

Proceedings of the 2nd  
Biennial South African  
Conference on  
Spirituality and  
Healthcare



# Proceedings of the 2nd Biennial South African Conference on Spirituality and Healthcare

Edited by

André de la Porte, Nicolene Joubert  
and Annemarie Oberholzer

Cambridge  
Scholars  
Publishing



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This book first published 2018

Cambridge Scholars Publishing

Lady Stephenson Library, Newcastle upon Tyne, NE6 2PA, UK

British Library Cataloguing in Publication Data

A catalogue record for this book is available from the British Library

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ISBN (10): 1-5275-0385-2

ISBN (13): 978-1-5275-0385-4

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## FOREWORD

# SPIRITUALITY AND HEALTH: TOWARDS WHOLENESS IN FRACTURED SOCIETIES

In recent years the body, bodily theologies, and theologies of embodiment have grown in depth and impact.<sup>1</sup> One cannot consider health, healthcare, or the absence thereof, without reflecting on the body from a theological perspective. Protestant theologies have for too long devalued the body, in some cases perhaps with disastrous consequences.

In the South African context it is hard not to think of the body without also considering the many ways in which women, children and black people have been *disembodied* and exploited over the years. Certain bodies have been systematically excluded from certain places or denied access to vital resources required to ensure health and well-being. One cannot consider healthcare and systems designed to mediate healthcare purely in neutral terms, and not acknowledge the ways in which healthcare systems themselves are often expressions of deep societal fractures.<sup>2</sup> In a society marked by gross inequality, access to decent and affordable healthcare has been an unattainable luxury for millions of people.

Pathological systems and institutions of care – healthcare systems devoid of life-affirming spiritualities – cannot ensure the healing and wholeness of those depending on them. And it is for that reason that this is such an important and timely volume. In this publication the relationship

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<sup>1</sup> See for example: E.E. Uzukwu, *Worship as Body Language. Introduction to Christian Worship: An African Orientation* (Collegeville, MN: Liturgical Press, 1997); L. Isherwood and E. Stuart, *Introducing Body Theology* (Cleveland, OH: Pilgrim, 1998); J-A. van den Berg, “An Embodied Spirituality: Perspectives for a Bodily Spiritual Anthropology,” *Acta Theologica* 28(2) (2008): 118–132; J. Meiring and J.C. Müller, “Deconstructing the Body: Body Theology, Embodied Pastoral Anthropology and Body Mapping,” *Verbum et Ecclesia* 31(1) (2010), doi: 10.4102/ve.v31i1.367.

<sup>2</sup> See Jean-Marc Éla, “The Health of Those without Dignity,” in *My Faith as an African* (Maryknoll, New York: Orbis Books, 1988), 67–85.

between spirituality and healthcare is considered on the basis of a firm conviction that these cannot be mutually exclusive, but must necessarily be considered and practised in close conjunction.

This volume endeavours, among other things, to:

- affirm the importance of spirituality, or theological reflection, for healthcare
- affirm that healthcare systems should work towards the spiritual, physical, psychological and social wholeness of people and communities, celebrating body, mind, spirit and soul as equally important and – although this is not always acknowledged – indissolubly linked
- explore the role of both spirituality and churches, faith-based organisations and religious resources in enhancing healthcare and wholeness
- emphasise integrated, multi-sectoral and multi-disciplinary models of healthcare, valuing the diverse gifts and contributions of different partners, but doing so critically

The contributions gathered together in this volume allow readers to explore diverse facets of healthcare through the experiences of patients, healthcare practitioners, family members and faith-based or pastoral care workers. They represent a diversity of scholarly and practical wisdom and insight as offered by theologians, pastors, therapists, medical and healthcare practitioners, and social workers. The authors have employed a wide range of research methods to source information and to gain and deepen their and our understanding of their respective themes, and they have therefore made an extremely valuable contribution to this field of study.

Some years ago Dr Andre de la Porte asked whether the Centre for Contextual Ministry at the University of Pretoria would be willing to host this research theme. We agreed, and are delighted to be associated with this research project on spirituality and health. We value the vital contribution made by this publication and trust that it will stimulate further and deepening conversations about and insights into these and related topics. We congratulate Andre and his team of co-authors and research associates, and express our deep gratitude for your leadership in this developing field.

Our own vision, as a Centre, is the creation of healthy communities through the formation of community and church leaders. We are committed to creating diverse spaces in which community and faith-

based workers can foster spiritualities and reflective practices that will support communities as they strive towards wholeness in every sphere of community life. Implicit in such a vision of wholeness is an understanding of the importance of spiritual, physical, socio-economic and mental well-being, all in relation to one another. It is therefore natural that one would embrace a commitment to spirituality and healthcare on the journey towards wholeness.

What is heartening is the movement towards trans-disciplinarity that became evident in this process, as academic researchers from different disciplines worked with practitioners and community members, including patients, to reflect on important health-related themes, while considering how spirituality can contribute to possible healthcare solutions, enhance holistic well-being and foster wholeness.

My hope is that this endeavour will go from strength to strength, and that this project will contribute imaginatively to the discourse on spirituality and healthcare that seeks to advance wholeness and justice for all.

Stéphan de Beer

*Centre for Contextual Ministry & Department of Practical Theology  
University of Pretoria*

April 2017

## PREFACE

The past ten years have witnessed a dramatic increase in the number of studies in the field of spirituality in healthcare, the majority having been conducted in North America, Europe and Australia. This research has demonstrated robust links between spirituality and health, with an emphasis on the importance of integrating spirituality into the practice of healthcare. A multi-disciplinary approach is needed, with the person at the centre, making room for the distinctive perspectives and practices of social scientists, health professionals, chaplains, and clergy. The availability of spiritual and pastoral workers trained to work in healthcare is a significant theme.

In South Africa, spirituality and healthcare is an emerging theme, which has generally been approached from the perspective of a single discipline. It must be acknowledged that although the government has introduced ambitious plans (which are part of the National Development Plan toward 2030), South African healthcare is in crisis. Problems relating to infrastructure, management, human resources and the supply of essential medicines have become critical. This situation is compounded by a high burden of disease and enormous disparity in levels of service delivery, particularly between the public and private healthcare systems. In the midst of this we find the individual person and his or her family and community, bent under a heavy burden of suffering caused by disease, poverty, crime and violence.

Illness can bring about an existential and ontological crisis as people are confronted with the fragility, vulnerability and finitude of the human condition. This experience is intensified when children are involved or affected. There is a good chance that the majority of people are trying to make sense of this within a spiritual framework, and that they belong to a faith-based community.

Practitioners in the healthcare, spiritual care, counselling, and other helping and caring professions meet people in this space of disarray. Many view this work as a calling. This conference will bring together leading experts, as well as representatives of a wide range of disciplines and perspectives, to explore the ways in which spirituality interacts with healing, growth and wholeness in healthcare.

In South Africa (and indeed in Africa) there are no programmes dedicated to the study and promotion of spirituality and healthcare. The 2<sup>nd</sup> Biennial South African Conference on Spirituality and Healthcare was organised by HospiVision and the Centre for Contextual Ministry at the University of Pretoria to foster development in this field. The conference also created a platform for various disciplines to showcase their work and for practitioners in this field to share their experience. The disciplines of medicine, spirituality, pastoral counselling, nursing, social work, psychology, audiology and practical theology were represented at the conference.

The following institutions were involved: the University of Pretoria, the University of South Africa, the University of the Witwatersrand, North-West University, the University of Stellenbosch and the Institute for Christian Psychology. International universities represented at the conference included George Washington University and Fordham University in New York. Several national organisations working in this field were also involved, namely the Cancer Association of South Africa, HospiVision, Intern Trauma Nexus, the Centre for Christian Spirituality, Godly Play South Africa, the Organisation for Paediatric Support in South Africa (OPSSA) and the International Children's Palliative Care Network.

The presence of Professor Christina Puchalski from the George Washington Institute for Spirituality and Health as keynote speaker also gave an international flavour to the conference. Her presentations on the essential role of spirituality in a whole-person model of care and the spiritual discipline of compassion both informed and inspired participants.

In this volume you will find a selection of papers offering a uniquely South African perspective on spirituality and healthcare. The contributions begin with an exploration of the unfolding link between spirituality and healthcare, followed by a discussion of a base anthropology for a pastoral hermeneutics of care. This is followed by papers on various approaches that constitute a paradigm for coping in times of stress and the effect of a faith-based education programme. The non-profit sector plays an important role in healthcare, and a model for this and the influence of Christian community psychology is discussed. Two contributions discuss spirituality and healthcare from a social work perspective. The importance of promoting a caring presence in nursing is highlighted. Two contributions focus on ethics in spirituality and healthcare. Specific focus areas are covered next: hearing loss, the role of churches in caring for children, post-traumatic embitterment, head and neck reconstructive surgery and the role of volunteers. In conclusion the ideal body and its celebration in the Song of Songs of the Hebrew Bible is discussed.

## ACKNOWLEDGEMENTS

Organising a conference in two cities and publishing the proceedings requires a team effort. We would like to acknowledge the support received from the HospiVision board and staff members as well as the Centre for Contextual Ministry at the University of Pretoria, in particular Dr Stéphan de Beer, the director. We would further like to thank the conference teams: Wanda de Jager and Annette de la Porte (Cape Town) and June Kriel and Eva Dabon-Kriel (Pretoria). Numerous HospiVision staff and volunteers provided support with registration and provided practical assistance on the days of the conference. Prof. Christina Puchalski contributed her time and expertise, for which we are very grateful. We wish to thank Prof. Nicolene Joubert of the Institute for Christian Spirituality, our other keynote speaker and also one of the editors of this volume. Professors Daniel Louw and Christo Lombaard provided valuable support and input during the organising phase and also at the conference itself. Our presenters travelled from far and wide to share their experience and expertise. A sincere word of appreciation has to go to the Language Services of the University of South Africa for the professional language editing of the volume. The University of South Africa provided conference folders. The Dutch Reformed Congregation of Riviera-Jacaranda provided a venue free of charge for the Pretoria conference. Most of our suppliers for the conference offered generous discounts. Last but not least, we would like to thank Cambridge Scholars Publishing for taking on the project and for their editorial support.



# SOMETHING OLD, SOMETHING NEW... THE UNFOLDING LINK BETWEEN SPIRITUALITY AND HEALTH<sup>1</sup>

CHRISTO J.S. LOMBAARD<sup>2</sup>

## **Abstract**

Even though from ancient times matters of religion and health have been linked, and in various ways, in the modern age this link has not been afforded institutional or academic respectability. This situation, however, has changed of late, perhaps as a reflexive part of the dawning post-secular age. Recent academic-institutional developments, although quite diverse, in locations such as Washington DC in the United States of America, Zürich in Switzerland and Pretoria in South Africa, including the establishment of two academic chairs, give expression to this unfolding academic linking of health and spirituality. Across continents, a number of conferences exploring this link took place during 2016. In this paper, these developments will be taken into review, and some key persons associated with the respective institutions acknowledged.

## **Keywords**

Spirituality; health; new institutional developments

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<sup>1</sup> This contribution reflects the work done for the session entitled “Of Sound Body and Spirit? The Newly Unfolding Linkage of Health and Spirituality” held during the Relocating Religion conference of the European Association for the Study of Religions, held from 28 June to 1 July 2016, in Helsinki, Finland, and for the Centre for Contextual Ministry (University of Pretoria) and HospiVision’s 2<sup>nd</sup> Biennial Conference on Spirituality and Healthcare: Wholeness in Healthcare, held from 24 to 26 October 2016, in Pretoria, South Africa.

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## **A Christian Impulse from the Bible**

In a certain kind of Bible usage practice – one to which I do not subscribe – a consideration of faith and health would commence with a reference to the commonly held notion that the author of the two related New Testament books of Luke and Acts was a medical doctor. Apart from the deuterio-Pauline literature in the New Testament which led the early church to connect the references to a Luke in Colossians 4 and 2 Timothy 4 to the author of the third Gospel, a connection no longer widely accepted in scholarly circles, there is another reason for the apparent attractiveness of a link of this kind to many Christians. This is the widely held assumption, in quite different strands of theology, that if something is found in the Bible, it is legitimated by the Divine. This is then taken as an indicator of acceptable current faith and life practice. However, once that supposition is laid bare one soon realises the weakness of such a deduction, on two grounds. First, many modern practices are also expressions of faith, and, although not to be found in the Bible directly, these are nevertheless well worth pursuing, such as wind power as a source of electricity. Second, there are many practices to be found in the Bible which are best not pursued, such as warfare. A third matter comes into play here: there are minor strands of Christianity which, despite the demonstration of a referential connection between Scripture and health, view some kinds of human intervention in healthcare (such as blood transfusion) as an indication of distrust in the Divine, who should be relied on to cure or not to cure according to the holy will. Each of these orientations towards a connection between the Bible and health may be discussed in some depth, but for the present purposes it is not the matrixes of these possibilities that are of prime importance; rather, the link between the Bible and health, or in more general terms, the link between spirituality and well-being, is under consideration here. Why is it that people in general make this connection? From this follows a second question: how is this connection being made in the academic world in our time?

