



Engaging Hearts and Minds... And the Spirit

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ABSTRACT

Since the tragic events of 9/11, faith has become an important discourse in society as a whole. This article explores aspects of that discourse in our multi-cultural society with special reference to mental health and well-being, and describes a conference set up by NIMHE/Staffordshire University and the National Forum on Spirituality and Mental Health to explore how belief systems can affect people's well-being and their recovery from mental illness.

KEYWORDS: FAITH; MENTAL HEALTH; MULTICULTURALISM; SPIRITUALITY; COMMUNITY

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A changing discourse

Every so often an event occurs that utterly changes people's view of the world. The tragic event on September the 11th, 2001, with its triple assault on the pillars of Western capitalism – the World Trade Center (finance and commerce), the Pentagon (industrial–military complex) and the White House (global politics) – was one of those markers in the sand.

Since the collapse of the Communist block, capitalism has been 'the only game in town', for good or ill. Commentators such as Zygmunt Bauman (1997) and religious leaders such as the late Pope John Paul II have questioned whether untrammelled capitalism is really such a universal 'good'. Bauman speaks of 'absentee landlords' in the capitalist system, who wield power without responsibility, Muslims emphasise the importance

of the family, as opposed to rampant US-style individualism (Okasha, 2007) and the Roman Catholic Church uses a phrase 'the common good' to emphasise our responsibilities to common humanity as well as ourselves. While prosperity has undoubtedly risen in the Western world, we have seen massive increases in inequality between rich and poor in the USA and, as so often happens, a shadowing of that effect in the United Kingdom. Relative poverty, as a concept, has come back into the frame, from people such as epidemiologist Sir Michael Marmot (2005) and sociologists on the other side of the 'pond', such as Richard Sennett (2006).

Individual and group spirituality, and organised religion, are perhaps among the few bulwarks against the absentee landlord ethos, and commentators such as Madeleine Bunting (2006), formerly of The Guardian and now Director of DEMOS, and government initiatives such as Darra Singh's Commission on Integration and Cohesion (CIC, 2006) are considering how a secular society with its roots in Lockean liberalism can accommodate and, indeed nurture, faith communities. We are deeply ambivalent about religious groupings; when faith communities care for their own and dress respectfully, we laud their sense of civic responsibility; when difference becomes too acute, we accuse them of not integrating, and failing to become more 'like us' – whatever that means!

Celebrating difference in a civil society, and in the context of delivering public services, is one of the challenges of our age. When the trauma of the



London Tube bombings occurred in July 2005, the French adopted a censorious mien about the perceived failures of British multiculturalism. A brief time later, French cities were ablaze, partly as an adverse reaction to France's mono-culturalism – a situation which would not have surprised that most perceptive commentator of French society, Professor Rod Kedward (2006). The USA appears to have been most successful in integrating its new citizens, as America has a clearer perception of its identity and is not burdened with its reaction to a colonial past. This too is at a cost, however, as Americans show a very poor understanding of other cultures, either in the geo-political or economic spheres.

The discourse in mental health

In April 2006, the Mercia Group produced their *Review of the Evidence Base on Faith Communities* for the Office of the Deputy Prime Minister (Beckford *et al*, 2006) in which they maintain that:

Over the last 50 years, the discourse in Britain about 'racialised minorities' has mutated from 'colour' in the 1950s and 1960s... to 'race' in the 1960s, 70s and 80s... to 'ethnicity' in the 90s... and to 'religion' in the present time (p11).

This analysis may sound a bit too neat to some, but a reading of the daily press, a purview of research, books and journals, and discussions 'on the streets' does lead one to think that faith is one of the most prominent national and international issues of the day.

In mental health, as in other areas, this seems to have been driven by a number of complex factors, for example immigration and the effects of the movement of peoples, on a scale unsurpassed at any time since the fall of the Roman Empire, with differential effects on first-, second- and third-wave immigrants (McKenzie, 2006; Patel, 2006). We may tend to think about a major influx of peoples from the Indian sub-continent, but the inflow of peoples from Eastern Europe, for example, is not just about 'Polish plumbers',

despite what the tabloid press might say, but also about a revival of religious interest driven by a number of peoples who have experienced the reaction to oppression under the Communist regime. It is interesting to note that *The Observer* gave three pages recently to the influx of Roman Catholics from different quarters of the globe, forming 'a diverse new flock that is re-vitalising – and re-inventing – the faith' (Vulliamy, 2006).

