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Holistic Health Care and Spiritual Self-Presence [1]

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Abstract: In this paper, I present evidence of the developing interest in spirituality in healthcare and treat three questions it raises: (1) what makes a person and a life spiritual so that a strictly medical model of health and care won't do?; (2) what is the scope of healthcare?; and (3) what makes care in healthcare 'spiritual' precisely? In addressing the first question I attend to the etymological roots of "spiritual" and articulate how the notion of "spiritual" in Pauline biblical texts is being retrieved today in spirituality studies and research but in a way, also, that does not attach it strictly to religious affiliation. In addressing the second question, I highlight the holistic meaning of healthcare by first attending to the etymological roots of health. I then show that adequate healthcare also requires reflection on the notion of the good and illustrate what I mean by interpreting a biblical narrative. In addressing the third question, I draw on lived experience to illustrate how care-providers may need enhanced religious literacy to read and respond to care-seekers irrespective of their own personal beliefs. However, I also argue that what makes care distinctively spiritual in the first instance has less to do with the subject matter of the care—the *what* of the care—and more to do with *how* carers act, with, that is, the self-presence of the carers.

Keywords: spiritual care; self-presence; holistic; authentic

1. Introduction

It is clear that there is growing interest in spirituality in healthcare, including mental healthcare [2–5]. The first international conference of its kind in Ireland[2], which was held at Trinity College Dublin (TCD) and organised by the School of Nursing and Midwifery, and the Spirituality Interest Group (SIG)[3] which the School hosts at the College, is evidence of that developing phenomenon. Among the questions the phenomenon raises are:

(1) On what grounds is a strictly medical model of healthcare inadequate?
(2) What is the scope of healthcare?
(3) What makes care in healthcare 'spiritual' precisely?

[1] This article was the opening keynote paper at the first international conference on spirituality and healthcare of the School of Nursing and Midwifery and the Spirituality Interest Group, Trinity College Dublin, Ireland, in June 2015. Available online: http://nursing-midwifery.tcd.ie/events-conferences/ sowingtheseeds_conf2015.php (accessed on 28 December 2015) [1].
[2] There was a previous international conference of a similar kind in Ireland in 2011. The title of that conference was "Mental Health, Practical Theology, and Spirituality". It was held at All Hallows College, a linked college of Dublin City University. Available online: http://www.allhallows.ie/wp-content/uploads/2013/06/A-Conference-Mental-Health-Practical-Theology-Spirituality-June-2011.pdf (accessed on 7 November 2015) [6]. The author of this article was a speaker and chairperson at the conference and a member of the organising committee.
[3] I am a member of this group from very early on.

This paper will address each of these questions in turn. In doing so it will draw on epistemology, cognitional theory, existentialist philosophy, hermeneutics, etymology, ethics, sociology, gender studies, scripture study, church history, theology, spirituality, and narrative method, but in a way that flows through the text rather than in a formally raised up way. The paper will aim in this way to show the value of a spirituality perspective on healthcare and of lived spirituality in healthcare.

2. Spirituality and the Movement to a Person-Centred Approach to Health

With regard to the first question, what does being spiritual mean?, a strictly medical model of health won't do because the life of each of us is a personal life, with others. As personal we experience our lives against the background of questions like, who am I, where have I come from, why did I come to be, where am I going, why do I have to die, what does my life-story and particular experiences within it mean, how do I want to live my life, how am I living my life, what legacy will my life leave, how will I be remembered? Sometimes these very personal questions loom large for us, much of the time they lie in slumber deep. However, they mean that our health, what affects it, and what effects it has will be more than a medical matter for us and those connected with us.

These kinds of questions come from our deep inner core and disclose to us that we are spiritual beings, beings endowed with the capacity to transcend simply being there, and to experience being engaged by the mystery of our personal life, and all life.

Growing attention to this dimension of ourselves as beings with a personal life which is experienced as vulnerable and mysterious is putting pressure on societies to integrate healthcare into a spirituality framework. Some may find it strange that a turn to the spiritual identity of persons is influencing a movement towards understanding and relating to a patient/service user as a whole person whose life is lived through self-implication. They may find it strange because spirituality has often encouraged a view of the person as a dual entity of body and soul and given this dualism a hierarchical structure. According to that structure the soul mattered more than the body. However, this hierarchical dualism that developed over the centuries—although it was never the only understanding—was actually an aberration from how the term spiritual was understood when it first began to be used. Scholars trace the historical origins of the term "spirituality" to Christian origins, and, in particular, to St. Paul's use of the term "spiritual" in his letters to newly established Christian communities not long after the death of Jesus.