## **Far and Wide**

Naturally, the New Testament constitutes a relatively recent location in human history in which to find a health–faith connection, and also one which is influentially constitutive for the Christian-Western/ised cultural stream. The health–spirituality connection however goes further and wider: further into its own biblical history, for instance to the cultural bed

in which the Old Testament was born, and wider, namely across all cultures and religions through the ages. Noteworthy in the latter regard is that probably the single exception across civilisations to a reflexively assumed connection between health and faith is the modern/ist Western culture, in which matters of health and matters of faith have been separated. Often when this separation is mentioned, it is done with negative intent, and perhaps a touch of nostalgia, and not infrequently with reference to Ayurvedic medicine from India and Eastern medicine from China; locally, traditional African plants and medicinal practices at times attract similar attention and emotive responses. However, the separation of health and faith in modern medical practice (often called Western medicine, although that would in our time be accurate only as a historical indication of a now global service) has had to break through many barriers and bonds created by religious institutions in order to reach its unprecedented heights of medical successes, the benefits of which we all have reaped. No negative connotation is therefore implied when this separation of religion and medicine is discussed here. Furthermore, as is the case with the separation of religion and state in modern democracies, a sobering realisation is that the split has never been absolute. Examples of this continuing mutual involvement can be seen in the way that many religious bodies have been, and continue to be, involved in carrying this form of medicine across the world (a matter that the current decolonialist discussion may at times sketch one-sidedly negatively, to its own undeserved disadvantage) and in moral deliberations concerning medical matters (although ethical action does not require religion, no ethical system can function without also critically engaging with its historical roots, which always includes religion). Formally, matters of faith and matters of medicine thus remain interlinked, even though that connection is now differently constituted – more intellectually, more bureaucratically, and more independently – than in other societies and also in different, less formally arranged spheres of modern societies.

That the body and its health are existentially linked to one's sense of life, one's awareness of death and the various connections between these two poles of being (such as questions about the existence of the divine and/or eternity and/or restoration to health)<sup>3</sup> is hardly surprising. Both touch our sense of being deeply: the way we *experience* ourselves, our relationship with all around us and the big questions about life and

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<sup>3</sup> The *Schadenfreude*-like sentiments of some religiously inclined people directed at atheists who later in life come to question their atheism are hardly a commendation for faith.

death share a common resonance. For the vast majority of people, health and spirituality are in this respect phenomenologically entwined.

The experiential is a central category in the discipline of Spirituality Studies, reflecting a core element of human religiosity: the usually unreflected, reflexive element of faith. In this, spirituality is metaphorically akin to any of the human senses, such as taste or smell, in that it is an innate part of being human, but differently present in each individual, and differently guided within each social and even material environment. This is not meant in any deterministic way, but the facilitative influences of the cultural and material environments should never be overlooked. Although spirituality may be less observable than the physical senses, for many people it is more concrete, that is, more foundationally constitutive of their sense of being. For many, perhaps most people, their faith does not fall into the category of a “nice to have”, but is something so foundational to their sense of being that they are willing to give up their lives for it, or substantively change the course of their lives because of it. This deep awareness, its orienting sentience, and the implicating commitment as corollary may be described by the term “spirituality”.

Spirituality is often understood as the broadest sense within humanity of the highest tenets subscribed to and the most thoroughgoing responses to those tenets. These responses include what is done and what is not done, along with the manner of either doing or not doing. With spirituality being the broad, umbrella term, religion is then the more structured framework within which these sensibilities find expression and reflection. However, it could be argued that the “done/not done, and how” is already a matter of religion. In either case, the more concrete expressions of human awareness of matters spiritual are usually assigned to the phenomenon of religion. On the other hand, whereas religion is, as just indicated, accepted as being the more or less institutionalised channelling of the spiritual awarenesses of humanity, and with theology as the intellectual reflection upon that, the term “spirituality” is, again, commonly employed to refer to the tacitly experiential aspect of faith. This refers to the sense of the divine, or at least a supra-human significance, which is felt, not only emotively but also acutely existentially, by individuals and groups, as expression is given to these deep sensations. Spirituality may thus in the academic literature be found to refer to both this broad, overall sensibility regarding existential (which in this context is perhaps too philosophical a term) questions of life, and to the intensely felt reverberations thereof as mediated by a whole range of often both tangible and elusive factors. Along with this goes a popular,

and ever more regularly also journalistic, approach to spirituality in which the term is taken as roughly synonymous with religion, but usually with the unfavourable implication that religion is a negatively bureaucratized and somehow outdated expression of faith.

In view of this range of meanings and even more extensive range of nuances, the meaning of the term “spirituality” cannot be firmly fixed, and it requires a sympathetic reading to discern what is meant within each publication, and even in different parts of the same publication. Central here should be, though, the realisation that spirituality has to do with a massive solidity of something so ethereal that it can hardly be described, yet which is so foundational to human life that without this experienced sense of validity of existence many, perhaps most, people would find themselves in a state of disorientation and shock.<sup>4</sup> What may to some natural-scientific minds skilled in the distancing effects of mediating methodologies seem esoteric is for many or most people a reality so foundational that a life without the divine would be something akin to non-life. The utter concreteness of faith for the greater part of humanity should not escape academic cognisance.

This realisation again of the profound esteem in which people hold their faith is one of the core moments in the switch from a postmodern to a post-secular worldview. Whereas in the postmodern constellation of life tenets all is understood at the hand of the metaphor of language, so that God and belief are afforded validity, but in no more than an internally referential language game, the post-secular must acknowledge a sense of realism. People do not live or die for what they sense to be a language game of metaphors and traces of meaning. Much as all of life, and the more so its most fulfilling parts (such as love and ethics, as opposed to more concrete but less central parts, such as an apple or a bolt) are metaphors (Van der Merwe 1991:65-108) and traces (Derrida 1976), few people can attach their existential worth to *something* that does not constitute *some real thing*. The God concept here, currently unfolding ever more fully in the implicit public perception, is different from that in pre-modern realism, in modern scientific positivism and in the postmodern metaphor. Rather, developing in our time<sup>5</sup> is a sense of refined realism,

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<sup>4</sup> Is it perhaps just such a state of un-human shock that gave rise to the isms of the previous century, and the resulting wars, as a consequence of which so many lives were lost or destroyed?

<sup>5</sup> Seminal works in this regard include:

- Boersma, H. 2011. *Heavenly Participation. The Weaving of a Sacramental Tapestry*. Grand Rapids: William B Eerdmans.
- Goosen, D. 2007. *Die Nihilisme. Notas oor ons Tyd*. Pretoria: Praag.

perhaps a dawning mystical realism, or, to import an expression from literature studies, magical realism – the “sacred canopy” of Berger’s (1969) sociology of religion which has been so influential. This is seen, for instance, in the manner in which a number of disciplines, such as law, sociology and philosophy (Lombaard 2016, 1–6; cf. Waaijman 2007, 1–113), music (Potgieter and Lombaard 2015, 9–24) and literature (Lombaard and Jansone 2017) are taking the religious seriously again, although differently from before. It is certainly also being taken seriously anew and differently in the health sciences<sup>6</sup> (cf. Waaijman 2007, 88–95).

The author<sup>7</sup> Virginia Woolf (1926:32) speaks thus of health (and the absence of health) in her essay, “On Being Ill”:

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- Habermas, J. 2008. “Secularism’s Crisis of Faith: Notes on Post-Secular Society.” *New Perspectives Quarterly* 25:17–29.
  - Ingman, P., T. Utraiainen, T. Hovi, and M. Broo, eds. 2016. *The Relational Dynamics of Enchantment and Sacralization. Changing the Terms of the Religion versus Secularity Debate*. Sheffield: Equinox.
  - Kearney, R. 2010. *Anatheism: Returning to God after God*. New York: Columbia University Press.
  - Taylor, C. 2007. *A Secular Age*. Cambridge, MA: Harvard University Press.
  - Schrijvers, J. 2016. *Between Faith and Belief. Toward a Contemporary Phenomenology of Religious Life*. New York: SUNY.

<sup>6</sup> Some may be tempted to misinterpret the unfolding post-secular era as a large-scale return to religious life. Post-secularism, however, has nothing to do with a religious revival, but is instead a cultural climate in which religion is neither reflexively prioritised nor reflexively marginalised within society. Rather, religion is afforded a voice along with many other aspects of life interacting on the stage of society. This is for instance demonstrated by the fact that, following the dominance of Marx’s idea (1844 [1973]:162) that “Das religiöse Elend ist in einem der Ausdruck des wirklichen Elendes und in einem die Protestation gegen, das wirkliche Elend. Die Religion ist der Seufzer der bedrängten Kreatur, das Gemüt einer herzlosen Welt, wie sie der Geist geistloser Zustände ist. Sie ist das Opium des Volks,” the metaphor may be changed, as in the article by Wellman, Corcoran and Stockly-Meyerdink (2014, 650–672) entitled “God is like a Drug: Explaining Interaction Ritual Chains in American Megachurches”.

<sup>7</sup> The natural link between full personhood and health has found literary expression across the ages. Note how aspects of faith (here, quite critically so) find a natural place not alongside, but fully integrated with aspects of health. The first- and second-century poet Juvenal (*Juvenalis*) is known as the author of the famous statement, *mens sana in corpore sano*, “a healthy mind in a healthy body”, doubly misinterpreted (cf. Nash 2008, 148; Colish 1990, 210–212) first as an exhortation to exercise the body, thus ignoring its wider context as a prayer for both mind and body, and second as a blessing expected from the gods, thus disregarding the

Considering how common illness is, how tremendous the spiritual change that it brings, how astonishing, when the lights of health go down, the undiscovered countries that are then disclosed, what wastes and deserts of the soul a slight attack of influenza brings to view, what precipices and lawns sprinkled with bright flowers a little rise of temperature reveals, what ancient and obdurate oaks are uprooted in us by the act of sickness, how we go down into the pit of death and feel the water of annihilation close above our heads and wake thinking to find ourselves in the presence of the angels and harpers when we have a tooth out and come to the surface in the dentist's arm-chair and confuse his "Rinse the Mouth—rinse the mouth" with the greeting of the Deity stooping from the floor of Heaven to welcome us – when we think of this, as we are frequently forced to think of it, it becomes strange indeed that illness has not taken its place with love and battle and jealousy among the prime themes of literature.

The closing words of this excerpt could be reformulated with respect to matters of faith:

... it becomes strange indeed that illness and spirituality have not long since taken their place ... among the prime themes of scholarly literature.

The realisation by many individuals that there is a reciprocal relationship between the health of their bodies and their spiritual sensibilities is coming to be echoed within Western/ised health practice.<sup>8</sup>

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satirical nature of this poetic prayer. Herein could perhaps lie the seed of the splitting of faith from health; nevertheless, to the ancient mind the one could not be considered without the other.

<sup>8</sup> One might ask how it is possible to make a distinction between the bodily self and the psychological-spiritual self within healthcare practice. Even in the exceptionally powerful Western cultural stream of the past three millennia, the unfolding conceptual splitting of the notion of what it is to be human into body, mind and spirit has for the greater part been understood as a relational undertaking, in this sense vaguely akin to the Christian concept of the Trinity, and with each aspect of being human considered unthinkable without the others. Even where one has been emphasised at the cost of another, this has been possible only in the mirror of the other. For instance, when in some streams of ancient Greek philosophy the idea of the soul was held to be all-important in relation to the body, this could only be done either with the body disparaged or with the body given over to its pleasures. In the early Christian conception of this in mystic-ascetic practices, which were numerically minor but ideologically highly influential movements, it was the deprecation of the body that served the enlightenment of the spirit. Yet, in such exercises of the soul, the body could never be escaped; our corporeality asserts itself continually. At times this happens paradoxically, such as

This goes far beyond the Flower Power 1960s and 1970s generation or the contemporary *bricolage* spirituality which may draw (often disconcertingly superficially) on crystals, traditional religions, ecological sensibilities, Eastern philosophies, quantum physics and more, all of which constitute serious expressions of religiosity, yet have failed in combining these commitments with serious scholarship. That tide has, however, changed, as can be seen in the work of three academic institutions on three continents, each reflected through the work of a representative researcher:<sup>9</sup>

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in Christian pietist history, in which the primacy of the soul in highly intimate personal religious life was greatly extended, but which enabled a missionary spirit that included in its mixed bag of positive and negative consequences (for a substantive historical and conceptual overview, cf. Bosch 1991) the establishment of hospitals in many parts of the world. This link between religion and health has been retained throughout the world in the names of a number of hospitals (think, for instance, of “St Mary’s” or “Good Samaritan”) and in the reference to nurses as “Sister”, an implicit acknowledgement (employing here the conceptualature of, for instance, Bailey (1998, 9–22)) of the important role nuns played in the history of patient care (this designation has recently come to be questioned, however, although more for its gender assignment than for its religious heritage). Yet, within the rationalist world of modernism as a philosophical view of life, and within the protocols of science as practised within medical fraternities, it has to a significant extent become standard practice that it is the body alone that should be treated.

This, here, as was the case above, is not meant as an accusation. Rather, it is meant as a characterisation; well known – yet also not exhaustive, since no body of human practice is so impermeable to other spheres of life that it encounters solely itself. Still, medical science has been as successful as, for instance, managerialist frameworks in institutions such as universities and churches, some political ideologies and all fundamentalist theologies, in regarding diverse aspects of life on *its* terms, rather than on *theirs*. In sociological analyses, this trait in the health sciences has been referred to as the medicalisation of society: medical frames of thinking, assumptions and metaphors come to dominate all with which they come into interaction – thus giving the meaning of the expression *médecins sans frontières*, usually associated with a noble organisation, an unintended, undeserved negative connotation.

In much of mainstream medicine, the world of being well has been reduced to the body. This is understandable, given factors such as the intellectual demands of studying an already vast field, the unavoidable constraints of specialisation, and the financial implications of research in such a complex field.

<sup>9</sup> Naturally, many other researchers could be included here too, such as Arndt Büssing of the Institut für Integrative Medizin, Universität Witten.

