is all the comfort he wants of them. Listening deeply – without leaping in with a desire to fix things or without taking on board the other's anguish in a kind of faux compassion – is an art of nursing. The distractions of the environment are not the only thing that get in the way of listening deeply; our own inner chorus of mental processes drowns things out too, arising from that fearful place in ourselves that wants to solve and fix and be sure.

Listening at this deep level does not come easy and is rarely arrived at simply by life experience. It takes courage and awareness to set aside ourselves and all our 'stuff' and to be fully present for, and attentive to, the other. The solution is to encourage the evolving of more aware nurses who can see beyond the masks that we present to each other. This can only be done in the view of many spiritual teachers, by adopting a commitment to spiritual practice and expansion of our consciousness that connects us to the deep peace and safety that lies in our very essence, our hearts, our souls – enabling us to let go of the fear that binds us to the masks we wear.

When we can confidently switch off our ego agendas, we can get ourselves out of the way and give our total attention to the other and thus 'have a brand new experience: by not interrupting or arguing he will hear things that he has never heard before. The speaker too will have a brand new experience. He will be aware that he is being heard by someone who is not going to come back to him with a reply, criticism or opposition. And not only is he heard, he hears himself.'<sup>39</sup> Thus, we learn to 'pay attention, to listen to what is not being said (or to what is being said but minimised)' and to learn the art of 'waiting' and 'asking the right questions' rather than having the right answers. The use of silence, waiting, getting the self out of the way and ensuring the space for the other to speak enable a deeper quality of listening to take place that can truly promote healing, understanding, compassion and connection. Deep listening, a natural part of the repertoire of nursing, helps the other, but in so doing we hear ourselves as well.

## Reflection

The territory of spirituality is fraught with difficulty for mental health nurses, but also great opportunities. Ask yourself:

- How far have you explored and integrated your *own* spirituality?
- How safe do you feel at the edge of professional boundaries, where spiritual care slips across into religious care?
- Can you pray with patients and support them in other religious practices associated with spiritual expression?
- To what extent can you be sure of the spirituality of another person, if you are not sure of our own?

## SUMMARY

I have explored my views on these topics in the previous paragraphs, and now it is your turn to explore these possibilities. It is indeed an ethical and practical minefield, perhaps explaining why so many nurses have steered clear of it. But, as I have suggested above, the landscape is changing and it seems nurses have no choice but to respond; the status quo does not appear to be an option.

The renewal of *soul* in the wasteland of health care, and our culture more widely, will arise paradoxically from the very newness which helped to set it aside. The Essence will be the same, but its form and manifestation will be different and unique to its time. We see it now in the shifting sands of the reordering of the religions, the movements in our understanding of the nature of consciousness, the ecology movement, and the rise of 'integrated' or holistic health care. These and other signs suggest that the wasteland may also be the fertile ground for a renewal and reintegration of Essence, of Soul, into health and healing. The alternatives are there, becoming more known and drawing greater allegiance. For those in the field of mental health care, perhaps excitedly, perhaps with fear, the re-spiriting of health holds out the prospect of a completely different vision for mental health care of the future, where the old paradigms are challenged, broken down and reformed and ways of alleviating spiritual pain renewed and discovered. The tension between the material and the spiritual is an unnecessary one, for a truly holistic way of seeing is able to embrace the paradox of opposites, the challenge of diversity. It does not have to be a case of science or spirit, but maybe science *and* spirit, and mental health nurses willing to venture out into this way of seeing may yet reap immeasurable benefits for those we seek to serve, and ourselves.

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