However, Paul did not contrast spiritual with bodily or material (1 Cor 2: 1315 NRSV). For him spiritual did not refer to a part of the person or to life in certain restricted spheres. It referred, rather, to a way of being a whole person, of living the first and only edition of one's whole self as a personal life under the influence of the spirit of God's love. The opposite, for Paul, to "spiritual" was a way of living as a whole person that contradicted this commitment.

Sandra Schneiders is, perhaps, the most influential figure in the field of study that is the academic study of Christian spirituality. She has retrieved in her work the Pauline vision of spirituality being about a concern for what is holistic [7], and this concern is evident now, also, in the work of many other leaders in the field [8–16]. She defines spirituality as "the experience of conscious involvement in the project of life-integration through self-transcendence towards the horizon of ultimate value one perceives" ([7], p. 16). According to this definition the scope of the spiritual is one's whole life, and not episodic experiences out of the ordinary, or in special places, and the orientation of the spiritual is towards whole life-integration.

Her definition also defines spirituality first of all in terms of common human spirituality and so takes cognizance of the fact that interest in the spiritual today is not automatically tied to a particular religious affiliation, such as Christianity. Interest in the spiritual outside of a religious worldview is to be expected once it is accepted that to be human is to be a spiritual person in the way I referred to earlier so that the spiritual dimension of a person exists prior to the person choosing a religious affiliation to identify, express, and fulfil it—if they do. An approach to one's life in terms of integrating all that affects it as a personal reality, irrespective of how the horizon of ultimate value is perceived, cannot

leave out healthcare. Spirituality scholars, researchers, and practitioners who conceive spiritualty in this way will, inevitably, pay attention to it. So, for example, it is no surprise today that there are journals like *Journal of Spirituality in Mental Health, Journal of Religion, Disability & Health, Journal of Religion, Spirituality & Aging, Journal of Spirituality in Addiction & Recovery*, and that the founding chair of the British Association for the Study of Spirituality, John Swinton, who is a Professor of Practical Theology and a former psychiatric nurse, has published in the area of spirituality and dementia and spirituality and disability [17–19].

3. The Scope of Health

This brings me to my second question, what is the scope of healthcare? The word "health" comes from the same root as the words "whole" and "holy". An approach to healthcare, therefore, informed by this etymological basis will want to focus on what I call "holy wholeness". It is also worth noting that catholicity comes from the Greek *kata-holon*, meaning a concern for the whole.

Just as some earlier understandings of spirituality conceived it in a somewhat diminished way so, also, a focus on health as wholeness goes against much of contemporary understanding which views it as being a scientific or medical issue to be researched and treated by medical and clinical professionals only or mainly. A focus on health as wholeness cannot confine itself to a medical model and cannot, either, confine healthcare settings to hospitals, hospices, residential care homes, and general practitioner clinics. A focus on health as wholeness raises the philosophical question of what is the good since health as wholeness implicates in some sense the whole order of society, including its religious traditions.

To illustrate these points about the scope and settings for healthcare, I will turn to the story of the stooped woman in the Christian scriptures, in Lk13:10-17. In the process I will be illustrating how biblical study can serve reflection on and response to the relationship between spirituality and healthcare. It can do so, not only for Christians, but also for all people of goodwill who wish to learn from each other's resources.

> Now he was teaching in one of the synagogues on the Sabbath. And just then there appeared a woman with a spirit that had crippled her for eighteen years. She was bent over and was quite unable to stand up straight. When Jesus saw her, he called her over and said, "Woman, you are set free from your ailment." When he laid his hands on her, immediately she stood up straight and began praising God. But the leader of the synagogue, indignant because Jesus had cured on the Sabbath, kept saying to the crowd, "There are six days on which work ought to be done; come on those days and be cured, and not on the sabbath day." But the Lord answered him and said, "You hypocrites! Does not each of you on the sabbath untie his ox or his donkey from the manger, and lead it away to give it water? And ought not this woman, a daughter of Abraham whom Satan bound for eighteen years, be set free from this bondage on the sabbath day?" When he said this, all his opponents were put to shame; and the entire crowd was rejoicing at all the wonderful things that he was doing.

The embodied nature of this woman's existence illustrates how significant our bodies are for our whole way of being in the world, for our personal lives. Imagine what it was like for her as a person with a stooped condition. Imagine having to go through life without being able to raise your head properly, having to strain your neck upwards every time you try to see what is above you. Imagine all the shame and embarrassment she must have carried, the feelings of distress and undermining of her self-confidence, and the frustrations and tiredness from the practical difficulties of getting through each day. Moreover, there must also have been spiritual suffering engendered by inner struggle concerning the meaning and value of her life in a worldview where God reigned and she suffered. This characterisation of the woman's plight shows that the healthcare she needed went beyond attending to her physical infirmity. However, there are additional reasons for reading this

story as being about more than an individual woman with a physical infirmity in the physical setting of a synagogue when Jesus is present.