- In Washington, DC, the Institute for Spirituality and Health at the George Washington University School of Medicine (<https://smhs.gwu.edu/gwish>), as represented by the work of Christina Puchalski;
- In Zürich, Switzerland, the Center for the Study of Christian Spirituality ([www.theologie.uzh.ch/en/faecher/praktisch/cascs0.html](http://www.theologie.uzh.ch/en/faecher/praktisch/cascs0.html)), as represented by the work of Simon Peng-Keller (appointed to the chair of Spiritual Care);
- In South Africa, HospiVision ([www.hospivision.org.za/wmenu.php](http://www.hospivision.org.za/wmenu.php)), very recently located in Stellenbosch, but formerly associated with the Tshwane District Hospital and the Centre for Contextual Ministry, University of Pretoria, as represented by the work of André de la Porte.

A brief review of the work of these institutions and figures will give a good sense of how, in our time, spirituality and health in combination are being treated differently from the way they have been within the broadly held perception about mainstream health care. Perception, because, as indicated above, the separation between medicine and religion has never been fully enforced, with as another and quite obvious example the chaplaincy services available in many healthcare institutions.

### **Three Leading Institutions**

In Washington, DC, GWISH – the George Washington Institute for Spirituality and Health, under the leadership of Christina Puchalski – has since 2001 done pioneering work on the relationship between health and spirituality. Caring as a part of curing is emphasised, with instruments for spiritual evaluation being designed, surveys undertaken and books published in order to serve medical practice, as a further focus. Compassion features among the more prominent terms of care in these resources, along with other language more usually encountered in programmes designed for theologians and social workers.

If a single article to convey an understanding of the work of GWISH and of Puchalski were to be recommended, it would be:

- Puchalski C.H., B. Blatt, M. Kogan, and A. Butler. 2014. “Spirituality and Health: The Development of a Field”. *Academic Medicine* 69(1):10–16.

The Swiss CASCS, Center for the Study of Christian Spirituality, is a much younger institution, having been established in 2015 under the directorship of Rebecca Giselbrecht. Following shortly after her, with funding from both the medical and theological faculties, Simon Peng-Keller was appointed director. The primarily theological background of the centre is evident in its research focus on matters traditionally associated with spirituality as a discipline, such as Spiritual Direction, and the growing collaboration with theologians and spirituality research institutions in Australia, South Africa and Ireland. Peng-Keller's research background leans strongly towards spiritual life and pastoral care, with conferences on prayer and healing (also in the medical sense) a clear CASCS focus.

If a single article to convey insight into the historical-theological background of CASCS were to be recommended, it would be:

- Giselbrecht, R. 2015. "A Historical Decoupage Arguing for the Particularity of Theology and Christian Spirituality in Higher Education." *Ceļš* 65:177–196.

The following monograph makes a valuable contribution in drawing on psychology and mysticism as sources for pastoral care:

- Peng-Keller, S. 2003. *Gottespassion in Versunkenheit. Die psychologische Mystikforschung Carl Albrechts aus theologischer Perspektive* Verlag (Studien zur systematischen und spirituellen Theologie 39). Würzburg: Echter.

The South African faith-based organisation HospiVision, under the leadership of André de la Porte, operates from a strong pastoral background, with a practice orientation towards hospital ministry, the provision of courses, and more recently, research conferences. Over a decade and a half, reflected expertise has been built up based on specialised intervention in medical crisis situations. A wider focus on other societal problems and on children reflects the dire social circumstances of South African society that all faith-based organisations are confronted with, directly and daily. An expanding interdisciplinary approach seeks to deal with aspects of these problems in a more encompassing way than such organisations traditionally do.

If a single article to convey an understanding of the work of HospiVision and of De la Porte were to be recommended, it would be:

- De la Porte, A. 2016. “Spirituality and Healthcare: Towards Holistic People-centred Healthcare in South Africa.” *HTS Theologiese Studies/Theological Studies* 72(4):1–9.

## Conclusion

Apart from the developments mentioned above, a series of recent conferences on spirituality and health further demonstrate the growing interest in this field:

- In Helsinki, Finland: “Of Sound Body and Spirit? The Newly Unfolding Linkage of Health and Spirituality” – a session as part of the European Association for Religious Studies annual conference, “Relocating Religion”, June 2016;
- In Zürich, Switzerland: “Diesseits und jenseits leiblichen Verstehens: Beten im Kontext von Spiritual Care”, July 2016;
- In South Africa, two conferences just a few days apart, one each in Cape Town and Pretoria: “2nd Biennial Conference on Spirituality and Healthcare: Wholeness in Healthcare”, October 2016.

These are just some indications of recent scholarly activity, with further such developments already being planned for the coming years. The same holds for what follows: only some activities are mentioned, to convey a sense of the rapid developments in this field. Monographs, reference publications and journals on health and spirituality have namely begun to appear:

- A new monograph series: Possamai-Inesedy, A., and C. G. Ellison. 2016 onwards. *Religion, Spirituality and Health: A Social Scientific Approach*. Vienna: Springer.
- Cobb, M.R., C.M. Puchalski, and B. Rumbold, eds. 2012. *Oxford Textbook on Spirituality in Healthcare*. Oxford: Oxford University Press.
- Koenig, H.G., D.E. King, and V.B. Carson, eds. 2012. *Handbook of Religion and Health*. Oxford: Oxford University Press.
- Puchalski, C.M., and R.N. Ferrel. 2010. *Making Health Care Whole. Integrating Spirituality into Patient Care*. West Conshohocken: Templeton Press.
- Louw, D.J. 2008. *Cura Vitae: Illness and the Healing of Life*. Wellington: Lux Verbi.

- Journals, among which are:
  - *Journal of Religion and Health*
  - *Social Science & Medicine*

On a more modest scale, review articles are being published, such as:

- Mellacqua, Z. 2016. “When Spirit comes to Mind: Furthering Transactional Analysis Understandings of Spirituality in Health and Psychopathology.” *Transactional Analysis Journal* 46(2):149–163.
- Jors, K., A. Büssing, N.C. Hvidt, and K. Baumann. 2015. “Personal Prayer in Patients Dealing with Chronic Illness.” *Evidence-Based Complementary and Alternative Medicine*, Article ID 927973:1–12.
- Puchalski, C., B. Blatt, M. Kogan, and A. Butler. 2014. “Spirituality and Health: The Development of a Field.” *Academic Medicine* 89(1):10–16.
- Janse van Rensburg, A.B.R., C.P.H. Myburgh, C.P. Szabo, and M. Poggenpoel. 2013. “The Role of Spirituality in Specialist Psychiatry: A Review of the Medical Literature.” *African Journal of Psychiatry* 16(4):247–255.
- Vanderhaegen, B. 2010. “Palliatief Verpleegkundigen en Spiritualiteit.” *Pastorale Perspectieven* 146(1):45–58.
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The growing number of research students and post-doctoral researchers in various countries and from a variety of health-related disciplines who venture into Spirituality Studies, and the growing number who venture from Spirituality Studies into the health-related disciplines is remarkable.

Naturally, with a research field rapidly rising in popularity, misconceptions and power grabs towards the divine should be guarded against all the more vigilantly. This includes being wary of an instrumentalist view of spirituality, in which the “use” of spirituality should, for instance, include clear and practical health benefits in order to be of any value to individuals, medical professionals and society. Such a “therapeutic god” (Smith 2014, 172), and a concomitant spirit of entitlement (cf. Martin 2013) among believing patients and their medical, spiritual and other attendants, which far exceeds the boundaries of a

divine–human relationship based on humility and faith, would fit well with the kind of success theologies prevalent in many parts of the religious world. What kind of divinity would that presuppose, however, and what kind of faith experience? Voices critical of such an instrumentalist view of the divine (e.g. Sloan 2008; cf. Ellis 2000, 29–33) must be encouraged. Furthermore, if it were for instance to become clear that aspects of spirituality, or perhaps all expressions thereof, do not contribute to physical health, or mental or social health, would the implication then be that spirituality is best excluded from healthcare? Would a functionally useless God best be declared, for all practical intents, dead on arrival? These and other foundational questions should remain part of the considerations on health and spirituality. Moreover, an approach that values pluralism for the strengths that diversity brings (described in Balboni, Puchalski, and Peteet 2014, 1586–1598) combined with the intensely difficult matter of critical engagement with spiritualities which are not deemed “healthy”, that is, valid and nurturing, is already implicated in what constitutes this interactive study field of spirituality and health.

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WHOLENESS IN SPIRITUAL  
HEALING AND HELPING:  
TOWARDS A BASE ANTHROPOLOGY  
FOR A PASTORAL HERMENEUTICS  
OF HOPE CARE<sup>1</sup>

DANIËL J. LOUW<sup>2</sup>

**Abstract**

In the context of human well-being, anthropology plays a fundamental role in theories relating to therapeutic interventions. Alongside the cognitive, the conative, the affective and the bodily dimensions of our being human, spirituality should be viewed as a coherence factor that relates to purposefulness and meaning, dealing as it does with the transcendent and religious or sacred dimension of being. Transcendence refers to inter alia ideas, paradigms, belief systems and schemata of interpretation in which religious convictions and philosophies of life play a decisive role. Therapy should therefore probe the idea-matic realm of life. Psychotherapy and spiritual healing should be supplemented with philosophical counselling and wisdom counselling. With reference to the need for differentiation in a holistic and interdisciplinary approach to wholeness, it is proposed that spiritual healing in the Christian wisdom tradition (*sapientia*) should be qualified by the notion of *paraklesis*: encouragement and comfort based

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<sup>1</sup>This paper is based on a forty-year-long academic research project on the interplay between wholeness in soul care (*cura animarum*) and the most basic human existential and ontological need in light of the painful awareness of suffering, vulnerability and death, namely the quest for meaning and hope. It has been published in D.J. Louw, *Wholeness in Hope Care. On Nurturing the Beauty of the Human Soul in Spiritual Healing* (Berlin: Lit Verlag, 2016).

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on the faithfulness of God and a theology of compassion that embodies the *hesed* and *rahm* of the *passio Dei*.

## Keywords

Spiritual healing; philosophical counselling; pastoral caregiving; wholeness; pastoral anthropology

## Introduction

Among the most basic determinants in healing and helping are the undergirding anthropology that determines and directs processes of human well-being, and the patterns of thinking that create an interpretive framework of reference. How they view human beings determines the choices caregivers and therapists make in order to support their therapeutic approaches and justify the paradigmatic background of their basic theory.

In religious spirituality, doctrine on the essence of our being human shapes the character and identity of the professional or lay caregiver. Dogmatic conceptualisation of divine interventions (God-images) determines the quality of the pastoral encounter, the eventual therapeutic interventions in counselling procedures and the interplay between ‘soul care’ and human well-being.

In many developed countries and affluent societies human well-being is becoming more and more a biochemical pursuit of happiness. The pursuit of happiness is then about the upgrading of the human body and mind by means of chemistry and biological engineering. “The upgrading of humans into gods may follow any of three paths: biological engineering, cyborg engineering and the engineering of non-organic beings” (Harari 2015, 43). It is quite understandable why Harari refers to the new “biochemical and microchipped human being” as “*Homo deus*” – *Homo sapiens* upgraded (Harari 2015, 46).

This future scenario immediately suggests an investigation of the connection between meaning and the telic dimension (teleology being the significance and sense of purposefulness) of our being human. The pursuit of happiness cannot be separated from the dimension of spirituality in human health and healing. This leads us to an intriguing spiritual observation: We want the ability to re-engineer our bodies and minds in order, above all, to escape old age, death and misery, but once we have it, who knows what else we might do with such ability? (Harari 2015, 46).

What, then, is the interplay between the conceptualisation in anthropology (paradigmatic background) and the eventual outcome of

healing? Within the long tradition of *cura animarum* (the curing or care of human souls), what is the link between an anthropological understanding of spirituality, the dynamics of the human soul and the quest for integral healing (wholeness)?

### **Spirituality as Source of Healing in Hope Care in Light of the Plea for ‘Integral Spirituality’<sup>3</sup>**

Spirituality is increasingly coming to be acknowledged, even in the human sciences, as a vital component in helping and healing. As Handzo (2012, 21) asserts, there is a shift in the paradigm for how spiritual and religious needs are attended to in the healthcare process:

This shift is due to the increasing recognition of spirituality and religion as important to health, including the treatment of acute illness, coupled with the emerging recognition of what a professional, board certified chaplain can bring to this process (Handzo 2012, 21).

Research indicates that patients’ demand for spiritual care is high and increasing, and that people, including those who say that they do not view themselves as religious, are likely to turn to religion in response to stressful life events (Handzo 2012, 23).

Steger (2012, 165–175) argues that psychological well-being cannot ignore spirituality, that is, the general sense of transcendence and connection with something larger than oneself, and the pursuit of significance in that which is sacred about life.

Even from a sociological viewpoint, there is an attempt to re-evaluate the impact of the concept of spirituality on life and existential issues. Giordan (2007, 162) makes the observation that spirituality is no longer assessed purely according to its religious and traditional theological meaning: “Somehow, ‘spirituality’ has moved from the shadowy realms of theology to become a ‘fashionable’ sociological concept.”

Adrian Andreescu, in his psychological research into the value of prayer in processes of healing (2011, 23–47), is convinced that spirituality (the transpersonal realm of life) and religious experiences<sup>4</sup> contribute to

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<sup>3</sup> For Handzo (2012, 240), spirituality in chaplaincy refers to: “Interventions, individual or communal, that facilitate the ability to express the integration of the body, mind, and spirit to achieve wholeness, health, and a sense of connection to self, others, and [/or] a higher power.” See also Dorr (1990).

<sup>4</sup> In *Religion als Deutung des Lebens*, Gräß (2006, 52) connects the religious factor in our being to the need for self-actualisation and meaningful self-expression

healing and well-being. He refers to the notion of ‘trans-personal capital’, and contends that healing also comes from outside, and is not limited by internal sources: “I suggest that acquiring transpersonal capital requires at a primary level a conscious individual effort to inhabit and maintain a credible spiritual worldview, found to be largely congruent with the person’s own mediated and unmediated life experiences” (Andreescu 2011, 31).