The postmodern world and its pervading ethos of globalisation and consumerism are creating a backwash on our struggle for identity. Bauman (1997) speaks of the modern citizen as having, in an era of 'liquid modernity', continually to shape and reshape their identity, with the consequent stresses and strains this entails. Jonathan Sacks, the Chief Rabbi, another perceptive observer of our current ambience, speaks of the last century as one of ideology, whereas the 21st-century will have as its theme the struggle for identity (Sacks, 2002).

Users of mental health services and survivors have been very clear that they wish to be viewed as whole persons, living in complex environments, and that their spirituality is a vital part of their identity – that sense of self. This comes through very strongly from all user groups and user writings, and NIMHE responded in the autumn of 2001 when it set up its Spirituality and Mental Health Project (Gilbert, in Cox *et al*, 2007). This fits very strongly with the personalisation of care, espoused in the 2006 White Paper *Our Health, Our Care, Our Say*. One aspect of personalisation is that, post 9/11, many people of an Asian ethnicity are wishing to identify themselves by their religious, rather than ethnic, affiliation. Faith affiliation is often seen as a construct of age, but in fact a strong religious identification is often now seen in younger people in different faith communities, for example Black Pentecostal, Christians, Muslims, Sikhs and Roman Catholics (often coming from Eastern Europe).

Policy-makers are wrestling with the dilemma that human beings are intrinsically social animals, and yet the Western world is becoming more



individualised and atomised. Work by Richard Layard (2005) and David Halpern in the Downing Street Strategy Unit (see Hinsliff, 2007) are looking at the relationship between health and happiness. Research from America indicates clearly that adherence to a religious faith aids mental and physical health and longevity (Swinton, 2006). The evidence in this country is less clear, especially about individual spirituality as opposed to membership of a faith community (King *et al*, 2006).

The NIMHE Project

The NIMHE Spirituality and Mental Health Project was set up in September 2001 by Professor Antony Sheehan, then leading the Core Group to set up the National Institute. Peter Gilbert became the project lead. The lead director is Paddy Cooney from CSIP South West. The Project focuses on two main issues.

- Spirituality may be viewed as an expression of an individual's essential humanity, and the wellsprings of how she/he live their lives and deal with crises that can leave the individual drowning rather than waving. It is, therefore, an essential element in assessment, support and recovery for users and carers in a whole person approach. It is also vital in work with staff, in the creation of person-centred organisations.
- Establishment of positive relations with the major organised religions and faith-based organisations is seen as essential, at a time when a harmonious relationship between statutory agencies and faith communities is crucial. This is especially so in an age of global communications, when the international, the national and the local are continuously interacting with each other (Coyte *et al*, 2008 forthcoming; Cox *et al*, 2007).

The Project has a number of elements to it.

- To address providers' recognition of and relating to people's spiritual and religious needs, pilot sites were set up in 2005 around a specific framework (Aris & Gilbert, forthcoming), and a national symposium for the pilot sites took place at Lincoln University in May 2005. The pilots are

not driven by performance indicators, but by the impetus within the pilots themselves – usually impelled by a combination of users, professionals and voluntary organisations (some of which may be specifically faith-based).

- To address commissioning for services that will respond to the spiritual needs of service users.
- To assist in the commissioning process, commissioning guidance is currently in preparation.

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

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

Other aspects of the project include working with a growing number of 'centres for spirituality' in universities, to build up a UK-wide body for the study of the subject and research, working on commissioning guidance, keeping up links with the Scottish Executive and the Welsh Assembly Government, and putting out publications which are designed to appeal to a wide range of audiences.

The symposium concept

Because of the increasing research base on the interaction between faith and mental health, views from service users and survivors about the positive



benefits of having their spiritual needs addressed, the problems associated with organised religion, and the work that took place in 2004 with the Church of England over the production of a Parish Resource Pack (NIMHE/Church of England Mentality, 2004), it was decided to set up a Multi-Faith Symposium at Staffordshire University on 1st November 2006. The aims of the day were ambitious (*Box 1*, below), and the team had to manage a number of practicalities and tensions to

enable a successful and fully representative event (*Box 2*, below).