There is no presuppositionless reading of a text. We read texts with our existing knowledge and interests and through the quality of presence we bring with them to the text. The contemporary reader versed in a knowledge of sociology, gender studies, and hermeneutics, for example, and who is present to the text and himself or herself with an open spirit, asks about the role society may have played in the woman's condition and imagines what is going on in the biblical story with a consciousness of such questions.

Secondly, he or she realizes, if they are present to themselves as a Christian reader, that while sin, understood as a rejection of God's love, is an individual act, it also has social characteristics. It has social conditions, social effects and a social context. The absence of God's love, therefore, for such a reader, in how a society is present to itself has tentacles that spread into groups, societies, traditions, history, and the cosmos. The absence of God's love in the society is located in not only the exercise of innate tendencies but also external forces institutionalised in the society that come to be internalised by people and lead them to make harmful responses. This absence of God's love can be present, also, in the religious tradition as a social reality.

Reading the text in the light of such knowledge helps to explain why Jesus did not deal with the woman's plight by going to her after the religious service and attending to her quietly in a one to one way. Instead he interrupted his teaching to the congregation, called her forward, and addressed her condition in a very public way and from his position of spiritual authority in the synagogue that day.

This suggests that, firstly, he was pointing to the anomaly of people coming together to attend to religious matters on the sabbath, but being blind, in reality, to the call of God in the congregation itself, and, secondly, that he heard that call with respect to the suffering of women in a way that recognized the role of the culture and religious tradition in such suffering.

On the first point, Jesus experienced the stooped woman in terms of his self-understanding about being sent by God to set the oppressed free (Lk4:18). The priority of setting the oppressed free for the sake of forwarding God's kind of love in the world meant that the Sabbath, for Jesus, was to be a day of release from the effects of what in the worldview of his time was called the fallen order. Jesus expresses this liberating meaning of the Sabbath for him in relation to the situation of the woman when he justifies what he does in the synagogue with the words: "Ought not this woman . . . be set free from this bondage on the sabbath day?" (Lk13:10-16).

Jesus's understanding of the role of the Sabbath in human wellbeing contrasts sharply with that of the leader of the synagogue: "But the leader of the synagogue, indignant because Jesus had cured on the sabbath, kept saying to the crowd, 'There are six days on which work ought to be done; come on those days and be cured, and not on the sabbath day.'" We have here, therefore, an example of how two people with authority in the same religious tradition can interpret that tradition very differently, with considerable implications for the health and wellbeing of women. Obviously, the call of the text to readers is to identify with Jesus, not only in the text, but also by implication in how he would deal with similar situations today.

Secondly, Jesus, by calling the woman forward, may have been regarding her suffering as a form of gender oppression, as an example of what the Latin American Catholic Bishops gathered at Medellín, Colombia, in 1968, called "institutionalized violence"[4]. For if this woman's physical infirmity was rooted in cultural factors to do with her gender role of having to carry heavy loads that would damage her spine, as a hermeneutics of the imagination based on research on women's lives in Ethiopia in the late 1990s suggests ([20], p. 51), then other women, too, in Jesus' time would have

[4] Institutionalised violence is violence that is embedded in a society, culture, system, organisation, or tradition, so that individuals who are part of these social forces can find themselves enacting or accepting such violence without even realizing what they are doing at times or believing that this is the way things have to be.

been similarly afflicted by this form of institutionalised violence of kyriarchy[5] and androcentrism[6]. On this view Jesus' reference to Satan inflicting 18 years of suffering on the woman can be regarded as a reference to the social sin of kyriarchy embedded in the culture and reinforced by other factors that were destructive of women's wellbeing on the site of their embodiment. On this view Jesus by his actions is revealing God's liberating love as a love aimed at transforming social structures, cultural ideologies, and religious traditions—and not simply individuals.

Reading the Lukan text receptive to socio-cultural realities also helps us to understand why Jesus in Luke is never again invited to the synagogue and why he is charged later in that Gospel of being "an agitator of the people", which led to his crucifixion. Why would his healing of a single woman from her physical infirmity have provoked such a reaction against him by some if it was not because there was more going on in the story, if it was not because he did not, as could happen with a medical model, abstract this woman's embodied infirmity from the need for a holistic model of socio-cultural liberation.