For Clifford Geertz (in Drehsen et al. 2005, 210–211), religion<sup>5</sup> provides a system of symbols which help a human being to express a state of mind/mood (*expressive power*) and to be motivated to act and to perform (*performative power*). Religious symbols function as expressive means to articulate and to signify the ultimate, that which transcends our comprehension (*Deutung des Unbegreiflichen*). In this regard, rituals and their embeddedness in culture are important. Religion even helps to stabilise and to synchronise the need for a collective identity and individual constructs for meaning identification. In this regard, religious structures and cultural art are used to enhance the social interconnectedness of a group of people or tribe.

For Peter Berger (in Drehsen et al. 2005, 262), religion is related to our basic need and quest for meaning. The social and public reality is an attempt to establish a network of meaning which Berger calls *nomos*. In this regard, religion provides a general impetus for meaning which implies a kind of “sanctification of the cosmos” (*Religion als heiliger Kosmos*). Religion surfaces within the experience of our human limitations; it is a kind of border experience when humans experience or are exposed to threat. Everyday experiences are then translated and articulated into a comprehensive cosmic system that in its normative direction becomes a holy cosmic network.

The plea for spirituality in care and healing is also being made in the other human sciences. In the *Oxford Textbook of Spirituality in Healthcare* the editors (Cobb, Puchalski, and Rumbold 2012, vii) point out that the notion of spirituality in healthcare is closely related to the realm of human suffering, and argue that if healthcare has any regard for the

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(*Selbstdeutung*). “The word ‘religion’ comes from the Latin term *religare* from *re* – again and *ligare* – to bind. Thus, religions talk of spiritual experiences as the re-binding to God” (Puchalski and Ferrell 2010, 22).

<sup>5</sup> Early in the development of his theory for rational-emotive behaviour therapy, Albert Ellis was convinced that religion, faith and spirituality contribute to irrational thinking. Relating religious spirituality to what he called ‘Jehovian *musts*’ and monotheistic religion Ellis and Grieger (1977) viewed the notion of spiritual healing with scepticism and criticism.

humanity of those it serves, it must engage with spirituality in its experienced and expressed forms: “Spirituality is for many people a way of engaging with the purpose and meaning of human existence and provides a reliable perspective on their lived experience and an orientation to the world” (Cobb, Puchalski, and Rumbold 2012, vii). Thus, Pellegrino (2012, vi) is of the view that healing of the psychosocial-biological is of itself insufficient to repair the existential disarray of the patient’s life without recognition of the spiritual origins of that disarray.

In spiritual care, it is not automatically accepted that spirituality contributes to health in general – indeed, spirituality can be a hampering factor, and possibly add up to spiritual pathology. Glenn and Robitaille (2012, 146) offer the following observation on the situation in which faith becomes unhealthy:

When faith is unhealthy, it is generally the processing of beliefs that is dysfunctional rather than the actual beliefs.... When faith is unhealthy, the God Presence/transcendence is cast as severe, exacting, malevolent, and/or indifferent.... When faith is healthy, the believer engages the God Presence/transcendence as life-giving, life-affirming, and benevolent.

It is clear that in an integrative approach, it is virtually impossible to separate the religious dimension from the psycho-social dimension of spirituality. However, in an interdisciplinary approach, and dealing with the dynamics of cultural plurality and diversity, differentiation is necessary in order to demarcate the contribution of each discipline to a holistic approach in healing and helping.

### **Healing in Psychotherapy: The Need for Differentiation**

Harding (1985, 25) considers a helping relationship to be fundamental to all therapy: “the essence of counselling and psychotherapy includes the idea of helping another through a caring relationship.” Therapy deals with the complexity of human nature in all its aspects. It focuses primarily on the inner being – emotional, volitional, attitudinal, rational, psychological and spiritual. Its main objective is to encourage constructive change in the person's behavioural components, as well as the possibility of increased health in the physical, relational and social dimensions of a person's life.

In psychology, the concept of therapy is closely connected to a number of theories pertaining to personhood, personality and human behaviour (Tan 2011). It should be borne in mind that psychotherapy is a comprehensive concept that includes a variety of techniques. Various theories on the human psyche and its connection to the cognitive, the

conative and the affective determine the meaning of the concept (Tydemann 1989, 524).

When attempting a definition of the term “psychotherapy,” in the *Dictionary of Pastoral Care and Counseling*, Strunk (1990, 1022) justifiably laments: “The term psychotherapy has become a lexicographer’s nightmare.” At most, one could say that a variety of psychotherapeutic groups exists. These may be divided into the more psycho-analytical/psychodynamic therapies, which strongly apply the unconscious factor; behaviouristic/cognitive psychotherapies, which apply learning theories, knowing processes and modification of behaviour; and existential/transpersonal psychotherapies, which apply value systems, cultural factors and philosophical elements concerning the question of meaning. What is important to emphasise here is that therapy is merely a helping medium, and must never become an absolute goal in itself.

One can say that pastoral therapy and psychotherapy operate within the same realm of helping, communication and self-insight. However, the context, content and eventual outcome and goal are different.

In wisdom thinking, the difference is demarcated by *sapientia*: the knowledge of the heart as determined by unselfish love, grace and vivid faith in the presence of God. Divine presence and human disposition constitute a spiritual praxis of meaningful living – a taxonomy of virtues and virtue ethics (Sperry 2002, 78–91). It deals with a different understanding of ‘soul’ and acknowledges the interplay between the inhabitational penetration of life by the Spirit of God and the responding willingness of human beings to behave according to directions emanating from what is known in theology as the will of God.

What, then, is the core difference between psycho-spirituality and *sapientia*-spirituality?

### **The Spiritual Dimension in Pastoral Therapy: Compassionate Being-with**

In pastoral therapy the praxis of God, the spiritual realm of compassion and biblical sources for healing are different from the realm of self-help in psychotherapy. Self-insight should be supplemented by wisdom and faith. Religious contexts, “signals of transcendence” and the realm of the divine as connected to God-images determine its theoretical framework.

The main purpose of the pastoral conversation is to comfort people so that they are able to live meaningfully, and apply faith and hope to the daily existential realities of life. In terms of the Christian tradition of *cura animarum* and the theological paradigm for caregiving, my basic

assumption is that the pastoral encounter in ministry functions as an embodiment of the *paraklesis* metaphor.<sup>6</sup>

In the LXX, the Hebrew *naham*, which denotes sympathy and comfort, is in most instances translated as *parakaleo*. The prophet's task included comforting the people: "Comfort, comfort my people, says your God" (Is. 40:1). When *parakaleo* is used as a translation for *naham* specifically, it expresses compassion, sympathy and caring (Ps 135:14). When *parakaleo* is used as a translation for other Hebrew equivalents, it denotes encouragement, strengthening and guidance (Braumann 1978, 570). It is interesting that while in the Hellenistic world the stronger emphasis is on an ostracising admonition, in the Old Testament the accent is on comforting and supporting.

In the New Testament, one encounters a range of nuances: summon, invite, reprimand, admonish, comfort, encourage, support, ask, exhort. The link in Philippians 2:1 between solace in Christ (*paraklesis*), encouragement through love (*paramytheisthaz*), and communion with the Holy Spirit (*koinonia*) is significant. These concepts, again, are linked to the notions of empathy and compassion. When *parakaleo* expresses admonition, it focuses on comfort and preservation and must therefore not be viewed primarily as a moral instruction, but as a loving involvement fulfilled because of 'God's mercy' (Rm. 12:1). *Parakaleo* is also linked to the term *parakletos*, which can be translated as helper, advocate, counsellor, comforter, and persuader/convincer. Owing to the association with advocacy, the metaphor communicates the work of the Holy Spirit as an advocate who intercedes on behalf of the helpless and the voiceless. In this regard, the caregiver becomes a kind of 'activist' on behalf of the outcast and marginalised in society. Every aspect of advocacy in paraclitic interventions in pastoral caregiving is determined by the core theological factor, namely compassion as expression of the *passio Dei*.

Different languages have different words to express compassion as co-suffering. Davies (2001, 234) identifies these as including the Latin *commiseratio*, the Greek *sumpatheia* and the German *Mitleid*. (To this list we can add the Afrikaans *medelye*: suffering with.) Other terms used to express a mode of care are the Latin *clementia*, *misericordia*, *humanitas* and sometimes *pietas*, the Greek *eleos* and *oiktos*, the English 'mercy' and 'pity', and the French *pitié* (Davies 2001, 234).

While compassion suggests 'fellow-suffering' as suffering with, mercy in the Bible implies a kind of rationality informed by principles and values to

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<sup>6</sup> Hunter (1995, 18) argues: "The metaphor for healing is not new in pastoral care. Healing imagery as a metaphor for ministry has its roots in the Bible, principally in the healing ministry of Jesus." See also Firt (1986, 82).

express righteousness. Mercy implies a juridical component as well (Davies 2001, 246).

The Christian poet Lactantius, who lived from the third to the fourth century C.E., made a connection between the concepts of compassion, *miser cordia*, and *humanitas*. He viewed compassion as a corporate strength granted by God (*hunc pietatis adfectum*) in order that humankind should show kindness to others, love them and cherish them, protect them from all dangers and come to their aid (Lactantius in Davies 2001, 35). Compassion thus creates a bond among the members of human society and nurtures human dignity. “*Humanitas* is to be displayed to those who are ‘suitable’ and ‘unsuitable’ alike, and ‘this is done humanely (*humane*) when it is done without hope of reward” (Lactantius in Davies 2001, 35).

According to Martha Nussbaum, compassion should be preferred in order to express “the basic social emotion” (in Davies 2001, 238), connecting both the cognitive and the affective. For Nussbaum, compassion is a certain kind of reasoning, a certain kind of thinking about the well-being of others.

For the rabbis in the Jewish tradition the compassion and creativity of God were modalities of the divine presence in the world (Davies 2001, 243). Compassion demonstrated an active and historical presence with and for Israel, serving in the formation of a holy fellowship of people who would be mindful of the covenant and reverently honour God’s name and faithful promises.

As the signifier of a divine quality which can apply also to human relationships, the root *rh̄m* has much in common with the noun *hesed*, which denotes the fundamental orientation of God towards his people that grounds his compassion action. As “loving-kindness” which is “active, social and enduring”, *hesed* is Israel’s assurance of God’s unflinching benevolence (Davies 2001, 243).

The language of love and mercy, as used in reference to God, has its origins in the close familial relations denoted by *hesed* and *rh̄m*.

Human love and compassion therefore provide the analogical language for divine love and mercy which, in the image of a parental *rāham*, tend at times towards an affectivity which is analogically evocative of a divine compassion. However, if *hesed* and *rāham* are primarily qualities of God’s righteousness, those who serve God as his righteous people are called to display love and mercy to those around them. They who fear the Lord are themselves “gracious (*hannūn*), compassionate (*rahūm*) and righteous” (Davies 2001, 246).

Compassion as the embodiment of divine *hesed* and *rhḥm* is focused on the quality of life. Life should become soulful, hence the fact that Hebrew thinking connects the urge for life and *ruach* (spirit) as core elements of the human soul (*nēfēsh*). It also indicates the paradigmatic framework of pastoral caregiving.

“Pastoral” is derived from the Latin *pascere* (Waruta and Kinoti 2000, 5), which means to feed and nurture the flock. The shepherd/flock metaphor (*cura pastoralis*) (Nauer 2010, 56) has traditionally been viewed as an expression of God's loving care for human beings in need. “In view of this Latin root, the adjective ‘pastoral’ suggests the art and skill of feeding or caring for the well of others, especially those who need help most” (Waruta and Kinoti 2000, 6). Pastoral care thus refers to both healing (Greeves 1960) and compassionate helping, hence the emphasis on becoming ‘whole’.

On becoming whole presupposes a very specific understanding of soul in a pastoral anthropology.

### **The Focus of Compassionate Being-with: Anthropology and the Notion of the Human Soul**

“Soul” is not so much a substantial entity within the human body as it is a qualitative concept conveying the vitality of a life, a vivid principle that constitutes an acknowledgement of the presence of God. It is a relational term, indicating the quality of human relationships, hence the normative dimension of love, namely to love God and to love fellow human beings.

When *nēfēsh* is translated as *psuchē*, it signifies that which is vital in a human being in the broader sense of the quality of life and human relationships. In combination with heart (*kardia*) and mind (*nous*), soul in the New Testament denotes the seat of life, or even life itself. It represents the person in the broadest sense and indicates the quality of life experiences (*habitus*). Soul therefore does not refer in the first place to a different anthropological category, but to a different mode of being (Harder in Brown 1978, 684).

The mode of being as expression of the dynamics of soul is described in wisdom thinking as *habitus*. With reference to a pastoral anthropology *habitus* is the translation of attitude as the exemplification of the intentionality of Christ (*phronesis*, Phil. 2:5). *Habitus* is more or less the equivalent of *nēfēsh* as a qualitative principle for life. Soul therefore indicates the stance of a human being (being function) before God. It

stands as an equivalent for attitude (*phronēsis*).<sup>7</sup> And again, attitude should exhibit and en flesh the compassion and comfort of God.

To speak of God as a *compassionate companion* is to accept his injunction that we ourselves, within the unique meaning of the human soul (*nēfēsh*), should be compassionate, “and it is to understand that undergoing the dispossession of self, entailed by compassion, is to align our own ‘being’ with God’s ‘being’, and thus, performatively, to participate in the ecstatic ground of the Holy Trinity itself” (Davies 2001, 252). This being-with God should then be demonstrated in a taxonomy of spiritual practices and soulful expressions.