The nine faiths invited were Baha'i, Buddhism, Christianity, Hinduism, Islam, Jainism, Judaism, Sikhism and Zoroastrianism and the Humanists.

It was not always easy to gain a theologian from some of the faiths where membership is still small. User representation from each faith/belief/tradition proved too much, even with a long lead-in process. Nevertheless, the user voice was strongly represented,

Box 1: THE AIMS OF THE SYMPOSIUM

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

Box 2: THE PRACTICALITIES

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

- Personal contact: working with relatively small groups, some of which have not been used to being involved as partners, requires a more personal approach than we may be becoming accustomed to in the more impersonal world of e-mails, and so on! Speaking to people personally is important
- Persistence: some groups praised the intent of the conference, but were not able to produce a representative. Although the project wishes to go through the official, national channels, if at all possible, one faith group came in through a circuitous route, through regional contacts, to produce strong professional representation from that faith
- Preparation: care is needed with issues such as representation, diet, space for prayer
- Publication: we asked each faith/belief system to produce a preparatory paper, which will be produced as a university monograph in 2007 (Gilbert & Kalaga, forthcoming)
- Pilots: it was essential to link as strongly as possible with the pilot sites, whence there was strong representation. There was a representative from each of the CSIP regional development centres
- Professional groups: again, linking with the professions was most helpful. The Royal College of Psychiatrists' Special Interest Group (Chair: Dr Sarah Egger) was particularly well represented
- Presence: the interaction between individuals and groups on the day, with a warm welcome from Staffordshire University's Vice-Chancellor, created a very vibrant and positive atmosphere
- Partnerships: the building of partnerships was essential before the conference, during it and after. It is notable now that a number of regional events, including one in Essex in 2007, will see the benefit of relationships built up during the 1st November symposium.



in the spoken and the written word. However, a better spread of user involvement across belief systems is something to be aimed for in the future.

One issue that was evident in the process of setting up and running this symposium was that it is a mistake to couple faith and ethnicity, assigning a 'faith' to an individual because of her/his ethnicity. The members of the Muslim faith in this country come from a wide range of areas with different traditions – the Indian sub-continent, the Middle East and Africa, to name but a few. The Hindu representatives were a Hindu priest with Caucasian ethnicity and a psychiatrist of Indian ethnic origin. The faith tradition and culture of an individual or group may be very different, depending on the part of the world from which they originate and their immigrant experience. African Muslims often speak of coming from a Sufi tradition within Islam. Conversions to different faiths are also a major factor. Assumptions about spirituality and religion are made far too easily. In fact, the excellent guides to belief systems which a number of NHS trusts have produced can, ironically, persuade staff that if they have read the paragraph on Jainism, then they know all about that belief system, without realising that there may be many stages and sub-sets of belief and that the ethos of a faith may differ according to the cultural origin of the individual or group. The case studies on which the multi-faith discussions were based proved fascinating areas for dialogue.

The outcomes sought were:

- greater understanding of the relevance of belief systems to mental well-being
- mapping of synergies between various belief systems
- promoting good understanding and positive working relations between faith communities and mental health services
- strengthening of networks between partnership organisations
- a plan for future partnership work in regard to research, publications inter- and intra-faith symposia, etc
- a record of the day.

Looking to the future – implications for practice

Some implications of this work are set out in **Box 3**, below.

Box 3: IMPLICATIONS FOR THE FUTURE

- Influence training and education. Unless practitioners are able and willing to recognise their own strengths and vulnerability, it is impossible for them to relate appropriately to others
- Explore in the pilot sites issues such as gaining information on people's religious affiliation, if any (complex in itself), and exploring with them their spiritual strengths and needs (much more complex and time-consuming – see Edwards and Gilbert, forthcoming)
- Build up positive relationships with faith communities, despite the pressure on chaplaincy services in the NHS at a time when their importance has never been higher
- Build on the success of how this venture has demonstrated what could be done at local and regional level

A number of regional events are likely to take place in 2007 and 2008, taking the issues raised in the Pilot Sites' Conference and the Multi-Faith Symposium into more detail. It would also be helpful to look at intra-faith issues, for example the complexities inherent in the diverse nature of Christianity and Islam in Britain.