Instead he cared for her in a way that called into question the ethos of the culture, the organisation of the society, and the way the religious tradition was functioning in relation to them. What we learn from him in this story, therefore, is that, while healthcare professionals cannot be expected to emulate the healing power of Jesus, adequate healthcare requires reflection on the nature of the good and engagement with society in ways that draw on such reflection. This vision of holistic health has considerable implications, for example, for healthcare training, policy, and practice, and for formation as a person, and education as a citizen.

4. What is Spiritual Care?

This brings me to the third question raised earlier, what makes healthcare "spiritual" precisely?

4.1. Spiritual Self-Care

Firstly, reading the story of the stooped woman in relation to Schneiders' definition of being spiritual shows how self-care can be spiritual. The woman takes the initiative to come to the synagogue to see and hear Jesus because, presumably, she believes it may benefit her to do so. In terms of Schneiders' definition of spirituality stated earlier, she is expressing her desire for life-integration regarding her infirmity by engaging in the self-transcendence that going to the synagogue with her humiliating and demanding infirmity requires of her. She is drawn to practice such self-transcendence, presumably, because of the relationship she perceives between Jesus and her horizon of ultimate value.

Reading what patients/service users seek and do as a form of spiritual self-care needs more attention in healthcare. Its significance has come home to me all the more visiting a close family relative in a nursing home.

Sometimes when I visit her there her first words to me are, "you are manna from heaven," and her eyes light up and she gives a broad smile of joy. You may be aware of the biblical story of the enslaved people who escaped from Egypt and set out on a journey to what they believed would be a land God would give them. Their journey was long and arduous and soon they began to get very disgruntled and to suffer from hunger and its effects. Then something extraordinary happened. They had an experience of what they called manna from heaven arriving to feed them (Exodus 16: 1-36). This story has obviously taken hold of my relative. She is on the final stage of her journey in this life, and it is not easy for her, but she lives it waiting on God to send her sustenance. This view of her awaiting divine intervention to care for her was also borne out for me when I asked her a few months ago when she was in a very frail state, "what keeps you going," and she said immediately, "prayer."

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[5] Kyriarchy from the Greek "kurios" meaning "lord" refers to a mode of social organisation where some people lord it over others.

[6] Androcentrism refers to a worldview where the male form of the species is considered normative for humanity.

By serving as a form of spiritual self-care that sustains her, her faith-experience and religious learning also illustrate the importance of care-givers having the literacy to read and respond to the religious spirituality of patients regardless of their own personal beliefs.

4.2. The Little Way of Love

Secondly, while religious literacy with respect to the religious affiliation of care-seekers matters considerably when those seeking care are religiously affiliated, it is not, what needs to be primary for care-givers providing spiritual care. What makes the provision of care distinctively spiritual in the first instance has less to do with the subject matter of the care—the *what* of the care—and more to do with *how* we act in relation to people in any situation or setting in which we find ourselves and especially when we are aware of the significance of the situation or setting for their health.

If spiritual care is identified by its subject matter, by what care-givers do, then praying with a patient, or reading a book to them about how saints dealt with suffering, for example, would easily be characterised as spiritual, but this way of identifying what makes care spiritual would be unnecessarily restrictive. When the emphasis is put, instead, on *how* care-givers act in relation to others in the concrete character of their existence then how care-givers are and act at all times rather than the subject matter of what they do at particular times is the primary identifier of spiritual care. However, in order for our caring way of being and doing to be spiritual in character at a common human level it must be rooted in what I call authentic self-presence.

Authentic self-presence is self-presence that genuinely desires to access, affirm and promote beauty, truth, goodness and love in the world since these are ultimate dimensions in compact human experience that have been differentiated over time. Such self-presence is not simply reflective in relation to situations and reflexive with respect to the quality of one's reflectivity; it is also embodied: it permeates the look in one's eyes, the sound of one's voice, the movements of one's body, the quality of listening, and the ease of one's overall presence.

What Pope Francis says about St Thérèse of Lisieux in his encyclical about the health of the planet is worth mentioning at this point. He refers to her invitation to us to practice *the little way of love* (my emphasis), not to miss out on a kind word, a smile or any small gesture which sows peace and friendship ([21], p. 114). The experience of caring for patients can evoke and foster this kind of humanity in care givers and even influence their spiritual development.

4.3. Social Love for Structural and Cultural Change

However, along with the importance of little everyday gestures, the love of authentic self-presence is also, as I said earlier, a social love that moves us to work collectively for cultural and structural change ([21], p. 115). For the Christian this love is grounded in being deeply affected by the kind of loving Jesus demonstrates in the story of the stooped woman, a loving which to some extent can be said to have cost him his life as I said already.