### **Spiritual Expressions/Signals of the Human Soul (Soulful Embodiment)**

In order to obtain clarity on the impact of spirituality on life issues and the existential realm of human embodiment, as well as on the notion of soulfulness in an anthropological understanding of wholeness, it is perhaps necessary to see whether it is possible to identify basic “expressions” or “signals” of the human soul. A diagram depicting an integrative approach to pastoral anthropology would help the pastoral caregiver to understand the unique character of caregiving and the identity of the caregiver in a team approach to helping and healing (Figure 2.1 A model for pastoral anthropology, p. 15).

In a pastoral anthropology we should reckon on at least the following six essential components in humanhood and a soulful dynamics:

- The affective: This represents the dimension of emotions and feelings.
- The cognitive: This represents the dimension of the human mind and the capacity for reason, analytical thinking and rational understanding and comprehension.
- The conative: This represents the dimension of the human will and its connection to motivation and inspiration.
- The body: This represents the dimension of corporeality and its connection to physical, physiological, biological, neurological

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<sup>7</sup> The root of the word from which the English ‘psyche’ is derived, *psuché*, means breath, or to breathe. The Hebrew word for soul, *nēfēsh* (Gen 2:7), means breath, exhalation, the principle of life (Seidl 1999, 751). *Nēfēsh* denotes the principle of life that makes a body, whether human or animal, into a living being. For a further discussion, see Louw (2008).

and hormonal aspects of human embodiment. Embodiment underlines the factor of vitality in our being human and the immediacy of desires, senses, sensuality and all basic drives, such as sexuality.

- Environmental ‘Gestalt’ and relational networking: Human orientation is existentially embedded and takes place within the structures of culture, social contexts, community dynamics and ecosystems. Human contextuality is essentially demarcated by the realities of suffering, misery and death.
- The spiritual realm of wisdom thinking and its connection to a sound conscience, moral awareness, integral, consistent and responsible thoughtfulness, comprehension, insight, and human responsibility (accountability). The spiritual realm of life includes worldviews and is defined by constructs and different schemata of interpretation representing belief systems. Spirituality also represents the aspect of *telos* (purposeful devotion) in soulfulness; it constitutes a disposition/*habitus* of God-directed dedication and space of sacred *eusebeia* in all relationships: an ethos of unconditional love.

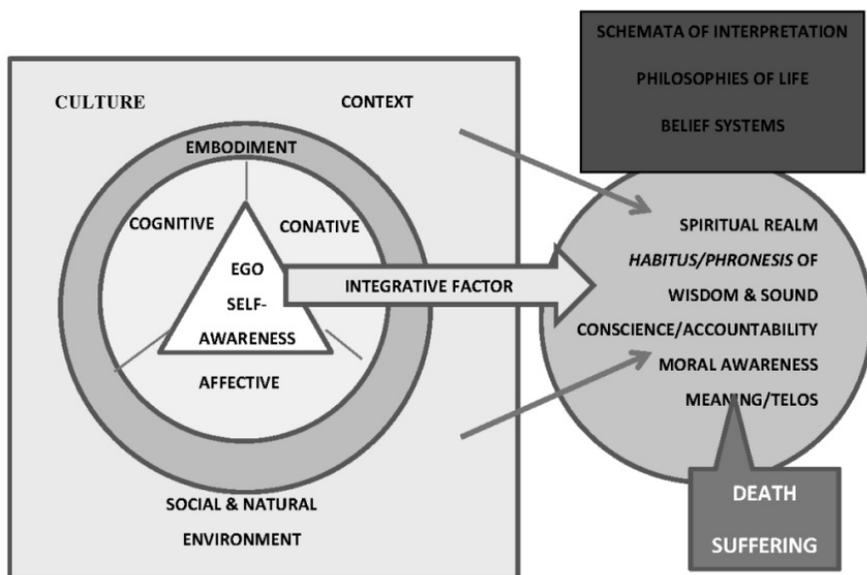


Figure 2.1 A model for pastoral anthropology

## Systemic Dynamics of the Human Soul: *nēfēsh*-disposition

Where does the human spirit, and therefore the spiritual realm, fit into this picture of the dynamics of the human soul?

One must acknowledge that it is in fact impossible to portray the dimension of the spirit and its representation of the existential realm of life. However, *the argument is that spirituality brings about cohesion and a sense of integration and wholeness*. Every element and dimension is an ingredient of what can be called the human spirit. The difference resides in the telic dimension of *habitus*: the quality and mode of being functions within the networking dimension of human relationships. It is determined in a religious understanding of ‘soulfulness’ by the belief system and God-image.

By the dynamics of wholeness as a spiritual category is meant the element of true discernment as an expression of wisdom. In the wisdom tradition of many religions and cultures, the mystical element of life comes to the fore. It operates as a kind of awareness of the more, the transcendent realm in life. One becomes aware of this kind of existential mysticism when one is overtaken by awe and wonder – moments when human beings become aware of the numinous in life. The point is: with reference to the aesthetic dimension in life, one cannot avoid experiences of the sublime and the fact that life entails more than factuality. Within the profane lurks the sacred, a kind of ‘knowledge of the heart’ (*sapientia*), the knowledge that life is valuable and indeed beautiful (*homo aestheticus*).

The beauty of life should be conveyed by means of the following spiritual expressions/signals of the human soul:

- (a) The quest for integration within experiences of disintegration (congruence and consistency)
- (b) The quest for appropriate categories, philosophies of life and paradigms for the interpretation of life issues in a comprehensive way, as well as from within a constructive, positive perspective (hermeneutics of life).
- (c) The quest for healing and wholeness within the existential realities of anxiety, guilt or shame, despair or dread, helplessness and loneliness, frustration and anger, greed and exploitation (modes of human suffering and factors contributing to estrangement and disorientation in life – intoxication of life).

The intriguing question now is how to trace back signals of spirituality that function as possible expressions of soulfulness in our

attempt to come to terms with life demands, and the quest to find spaces and places (safe havens) which communicate peace as well as signals of wholeness and transcendence?

The following spiritual expressions can be described as indicators or signals of soulfulness in our life journey towards wholeness, peace and healing:

- *Vocation and meaning: healing as a sense of purposefulness, belongingness and significance.* The meaning-question boils down to the following: towards what?
- *Virtue and value: healing as a sense of moral integrity, responsibility (respondeo ergo sum) and sensitivity.* Values create a normative framework for meaningful living. Virtue and value bring about authenticity, integrity and sincerity.
- *Vision and hope: the healing sense of expectation, anticipation of something new and constructive change.* The pivotal question in hoping and visioning is, where to? In this regard, healing-interventions need imagination and the creativity of aesthetic thinking, namely what may contribute to a common good and the well-being of human life.
- *Volition and courage/boldness: healing as sense of devotion, commitment and outreach despite resistance.* Volition expresses different levels of motivation; it presupposes the quality of being functions: to be there for the other despite contradiction or resistance.
- *Vitality and embodiment: healing as a sense of aliveness (elan vital).* Vitality represents different levels of physical wellness and optimal levels of health. The fact is that we do not *have* a body, we *are* our body. A corporeal sense of aliveness is imperative for a wholistic understanding of soulfulness in anthropology. Care of the body and nutrition should therefore be rendered as spiritual issues as well.

### **Spiritual Expressions/Signals of Human Soulfulness**

The further implication in an integrative approach is that every part of the human anatomy is, in terms of wisdom thinking, spiritual and becomes a representation of the whole, namely the soulfulness of life. The human anatomy participates in the notion of the image of God and cannot be excluded from the spiritual destiny of humankind, that is, to represent God and his grace. The whole of the human soul is enfleshed in every part.

Nothing about the human anatomy and functioning can be called filthy or dirty. In the Old Testament the products of excretion, such as semen, were rendered as ‘unclean’, yet according to the eschatological perspective, nothing can any longer be rendered as unclean. The whole of life and the entire cosmos are under the rule of God and serve the glorification of the Creator. Wholeness is therefore an inclusive concept. Soulfulness is synonymous with embodiment, and vice versa. Spiritual wholeness is not possible without the wellness of the human body. Human health includes corporeality; the human anatomy is an external reflection of the inner beauty of the human soul, and should be cultivated in hope care.

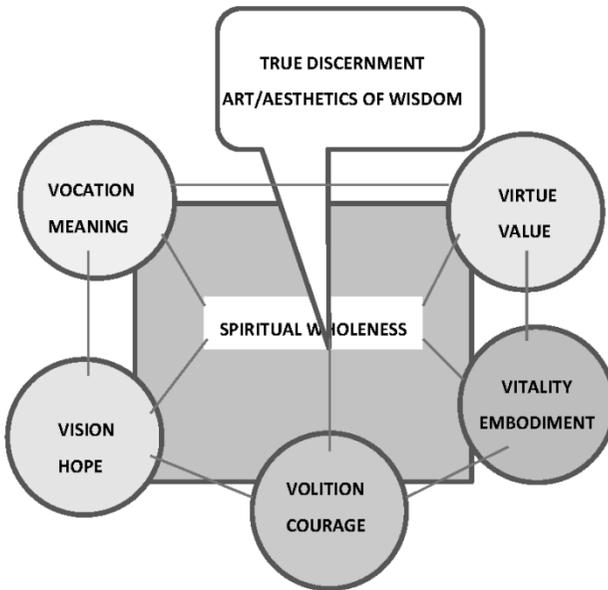


Figure 2.2 Signals of human soulfulness

This inner beauty is constantly shaped by ideas, perceptions and worldviews that construct patterns of thinking; hence the further argument that spirituality should not be reduced to merely the experiential level of habitus. Spirituality embodies ideas and depictions of life that influence the telic dimension of meaning, specifically human identity and the religious dimension of God-images.

## **Healing: The *Idea-matic* and Philosophical Roots of Spiritual Pathology**

In his book, *Religion before Dogma*, Douglas McGaughey (2007, 1) points out the importance of understanding the “practical,” not in the sense of pragmatics, but in the Kantian sense of practical reason. In his plea for practical theology as “relational theology” (2007, 240–242) he refers to the fact that our experience and consciousness are determined by conceptual structures, which contain “ideas” about experience and behaviour and operate as a regulative a priori for human behaviour. He calls them “synthetic judgements” constituting “a set of a priori transcendental ideas” that we must assume. “Spirit”, and its connection to ideas that determine and motivate human behaviour, is therefore of paramount importance in praxis reflection. Transcendental ideas function as a kind of spiritual realm within the dynamics of a relational networking. “Among these transcendental ideas are what we mean by God, freedom, and the self” (McGaughey 2007, vii).

The idea of health captured, portrayed and reflected in the notion of human wellness plays a fundamental role in wholeness. The connection between healing and life views is decisive in processes of spiritual healing. The basic assumption is that life becomes “sick” as a result of inappropriate philosophies of life and skewed perceptions and expectations. On the other hand, the healing of life sets in when convictions, perceptions and ideas/ideology are appropriate in terms of daily demands and criteria set by dominating cultures, contexts and customs.

In his book, *Ideology and Utopia*, Karl Mannheim (1966, 49) reflects on the sociological and philosophical meaning of ideologies in processes of conceptualisation. In his view the term denotes distortion of reality and a kind of scepticism – we are sceptical of ideas and representations as applied by systems of thinking. The ideas are regarded as more or less conscious disguises of the real nature of a situation, the true recognition of which would not be in accord with the real nature of things. The human schema of interpretation distorts reality: “These distortions range all the way from conscious lies to half-conscious and unwitting disguises; from calculated attempts to dupe others to self-deception” (Mannheim 1966, 49). However, there is another conception of ideology which can be differentiated from lies and distortions, namely a more inclusive total conception that relates to the concern with capturing “the characteristics and composition of the total structure of the mind” (Mannheim 1966, 50) of the epoch or thinking frameworks in the history

of humankind (modes of thought) within concrete social and cultural contexts. This is more or less what is meant by the concept *idea-matic*.

When ideas become detached from reality and make human beings 'blind' to the existential realities, they become sick (spiritual pathology). Bacon's theory of the *idola* refers to the fact that ideas can become phantoms or preconceptions that distort and become sources of error derived from misconceptions (in Mannheim 1966, 55):

The particular conception of ideology therefore signifies a phenomenon intermediate between a simple lie at one pole, and an error, which is the result of a distorted and faulty conceptual apparatus, at the other (Mannheim 1966, 54).

The point in Mannheim's sociological analysis of ideology is that the core notion in a constructive understanding of ideology is that a conceptual apparatus (an idea: see for example the notion and construct of *apartheid*) acts as a kind of *Weltanschauung* (conceptualised worldview: comprehensive framework of interpretation dictating the significance of daily life events). A conceptual apparatus determines meaningful interpretation and determines the conative in a very subtle and subconscious way. It feeds ideas and expectations in life. It is culturally embedded and used by economists, politicians and spiritual leaders in communities to influence human behaviour and decision-making.

One can even argue that *idea-matic* structures determine the appropriateness of belief systems and religious convictions. For example, when religious schemata of interpretation are intertwined with political aspirations toward power, the danger of religious and spiritual pathology sets in. When projected onto God, the ideology of power and religious indoctrination leads to fanaticism and spiritual pathology.

Spiritual healing should thus incorporate the transformation of irrational convictions, and the reframing of outdated philosophies of life. The categories which we apply to interpret life can become skewed and outdated (inappropriate in terms of new demands and paradigm shifts which take place while we continue to cling to old and outdated ones). Pathology is then closely related to what Reader (2008, 1) terms "zombie categories": the "living dead", the tried and familiar frameworks of interpretation that have served us well for many years and continue to haunt our thoughts and analyses, even though they are embedded in a world that is passing away before our eyes.