As the Mercia Group put it:

[the] focus on religion has been driven both by major international events, which have highlighted the political demands associated with religious movements, and by an increasing recognition by academics, policy-makers and service providers of the importance of religion in defining identity, particularly among minority communities. In addition, minority communities are increasingly seeking to press for the accommodation of their religious customs and practices within the legal and economic system of the UK (eg recognition of minority dress codes, family practices and financial structures) (Beckford et al, 2006 p11).



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Commentary

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SERIES EDITOR

ABSTRACT

Gilbert's article underlines the need for social and mental health services to recognise spirituality as part of the 'whole person'. To do this effectively in our multi-cultural, multi-faith society will require dismantling of stereotypes and sensitivity to the needs of BME communities.

KEYWORDS: SPIRITUALITY; HOLISTIC CARE; FAITH/BELIEFS

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Spirituality is that aspect of human existence that gives it its 'humanness'. It concerns the structures of significance that give meaning and direction to a person's life and helps them deal with the vicissitudes of existence. As such it includes such vital dimensions as the quest for meaning, purpose, self-transcending knowledge, meaningful relationships, love and commitment, as well as (for some) a sense of the Holy amongst us. (Swinton, 2001)

In this second article in the series on BME peoples and holistic care, Peter Gilbert has written about spirituality and mental health, illustrating this with impressions from the development and running of a symposium. The symposium reflects on the issues experienced in the coming together of a range of faith/belief representatives as they explored how health care services responded to the spiritual needs of the mental health service user. It begins to explore a couple of the questions outlined at the start of the series:

- Is there a difference between Western and Eastern notions of 'holistic' thinking and working with people?

- What are the mechanisms through which this 'holistic' way of working is exemplified in health and social care services designed for BME communities?

The current work on spirituality and mental health is part of a growing response to the need to work with the 'whole person', a key aspect of this journal's rationale. Because it deals with using spirituality as a tool for recovery and well-being, it responds to the multifaceted notion of the make-up of the human being – that we are more than a bundle of enzymes and proteins. We function on social, emotional, cognitive, psychological and spiritual levels.

What the symposium model offered was the potential to demonstrate the commonalities and differences as they emerged through the dialogue between different 'faith/belief' representatives when they responded to the content of the case scenarios designed for the event. This was achieved through an open discussion between theologian, practitioner and service user, to which the symposium audience could respond. Through this process, the complex nature of a range of spiritual experiences, definitions and benefits to the individual's mental health and recovery emerged. What also arose were issues and concerns for practitioners, and an acknowledgement that to progress change it was necessary to engage strategically with statutory organisations responsible for social care and mental health.

The pleas from the service users echoed the need to acknowledge the 'whole person' in the process of health care. To do this, the professionals needed to take into account the impact of institutional and individual racism in the mental health and social care system. Here practitioners would need to deal



with, for example, the problematic of the assumed overlap of faith and ethnicity. The presence of the Caucasian Hindu priest would have touched on the stereotypes (though held silently) of all those present on the day. Consideration of the latter links very well to the stereotypes currently developed about Islam and ethnicity on local, national and international levels. This will be just one of the challenges facing the practitioner as she/he works to respond to the whole person, requiring professionals to develop a complex and politicised knowledge and understanding of race, culture, ethnicity, identity and religion.

The work of the symposium provides another platform to consider aspects of recovery for individuals experiencing mental health problems beyond medication and traditional therapeutic intervention, whether psychological, social or biomedical, and that an individual's spiritual needs may be responded to with and without affiliation to a particular faith or belief. There is now a growing body of research evidencing the benefits of the impact of the spiritual experience for individuals who experience mental distress (Cornah, 2006).

Clearly, though, with the current global and national tensions about religion and particular ethnic groups, practitioners in mental health care need to develop ways to work sensitively with members of BME communities, responding in complex ways when interpreting behaviours in the context of mental distress. This is especially true if we follow through on Swinton's argument that:

spirituality is an intra-, inter- and trans-personal experience that is shaped and directed by the experiences of individuals and of the communities in which they live out their lives (Swinton, 2001),

and reflect on the experiences of racism and oppression experienced by many BME communities and individuals. Practitioners will need to learn a 'new language' to interpret the spiritual needs of all members of our multicultural society, one which does not make assumptions on the basis of religion, social division or ethnicity (NHS Confederation, 1996).

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