A third form of spiritual care, therefore (additional to, firstly, spiritual self-care and the attention by the care-giver to resources that work for the care-seeker irrespective of what they may mean for the care-giver, and, secondly, the little way of love), is manifested whenever people, for common human, or religiously specific, reasons, experience a determined desire to live authentically the first and only edition of themselves by engaging in developing together a depth level "culture of care" that permeates all of society.

4.4. The Horizon of Care at Foundational Depth in a Person

The quality of the desiring and embodied receptivity[7], relationality[8], reflectivity[9], and reflexivity[10] which we bring to people and situations on the micro and macro levels as a result of authentic self-presence—a self-presence that seeks beauty, truth, goodness and love for the world—is foundational for how we relate to ourselves and the wider world. It is foundational because there is no other way, methodologically, to access and respond to the world except through ourselves.

At foundational depth in ourselves self-attention discloses that the horizon of ultimate value we perceive is the horizon of beauty, truth, goodness, and love for the world. At that depth and in its correlative horizon we are vessels and vehicles of what can be called spiritual care. This quality of self-presence is also open to higher order transformation under the impact of lived experience.

Let me give an example from my own life of how a deeply personal experience can have a foundational effect on forming the quality of self-presence and horizon of ultimate value in a person.

When my brother, sister and I were small children my father would come and say goodnight to us when he arrived home in the evenings. One evening, aged five, I remember him asking had we said our night prayers. I replied I had a toothache. Pausing ever so slightly he responded that I did not have to pray then as God would understand how I was feeling. Utterly unexpectedly, his words immediately impacted on me in a way that led to a deep, warm, peaceful experience. I experienced myself in my embodied consciousness being reassured, being cared for; I experienced that my pain mattered, that I mattered—to God. I experienced and understood that God was a kind God, and that this profound realization was being gifted to me from beyond myself.

Reflecting on what happened that evening in later life has enabled me to identify this experience of spiritual consolation regarding the reality of God as a God of kindness being so powerfully transformative in my subjectivity that it became a foundational criterion for me in how to be an authentic human being. Whatever was in line with that experience could be trusted, and whatever contradicted that experience had to be rejected or resisted.

Sadly, this kind of spiritual self-presence can be missing in healthcare professionals. For example, when the nurse tried to introduce a relative of mine and two of his classmates by name to the consultant with whom they would be working when they were in medical training years ago he rudely interrupted her and said brusquely, 1, 2, 3. Similarly, we sometimes hear patients referred to as the cancer patient in bed 4, the spinal injuries patient in bed 5, *etc*.

5. Conclusions

Providers of healthcare are dealing, not simply with people faced with wellbeing or healthcare challenges, but people formed by narratives to do with being on a journey about the meaning of their lives. They make that journey against a particular historical and social background and with a capacity for in-depth experiences that have spiritual significance.

Spiritual self-presence and its quality of receptivity, relationality, reflectivity, and reflexivity, whether at the level of common humanity, or religious commitment,[11] in healthcare providers will result in them treating everyone as a personal reality. It will result in them seeking to have in view all

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[7] By "receptivity" I mean the disposition and capacity to receive evidence in one's subjectivity that is consistent with beauty, intelligibility, truth, goodness, and love in life.

[8] By "relationality" I mean the capacity in one's subjectivity to connect to what corresponds to beauty, intelligibility, truth, goodness and love in the concrete.

[9] By "reflectivity" I mean the capacity to distanciate from the given for the sake of higher order attentiveness, insight, judgement, and decision-making regarding the given.

[10] By "reflexivity" I mean the capacity to reflect on and evaluate the quality of one's receptivity, relationality, and reflectivity in terms of their correlation with beauty, intelligibility, truth, goodness, and love in life.

[11] Common human receptivity, relationality, reflectivity, and reflexivity that are grounded in religious conversion function in a person from the conviction that these capacities for beauty, intelligibility, truth, goodness and love, are rooted, ultimately, in and fulfilled by the enlightening and empoweringgift of God's love as creator and revealer.

the factors and forces in society, culture, ecology, and religious traditions that up to date knowledge and sensibility show impact health as a holistic reality. Moreover, it will enable them to appreciate the mutuality that needs to characterize healthcare: those in their care may have much to teach them about the care, including spiritual care, they need and seek. The call, therefore, is to bring such transformative spiritual self-presence to every lived setting, because where there is life, there is holistic health at stake.

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Abbreviations

SIG: Spirituality Interest Group
TCD: Trinity College Dublin

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