Briefly: Ideas (rational forms as patterns of reality) shape and determine human self-understanding within existential realities. In order to change people, it is necessary to dispute the presupposed framework or

form, and hence the role of philosophy in counselling, that is, the need for philosophical counselling.

Carl Rogers (1951, 4–5) acknowledges that psychology and psychotherapy are deeply rooted in American culture and determined by its philosophical underpinnings: “Some of its roots stretch out even further into educational and social and political philosophy which is at the heart of our American culture.” He notes that an operational philosophy determines the skilfulness of a counsellor (Rogers 1951, 20), and in his book, *Way of Being* (1980, xvii), articulates the value of a philosophical approach to healing and counselling. The identification of worldviews, and undergirding ideas regarding the outcome and significance of life, are fundamental for all modes of growth and meaningful change.

The advantage of philosophical counselling is that it investigates the appropriateness of schemata of interpretation and the paradigmatic context of wisdom thinking. It deals with questions probing the realm of intention, motivation, purposefulness, and eventual goals. Therefore, if we are to “heal” human beings, the ideas behind culturally shaped paradigms should be critically scrutinised and assessed in order to effect the healing of life (*cura vitae*).

## Conclusion

In the design of a pastoral anthropology, the schismatic dualism between a spiritual focus and a corporeal focus is fallacious and does not correlate with the pneumatological focus of Pauline anthropology, in terms of which the human body is the temple of the Spirit of God. Soulfulness is expressed in human embodiment as the enfleshment of the fruit (*charisma*) of the Spirit (the *inhabitational dimension of spiritual wholeness*).

In spiritual healing, both a holistic and wholistic approach are needed. It is often difficult to differentiate between the two. For the sake of clarification on a theoretical level, one can say:

- In a *holistic approach* (holistic healing) the emphasis is on the interplay, interconnectedness and mutual interdependency of the parts in order to contribute to the functionality of the whole. This approach emphasises the necessity of inter-disciplinary and intra-disciplinary interaction. It deals within the framework of a team approach with multi-perspectives. A holistic approach also

reckons with *complicated connections* within a systems model and tries to find solutions on different levels.

- In a *wholistic approach* (spiritual wholeness), the whole implies more than the sum of the parts and contributes to a sense of belongingness, a sense of purposefulness, a sense of calling and vocation in life, a sense of hope and anticipation of something new. It reckons with *complexity*: networking implies dealing with *paradox* without a rational solution. Wholeness stems from the *affirmation of being*; it also contributes to integrity, integral spirituality and intimacy (a space in which one is acknowledged and accepted unconditionally).

Hope care and its co-partner, philosophical counselling, should focus on wholeness as comprised by wisdom thinking: being-with the other as expression of kenotic love. In this regard, wholeness is not merely a psychological category; it is an ontological, existential and relational category. Hope could thus be formulated as a new state of being and different mindset: compassionate being-with.

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# THREE DIFFERENT, BUT RELATED, MINDSETS TO CONSTITUTE A PARADIGM FOR COPING IN TIMES OF DISTRESS

DIRK G. VAN DER MERWE<sup>1</sup>

## Abstract

Life is characterised by multiple forms of both suffering and happiness. How one experiences this dichotomy depends on one's choice of attitude, decision in that regard, and subsequent stance. The mind can be the greatest enemy in the case of someone in distress. However, it can also be the greatest therapeutic friend in the case of a person seeking to overcome distress. Sorrow can either feed that enemy or foster that friendship. The objective of the research reported on is to explore means of coping imaginatively during times of distress. In it I have combined three approaches that are closely related, but come from three totally different areas. The first approach comes from the sphere of counselling, and explores an aspect of the logotherapy of Victor Frankl. For Frankl, the human capacity for self-transcendence constitutes the basis of being human: through it humans express themselves and find fulfilment. The second approach comes from the sphere of theology, and relates to the guidance offered by the apostle Paul to the community in Philippi (Phil. 4:4–9). Paul advises his readers to seek joy and peace during times of distress by thinking about honourable and pleasing things. The final approach comes from the sphere of literature. It focuses on how "narrative fantasies" create virtual spaces and virtual realities in which to escape distress for as long as the fantasy exists. Whereas for Frankl the aim is to find meaning in life, and for Paul it is to find peace and joy in life, in narrative fantasies the aim is to experience excitement, pleasure, and

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enjoyment. These three approaches complement one another, for all three rely on the imagination.

## Keywords

Escape from distress; imagination; self-transcendence; narrative fantasy; meaning in life; things of excellence; joy; pleasure

## Introduction

The human brain is a remarkable organ. It has allowed humans to walk on the moon; to discover the universe(s); to invent computers and cell phones; to build the most magnificent cars and aeroplanes. Many tasks that we take for granted – like fastening our shoe laces and riding a bicycle – are achievements that robots and computers are unable to duplicate (Pinker 1999, 119).

My objective in this paper is to speak about how the brain, via the imagination,<sup>2</sup> can be used to cope with most kinds of suffering. In the magazine, *Spirituality & Health*, Cohen (2013, n.p.) shares important information about the connection between imagination and reality. She states that a person's mind can run away with them, leading them to act through suspicion or fear, but that people can also use their imagination as a tool to change their life.

She recounts that through the use of MRI scans it has been discovered that the cells in the brain that light up when a person performs a specific action also do so when he or she watches someone else performing the same action. This might explain why some people find action movies so exhilarating, or romantic movies so affecting. The same effect is achieved when people imagine themselves performing the action.

This paper contains an exploration of the way in which imagination can help in coping with distress. The first approach discussed comes from the sphere of counselling, and entails an aspect of the logotherapy of Victor Frankl. Frankl views the human capacity for self-transcendence as the basis of being human. Through it, humans express and fulfil themselves. The second approach comes from the sphere of theology, and relates to the guidance offered by the apostle Paul to the

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<sup>2</sup> Davies (2012, n.p.) explains that "imagination" can refer to "creativity in general – saying that someone has a great imagination, or no imagination at all. Secondly, people use the word to refer to mental imagery of some kind" – creating a mental picture of something.

community in Philippi (Phil. 4:4–9). Paul advises his readers to experience joy and peace during times of distress by thinking about honourable and pleasing things. The final approach comes from the sphere of literature. It focuses on how "narrative fantasies" create virtual spaces and virtual realities in which to escape distress for as long as the fantasy lasts. Whereas for Frankl the aim is to find meaning in life, and for Paul it is to find peace and joy in life, the aim of narrative fantasies is to experience excitement, pleasure, and enjoyment. These three approaches complement one another, for all three involve the imagination.

### **Therapy and Well-being: Victor Frankl's Logotherapy as a Mechanism for Finding (Virtual) Meaning in Life during Times of Distress**

The approach I discuss here comes from the sphere of counselling, and in particular Victor Frankl's logotherapy. The human race lives in "a broken world" – a world full of distress, of which some is inescapable, such as that associated with death, pain, and suffering: "Certain predicaments of the human life are unchangeable" (Havenga-Coetzer 2003, 100–101).<sup>3</sup> Frankl refers to the emptiness, meaninglessness, purposelessness, and aimlessness experienced by people as the "existential vacuum" (Havenga-Coetzer 2003, 38).<sup>4</sup> These things make people stressed, unhappy, and negative about life. However, for Frankl, "life is unconditionally meaningful, no matter what happens" (Marseille 1997, 5; Frankl n.d. (b), 3). Life is never without meaning (Frankl n.d. (b), 3).

In order to cope with these things, Frankl proposed a number of activities,<sup>5</sup> the most central element of which is self-transcendence. This concept appears in almost all of Frankl's fundamental writings (Wolicki 2002, 69).

The following is an example from Frankl's own experience in a concentration camp during the Second World War. The starving prisoners

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<sup>3</sup> According to Frankl, problems can be either physical, psychological, or existential (cf. Havenga-Coetzer 2003, 8).

<sup>4</sup> Boeree (2006, 6–8) refers to typical Frankl terminology to describe the existential vacuum: anticipatory anxiety. Similar ideas are hyper-intention and hyper-reflection. Frankl refers to depression, addiction and aggression as the "mass neurotic triad". For Frankl, various anxiety neuroses constitute the origins of the psychopathologies.

<sup>5</sup> These are activities, or rather approaches, such as: self-distancing, self-detachment, self-disclosure, self-actualisation, self-interpretation (cf. Havenga-Coetzer 2003, 88–90).

around him in the camp thought constantly about food. The lack of food was a source of mental torment, and they could think of nothing else. To distance himself from this mindset, Frankl imagined himself speaking in a well-lit lecture hall with comfortable chairs.<sup>6</sup> Through this imagined activity Frankl added meaning to his existence while in the concentration camp.<sup>7</sup> In my research I applied Frankl's principle of self-transcendence to constitute "*virtual* meanings in the imagination".

## Self-transcendence

For Frankl (1984, 66), self-transcendence constitutes the basis of being human. A person's ability to transcend the self enables him or her to reach beyond human conditions and circumstances. That is why Frankl (quoted in Kimble and Ellor 2000, 10) calls self-transcendence the "specifically human mode of being". Being human implies that people can surpass themselves, go beyond themselves to exceed their psycho-somatic conditions. To be human means to be directed toward another person or something other than the self (Frankl 1984, 168). One then forgets about the self when one serves a cause, fulfils a task, or reaches out to another (Frankl 1984, 66). Self-transcendence is the essence and foundation of human existence (cf. Frankl 1969, 55; cf. also Wolicki 2002, 68–72).

I used and applied Frankl's approach in this research, but in a different way from what Frankl intended with his axiom, "to find meaning in life". Frankl sees and interprets self-transcendence in a physico-existential way. In this research it is applied imaginative-existentially.

Havenga-Coetzer (2003, 89) defines Frankl's self-transcendence as

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<sup>6</sup> "I forced my thoughts [my emphasis] to turn to another subject. Suddenly I saw myself standing on the platform of a well-lit, warm and pleasant lecture room. In front of me sat an attentive audience on comfortable upholstered seats. I was giving a lecture on the psychology of the concentration camp! All that oppressed me at that moment became objective, seen and described from the remote viewpoint of science. By this method I succeeded somehow in rising above the situation, above the sufferings of the moment, and I observed them as if they were already of the past. Both I and my troubles became the object of an interesting psycho-scientific study undertaken by myself" (Frankl 1992, 67–68). This implies that part of his "rising above" certain circumstances implies a relocation of space and in time.

<sup>7</sup> Logotherapeutic techniques and their spiritual source (2010), <https://meaningtherapy.wordpress.com/2010/06/22/logotherapeutic-techniques-and-their-spiritual-source/>

the ability to look away from the self, from one's own pain, one's own circumstances, suffering or grief. It is the ability, to reach out to someone else to realize an ideal, or fulfil a task, and finally to reach out to a higher being, to God and in the process one forgets about oneself (see also Frankl n.d. (b), 3).

This definition refers to three levels at which meaning is pursued: God, other, self. According Wong (2016, n.p.), when people nurture all three of these levels of transcendence, they are able to develop good and healthy spiritual lifestyles.

*Seeking ultimate meaning:* For Frankl, ultimate meaning refers to Supra-meaning or God (cf. Boeree 2006, 10); people can vaguely understand it, but never truly comprehend it (Frankl n.d. (a), 10ff). Ultimate meaning echoes those presuppositions which stretch beyond rational analysis or explanation. Faith in ultimate meaning constitutes hope and comfort in the fact that physical death is not the end of everything. Some form of immortality exists (Wong 2016).

*Seeking situational meaning:* On this level people in distress must try to reach beyond their mental and situational constraints to connect with their own spiritual values and focus on their own spiritual principles. This involves being mindful of the present situation and recognising the possibility of rising thoughtfully above any form of dreadful circumstances (Wong 2016).

*Seeking social meaning:* Reaching out to others beyond self-actualisation can enable one to pursue other meaningful purposes. Engagements in and making valuable contributions to the lives of others will constitute different forms of meaning in the life of the person who has reached out.<sup>8</sup> Life becomes meaningful to the extent that one becomes involved in the lives of others (see John 13, Jesus serving his disciples) (Wong 2016).

In conclusion, people are normally self-centred. However, self-focus should be redirected towards someone or something else. The response should be to search for the meaning of something that should be more important to the person than the distracting problem. Meaning will realise when success has been achieved imaginatively. For Frankl, self-transcendence entails moving away from the self to something or someone else.

What Frankl proposes physically can also be experienced imaginatively. Virtual meaning in life lies in the person's imagination; the

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<sup>8</sup> Meaning refers not to general meaning in life, but to a given moment of meaning (Giovinco 2002, 73).

person who imagines and creates meaning will find meaning and experience it for as long as the imagination of it lasts. Virtual meaning can be experienced promptly. This is what happened to Frankl while in the concentration camp. Beyond his existential circumstances he found virtual meaning in other and better virtual circumstances, imagining himself speaking in a well-lit lecture hall to the benefit of others.

### **Spirituality and Well-being: Pauline Spirituality as a Mechanism for Rejoicing and Experiencing Peace during Times of Distress**

The approach I discuss here comes from the sphere of theology, and in particular the advice of the apostle Paul to the church in Philippi, in Greece. What Paul suggests to the Philippians (Phil 4:4–9) is something akin to Frankl's self-transcendence. His approach to distress establishes him as an archetype for the first-century Mediterranean world.

#### **Socio-historical Circumstances of Paul and the Philippians**

To understand Paul's advice to the Philippians requires an examination of their socio-historical circumstances. Antiquity also faced the brokenness of this world – only the nature of that brokenness differed from what is experienced today. The people of that time also experienced the inescapable misery of death, and of physical and emotional suffering. Mediterranean antiquity was marked by a profound pessimism about life. Suffering was interpreted and experienced as a prelude to and herald of death (Bloomquist 2007, 271); in antiquity, joy was hardly mentioned (cf. Dodds 1965).

Joy, however, was something that Paul thought he could offer to those in distress in Philippi. What makes his assertion so incredible is that his message was written from circumstances of extreme suffering (cf. Rapske 1994, 196–225; Bloomquist 2007, 274; see also DuBois 1991).

In Philippians 1:7 Paul reminds his readers about his own situation – he is in prison. He writes to update the readers in Philippi about his present situation and to tell them about the prospects for his future. He is in danger and is experiencing suffering, but at the same time rejoices and is optimistic (1:12–26; 2:24; Hawthorne 2004, Lvi).

Paul also writes to offer advice to the Philippians, who were a young Christian community at that time. In response to various rivalries (1:27; 2:4; 4:2) in the community, he exhorts his readers as early as in the first chapter to "strive side by side" with "one mind" and "one spirit"

(1:27) to overcome this particular problem. Paul views cognition as important, as seen in the exhortation to be "of the same mind" (2:2). Later in the letter he exhorts two women, Euodia and Syntyche, to be of "the same mind" (4:2, τὸ αὐτὸ φρονεῖν).

In this pericope (Phil. 4:4–9) of six verses Paul uses seven different Greek words that are semantically related and which can be connected to cognition.<sup>9</sup> This is quite remarkable because in such a short pericope these words<sup>10</sup> link with two very positive concepts, namely "joy" (twice) and "peace" (twice) to constitute the opposite of "worries" (4:6).

For Paul the mind plays an important role in dealing with his and the community's appalling circumstances. Paul cannot change his circumstances (just as to some extent the Philippians cannot change theirs), but he can use his mind to cope with the situation. In such moments the psyche must kick in. He communicates his own experiences to the Philippians, and his advice to them on how to cope with the difficulties they find themselves in is that "their respect for one another's integrity" (Hawthorne 2004, 244) should be known to everybody; they should talk to God about their needs, they should let their minds dwell on "things of excellence" that are "worthy of praise", and last of all, they should listen to Paul's directions. Of primary interest and relevant for this research is Paul's reference to λογίζομαι (4:8, "to give careful thought to a matter" (Arndt, Danker, and Bauer 2000, 598)), and the exhortation already mentioned to let their minds dwell on "things of excellence" that are "worthy of praise".<sup>11</sup> Owing to the importance of what Paul writes about prayer in this pericope, a brief analysis of the text (4:5–6) will be given to complement what Paul writes about contemplative thinking about the "things of excellence" that are "worthy of praise".

### Ultimate Focus (4:6–7)

For Paul, trust in the divine for support and the hope of divine involvement (4:4–7) should be part of overcoming dreadful circumstances for the believer. In this pericope Paul uses three semantically related words to exhort and influence the Philippians to help them to cope with their

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<sup>9</sup> Be known, 4:5; made known 4:6 (2x); understanding, 4:7; heart 4:7; mind, 4:7; think, 4:7; learned, 4:9; to think, 4:10.

<sup>10</sup> Verse 4 is the only one in which there is no such a word.

<sup>11</sup> For Victor Frankl, if a person is to rise above the distress in their life, they have to focus on finding "meaning in life" – something objective. Paul's focus is different. He emphasises joy, peace and the absence of worry in a person's life – something subjective.

circumstances; all three, "joy", "peace", and "not to worry" are connected with divine involvement. He could say this, because it was part of his life.

- *Rejoice* (χαίρετε): Paul starts this pericope on a positive note with two strong exhortations, both in the imperative mood: "Rejoice in the Lord always; again I will say, Rejoice" (4:4, NSRV). In 4:4 Paul adds emphasis to these two exhortations by adding the two adverbs "always" (πάντοτε) and "again" (πάλιν). He himself rejoiced while in prison, experiencing suffering and facing the possibility of an unnatural death (1:18–20). For him it is possible. These exhortations invite the Philippians to transcend their circumstances. Paul's joy in the Lord was connected to his hope of being freed (1:18–19). His hope was founded on the God of peace (cf. Hawthorne 2004, Lvii).

- *Peace of God* (εἰρήνη τοῦ θεοῦ): In 4:7 and 4:9 Paul refers to "the peace of God" and "the God of peace". That he could talk to God (the God of peace) about his circumstances contributes to his also having a sense of peace and joy. According to Paul, trusting Christians can partake of the peacefulness that characterises God's very nature when they have made their needs known to God (Hawthorne 2004). In 4:7 he says that God's peace will be with them; now Paul writes that God himself, who himself is peace, will be with them.

- *Do not worry: the Lord is near* (5), *you can talk to Him* (6), *He will guard you* (7). The third relevant exhortation (another imperative) in this pericope is negative, but it has a positive thrust: "Do not worry about anything" (Melick 1991). The absence of worry will make joy and peace possible and real. Paul provides three reasons why the congregation should not worry. First, because "the Lord is near" (ἐγγύς, 4:5). This may mean that the Lord is close, present, and hence aware of a person's circumstances. This would have brought peace to the sincere believer. When an anxious child knows that his or her father is near or close by, then the anxiety will disappear (cf. Hawthorne 2004, 245).

The second reason why the believers should not worry is because they can talk to God and make their needs known to Him (4:6). When believers are able to engage in dialogue with God and inform Him about their circumstances, they will feel much better. Paul has first-hand experience of this, and knows the calming, strengthening, and therapeutic effect it has on the believer (Hawthorne 2004, 246).

Even more exciting is that this divine being can respond to the concerns of the one praying in such a phenomenal way, as Paul himself experienced, that it is incomprehensible to rational thinking. The phrase "the peace of God, which surpasses all human understanding" infers that the peace that God provides is able to generate far better results than any

form of human design (cf. Hawthorne 2004, 247).<sup>12</sup> The believer's awareness and contemplative thinking about this can help the one who prays not to descend into misery (cf. Hawthorne 2004, 246).

The third thing Paul communicates about God is that he "will guard your hearts and your minds in Christ Jesus" (4:6). Those who trust God with their requests will find that He will protect their thoughts and feelings against the onslaughts of worry and fear (Hawthorne 2004, 247). For Paul this knowledge about and experience of God is a necessity for experiencing joy and peace of mind instead of worrying.

### Personal Focus (4:8)

Paul writes in 4:8, "Finally, beloved, whatever is true, whatever is honourable, whatever is just, whatever is pure, whatever is pleasing, whatever is commendable, if there is any excellence and if there is anything worthy of praise, *think* (λογίζεσθε) *about these things*."

Λογίζεσθε is the main verb of the verse. Λογίζεσθαι (4:8), "to focus the mind on," is a strong verb that Paul liked to use. Arndt, Danker, and Bauer (2000, 598) define the verb "think" (λογίζεσθε) as "to give careful thought to a matter, think (about), consider, ponder, let one's mind dwell on something". He could say this and do this because he had already spoken to God about his distressful circumstances. Of the forty occurrences of the verb λογίζεσθαι in the New Testament, thirty-four are found in Paul's writings. Within the range of its meaning are the ideas of to ponder or let one's mind dwell on, or even to contemplate.<sup>13</sup> He certainly intends through the use of this verb to suggest the result of the manifestation of it in activities (which relates to Frankl's meaning in life). This is evident in his advice that the Philippian Christians must carefully consider certain things. They must also evaluate them attentively for the ultimate purpose that these things should guide them into good deeds (cf. Heidland 1978, IV:289; Hawthorne 2004, 250). He asks them to focus their minds (λογίζεσθε) on the list of things referred to in 4:8, to attend fully to them, and to contemplate them carefully through action-provoking meditation. For Paul to think about such noble matters, the Philippians

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<sup>12</sup> This relates closely to Frankl's views on finding meaning in life when one becomes involved in the lives of others.

<sup>13</sup> λογίζεσθε, "focus your minds", relates to contemplative thinking. He advises them to think about positive things, things of excellence in life, such as truth, and things that are honourable, just, pure, pleasing, commendable, excellent, and worthy of praise. This exercise in going beyond the turmoil of a person's experiences and circumstances has to do with cognition, the brain, the mind.

must also practise them constantly (Hawthorne 2004, 252). This will help them to imaginatively rise above their circumstances. This is to move the mind's focus from the circumstances to things worthy of praise.

Although not stated explicitly, for Paul, *contemplative thinking* about the "things of excellence" that are "worthy of praise" and the *imagination* of the things the Philippians have learnt, received, and heard from him and seen him doing, make possible a form of self-transcendence, which will allow them to rise above their circumstances.

### **Narrative Fantasy and Well-being: Fantasies as a Mechanism for Experiencing Joy, Excitement, and Pleasure during Times of Distress**

The approach discussed in this last section comes from the sphere of literature, and in particular narrative fantasy. The logotherapy of Frankl has helped many people to find existential meaning in life, and Philippians 4:4–9, which could have been used in nouthetic therapy (see Adams 1982), has contributed to the liberation of many Christians from worries and stress through the contemplation of commendable things and trust in God.

The narrative fantasy approach can help a person to imaginatively transcend any form of distress for as long as the fantasy lasts. "Narrative" refers to the creation of one's own stories or fantasies. Within the context of this research, in narrative fantasy the focus is on the lived experiences of excitement and enjoyment embedded in the fantasies to draw attention away from the existential circumstances of suffering. The teachings of Frankl and Paul pave the way for this discussion of the use of narrative fantasies during times of distress: it is just another way of imagining. In narrative fantasies the objective approach of Frankl and subjective approach of Paul converge, as the focus is on both the self and the incorporation of the other.

If you watch movies or read novels for pleasure and excitement, then narrative fantasies are not as farfetched or childish as they sound. Le Guin (2006, 2) explains that in the past, and even today, fantasies were and are perceived as a genre of children's literature. However, she states that "to conflate fantasy with immaturity is a rather sizeable error," and that fantasy is the only genre that has the ability to cross age-lines (cf. Apostolides 2016).

Think about all the novels you have read, all the fiction movies you have watched over the years. Did you enjoy them? Of course you did! Do you still remember most of the heroes or main characters? Of course

you do! Narrative fantasies relate closely to novels and fiction. The fantasies all happen in the mind. The imagination creates its own times and spaces, events and characters, and the creator (you) can be part of this virtual or imaginative world.

According to Ricoeur (1965, 119), "The imagination has a prospective and explorative function in regard to the inherent possibilities of man." In his view (1974, 408), people can even perform beyond their potential. Imagination can allow people to explore their capabilities from other perspectives. In everyday situations, people may regard themselves as having and even experience having limited capabilities. Nevertheless, within the imagination, people can perceive themselves as capable of many things (Ricoeur 1981, 112; Apostolides 2016).

In the words of Albert Einstein, "Imagination is more important than knowledge. For knowledge is limited to all we now know and understand, while imagination embraces the entire world, and all there ever will be to know and understand".<sup>14</sup> He also known for having said that "Logic will get you from A to Z; imagination will get you everywhere,"<sup>15</sup> and "Imagination is intelligence having fun."<sup>16</sup>

While inhabiting this created or virtual world of fantasy, a person can create unlimited alternative possibilities, some of which have not yet been experienced in real life (cf. Reagan 1996, 106). Fantasies (the imagination) cultivate narratives, enabling people to transcend their limited existential spaces, their skills, and even their appearances. They can move anachronistically into another time and space and experience other faculties, some of which have never before been experienced or exploited: they can be good orators, exemplary leaders, excellent teachers, or exceed their past sporting achievements. In fantasies people can surpass or transcend their limited experiences through the creation of unlimited alternatives (cf. Thurston 1995, 47; also Apostolides 2016).

In the times and spaces of fantasies, the person who fantasises bypasses the protective barriers of convention that he or she has erected and the self-created narratives by which we make our lives more bearable (cf. Brown 2008, 268). In these narrative fantasies, people create new identities and characteristics for themselves. Hence, the innovation of fantasy through creative imagination stimulates people to engage with

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<sup>14</sup> <http://www.goodreads.com/quotes/556030-imagination-is-more-important-than-knowledge-for-knowledge-is-limited> from "Get Quotes Daily.

<sup>15</sup> [www.goodreads.com/.../2837-logic-will-get-you-from-a-to-z-imaginatio...](http://www.goodreads.com/.../2837-logic-will-get-you-from-a-to-z-imaginatio...)

<sup>16</sup> [www.goodreads.com/.../1138105-imagination-isintelligence-having-fun](http://www.goodreads.com/.../1138105-imagination-isintelligence-having-fun)  
10/10/2016.

their identity, character, self-image, qualities, religiosity, and spirituality from alternative perspectives.

Through fantasies people are able to create narratives to enable them to rise above the distress in life. The fantasies referred to in this research have been referred to as “narrative fantasies” with reference to the creation of stories in a person's imagination. These can be either similar to or totally different from those narratives (stories) in novels or movies. They can be unrealistic with regard to the person's characteristics, self-image, and qualities. Narrative fantasies help people to put into practice that which they cannot practise in reality; to become what they wanted to become, or even go beyond that.

In other words, people can transform their values, character, and activities through imagination, to live out in their virtual world the lives that they find more satisfying and which can give rise to considerable pleasure and excitement. These fantasies are created and constructed in the imagination to escape the existential reality of suffering or unpleasant circumstances that trouble the person now in order to experience the opposite, or something totally different from the existential reality, while the fantasy lasts. Narrative fantasies, in the context of this paper, are more than mere escape mechanisms. They are created primarily so as to experience joy, pleasure, and excitement.

The excitement and enjoyment experienced in this context are embedded in the superlative. In novels and fiction the author creates the heroes; in narrative fantasies the creator can become or is the hero. The "creator" (you) can become the main character in these created interplays. In these narrative fantasies you become the most beautiful, the most attractive, the cleverest, the strongest, the fastest, the richest, and so on. You are not becoming the best, you *are* the best! That is what makes it so exciting! The lived excitement of the virtual realities raises you above the situation of distress, creating a desire to be repeated and experienced over and over again.

## **Conclusion**

This paper explored immediate methods of coping during times of distress. In many instances circumstances cannot be changed rapidly, or even changed at all. However, the imagination can be harnessed to cope cognitively with situations of distress. The objective of the research carried out was to show how the imagination can create immediate relief during times of distress. The imagination can be utilised to create and discern virtual meaning in all circumstances through self-transcendence

(as proposed by Frankl), to contemplate the valuable things in life (as proposed by Paul), and to create narrative fantasies in virtual spaces and times in which a person can construct "other" realities as a means to experience excitement, pleasure, and joy for as long as the fantasy lasts.

The interaction between these three approaches should not be interpreted as being linear, with the approaches following one another consecutively, but rather as one in which the approaches operate in parallel, complementing and reinforcing one another.

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# THE VALUE OF APPLIED CHRISTIAN COMMUNITY PSYCHOLOGY IN HEALTHCARE

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## **Abstract**

Healthcare does not take place in a vacuum. It involves communities comprising individuals, families, religious organisations, religious practitioners, healthcare organisations and healthcare practitioners. Communities occupy a central position in a healthcare environment, potentially offering hitherto untapped resources, skills, knowledge and infrastructure that could make an extremely important contribution to healthcare. This article aims to illustrate how community psychology could be applied to empower communities and enhance healthcare services by facilitating collaboration between faith-based communities and healthcare organisations in a systematic manner. Illustrations are provided from a Christian community psychology perspective, but the proposed framework could be applied in any other religious context.

## **Keywords**

Community psychology; healthcare; Christian faith-based; ecosystemic; social transformation; empower; healing

## **Introduction**

In community psychology personal issues are viewed as a shared problem within a certain context. This implies that a troublesome personal situation affects not only the individual, but also the community or communities involved (Naidoo 2000, 7–8; Canning 2011). The interpretation by and

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response of the community to the suffering person's problem further influences the response to and management of it. For example, if a person is diagnosed with a terminal disease such as cancer, the impact and course of the disease affect the patient's body, mind, emotions, will and spirit. It also affects his or her family, friends, social groups, the workplace and the wider community (National Cancer Institute 2015, Wang et al. 2015, 2815–2816). The community psychology framework supports interventions that are holistic in nature (caring for the whole person) and aligns with the needs of the communities at stake (Canning 2011, 186–187; Todd 2011, 200–201, 204–205).

Community psychology is a more recent development in psychology, having emerged in the 1960s in the United States of America when civil rights were being fought for (Putman and Dueck 2011, 183–184; Yen 2007, 384). It stems from an increased awareness among healthcare professionals of the divide that exists between the medical and paramedical professions on the one hand, and those in need of healthcare on the other. The social action model of community psychology was developed with the aim of bridging this divide through active engagement in communities and emphasis on illness prevention and change at systemic levels (Arumugam 2001; Putman and Dueck 2011, 183–184).

In South Africa the concern with expanding access to healthcare services has been voiced by health leadership numerous times. Dr Aaron Motsoaledi (Motsoaledi 2014), the South African Minister of Health, acknowledges a link between mental disorders and social determinants such as poverty, violence, abuse and unemployment. There is also a high comorbidity between mental disorders and other diseases. Community psychology provides an intervention framework based on an ecosystemic perspective on health that could deal with these concerns holistically and reduce health disparities (Wolfe 2014, 231, 234).

## **Ecosystemic Perspective**

The development of community psychology signalled a paradigm shift in psychology from an individual to an individual-in-context or ecosystemic approach (Naidoo 2000, 8). This paradigm shift is facilitated and supported by contextual, systems and ecological theories as well as the emergence of postmodern worldviews (Naidoo 2000, 8–9; Visser 2007, 104–110). The emerging postmodern worldview emphasises the interconnectedness of all human systems with the environment, and disregards the biomedical model and practice of reductionism in

healthcare. This has led to an ecosystemic view of human nature or anthropology.

### **Anthropology**

The ecosystemic view of anthropology disputes the dichotomy of body and mind and postulates that a human being is a whole person requiring a healthcare approach that must be holistic in order to be effective (Visser 2007, 102–104). It further entails a crucial shift from a pathogenic approach to health, focusing on the disease that has to be cured, to a salutogenic approach, focusing on strengths, well-being and wellness. The ecosystemic view of anthropology forms the basis of the practice of community psychology (Lazarus 2007, 72–73). This implies a wholistic view of the person and the inclusion of his or her community in planning interventions and identifying, implementing and enhancing factors of resilience and strengths in the community at stake.

### **Environmental Systems and Health**

Ecosystemic anthropology and the whole person emphasis implies that health is related to the interconnectedness of a multilayered society. The developments of human beings as well as the onset of physical and mental diseases are influenced by the interconnectedness between environment and human beings (Visser 2007, 103–105). Health is seen as multidimensional, and furthermore is viewed in the context of resilience, strength and fulfilment. Community psychology acknowledges the influence of family systems and external environmental systems on health (Visser 2007, 101, 105–108). These systems are described by Bronfenbrenner (Bronfenbrenner 1986, 723–724; Visser 2007, 105–107) as the family system (microsystem) and external systems influencing the family system, that is, the mesosystem, exosystem, macrosystem and chronosystem.

The mesosystem entails the social environment, which includes school, church and friends. The exosystem refers to influence from a system that indirectly affects the development of the child, including health, and having a father who works abroad or does very dangerous work, such as that of a police officer. The macrosystem involves the socio-economic environment, status of the family and cultural contexts. The chronosystem refers to time and how development evolves over the lifespan of a person (Bronfenbrenner 1986, 723–724).

Lawrence et al. (2016, 266–267) argue that the application of an ecosystemic approach to healthcare will alter the focus in dealing with chronic diseases or non-communicable diseases (NCDs) from treatment through to prevention. These researchers emphasise that NCDs result from multi-factorial determinants and assert that an ecosystemic approach would bring about a reversal of the high incidence of these illnesses.

In accordance with this argument, applied community psychology, which focuses on the individual-in-context, and thus communities embedded in various environmental systems, could aid in disease prevention and health promotion (Visser 2007, 110–113). Interventions are co-designed with the community at stake with the aim of uncovering and utilising factors of resilience embedded in the community (Ornelas et al. 2012, 3–5).

### **African Worldview**

The ecosystemic framework harmonises well with the African worldview with regard to anthropology and ontology. African anthropology accentuates the collective self rather than the individual self. This is summed up as follows by Mbiti (cited in Menkiti 1984, 171): “The African view of the person can be summed up in this statement: ‘I am because we are, and since we are, therefore I am.’”

Belonging to and actively participating in a community constitutes an integral part of personhood. Existence is thus defined in interrelatedness rather than individuality, as is captured in the concept of ubuntu (Foster 2010, 247; Kruger, Lifschitz, and Baloyi 2007, 329–330). This view aligns well with the ecosystemic approach to health and disease, in terms of which health and disease are community issues rather than an individual issue.

Personhood in African thought is human-centred and directly related to one’s participation in communal life. This implies that human relationships shape true human identity. Gyeke (1997, 39–43) highlights the ontological importance and relevance of community in the total well-being of the person.

### **Postmodern Worldview**

Postmodern, participatory worldviews do not separate mind and matter, and they accentuate the systemic and holistic nature of all things (Kruger et al. 2007, 330–331). These worldviews harmonise well with the ecosystemic framework. Postmodern anthropology underscores the

participatory nature of human beings: thus a person exists as part of a community and is defined by interrelatedness. Postmodernists assert that the world does not consist of separate elements, but rather that all things are interrelated (Kruger et al. 2007, 329–331), and that the relationships between things shape and affirm communities.

Relatedness, or viewing people as relationally defined, implies the duty to accord each member of the community the same respect, dignity, value and acceptance. It underpins the meta-theoretical perspective on community psychology, that is, the ecosystemic approach.

### **Christian Worldview**

Christian anthropology claims that humans are made in the likeness of God. Humans relate to God and to each other. This belief correlates with the traditional African view of a relational-ontological identity (Foster 2010, 247–249). The idea that humans are made in the likeness of God implies that humans have the ability to show compassion, to be faithful, to be truthful and to distinguish between right and wrong.

Personhood in Christian thought is embedded in the belief in a personal God, the creator of all things, who is revealed in a tangible and visible human form in Jesus Christ. In His life on earth Jesus Christ revealed the fullness of giving yourself to others, which serves as an example of how we should live. Thus, we are able to have compassion, to love, to be faithful, to be truthful and to distinguish between right and wrong. We have the ability to recognise the likeness of God in others. Personhood develops and is expressed in our relationship with God and others (Foster 2010, 247–249). Christian ontology postulates that the essence of our being is embedded in a personal God that exists. God has created the universe and sustains everything. Christian anthropology and ontology underscore the aspect of relatedness, and harmonise in this regard with the ecosystemic framework.

DeKraai et al. (2011, 255–258) make the observation that ecclesiology, the Christian doctrine regarding the church, places Christian faith organisations in a unique position to support community healthcare services. Ecclesiology states the belief that the church as a community of believers in Christ is called to actively represent God's love to the world. The functions of the church are to worship God, serve one another, participate in the world and reach out to the sick, the lonely, and those in need. For DeKraai et al. (2011, 256–258), faith-based communities have inherent resources that could enhance the services of healthcare organisations.

This perspective relates to the Christian perspective of God's plan of salvation and wholeness for individuals, communities and the Cosmos.

## **Community Psychology and Faith Communities**

The assumptions, values, aims and methodology of community psychology provide a framework for faith-based communities and community psychologists to work together to solve contextual and health problems on a bio/psycho/social/spiritual level. These partnerships could aid and support intentional social actions to bring about social change.

### **Assumptions and Values**

There are clearly articulated assumptions and values that form the core of community psychology and could be assessed from a Christian spiritual perspective. These assumptions and values are consistent with a systemic and holistic worldview, in other words, the belief that the world does not consist of separate elements, but rather that all things are related. Relationships affirm communities. Relational values include respect for the diversity of social identities (Roos et al. 2007, 395–396). Values such as participation, collaboration, justice as a goal for action, community empowerment, respect for others, prevention rather than cure, and the promotion of health and well-being converge in the biblical notion of “love your neighbour as yourself” (Canning 2011, 190–191; Mt 22:39<sup>2</sup>). These values support both Christian and traditional African thought on personhood as discussed above.

Assumptions and values are based on an ecological perspective for viewing human behaviour, which implies the assessment of the environment, its resources and how to improve it. DeKraai et al. (2011, 256–257, 258–264) propose a model based on Bronfenbrenner's approach to allow faith-based communities to systemise their collaboration with healthcare providers for greater effectiveness. These authors are of the view that a multifaceted, comprehensive and well-coordinated response is required to deal effectively with behavioural health disorders, and that faith-based organisations have a variety of assets they could harness to prevent diseases and develop communities (DeKraai et al. 2011, 255–259).

Furthermore, adaptation as a means to development and change is postulated. The focus is on well-being, prevention of physical and mental

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<sup>2</sup> Holy Bible. The New King James Version, Prophecy Edition.

illnesses, promotion of healthcare, participation, collaboration, empowerment, and justice as a goal for action.

Research is action based, and diversity is reflected in theories and methods. The process is not linear, however, but circular. The assumptions arise from the values, which support and steer the methodology of action-oriented research and practice. Action-oriented research generates data that could inform and benefit communities (Worthington, Miller, and Talley 2011, 211) and shape and affirm assumptions. Participants are debriefed once the assessments and interventions have been completed. Interventions are discussed and modified to meet the needs of the community (Worthington, Miller, and Talley 2011, 212).

The following diagram illustrates the circularity of the assumptions, values and methodology.

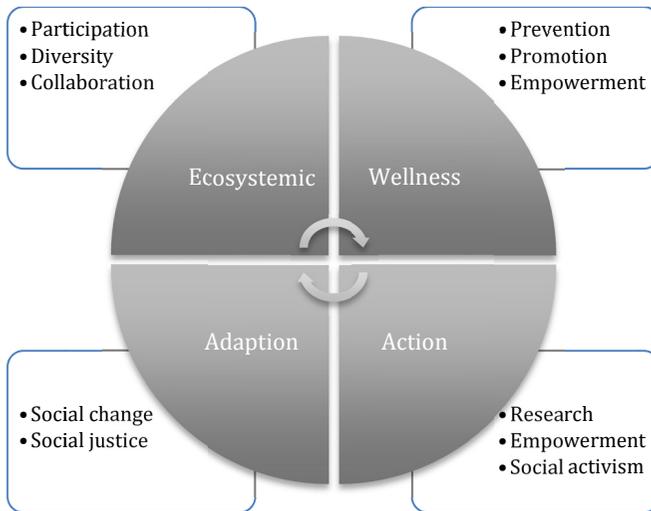


Figure 4.1 Assumptions, values and methodology

## Aims and Methodology

The methodology implemented in community psychology practice entails an appreciative inquiry, action-oriented research, and community-based interventions (Canning 2011, 190–192; Swart and Bowman 2007, 442–443). The interventions are co-designed by the researcher and the community participants (Worthington, Miller, and Talley 2011, 211–212),

with the objectives of preventing health problems; building resilience; supporting patients, families and the community; and expanding healthcare resources (Canning 2011, 192–196).

### **Appreciative Inquiry**

Engagement with the community calls for a mindset characterised by appreciation and openness to learning. The appreciative inquiry (AI) process allows researchers to adopt this mindset in engaging with a community and to follow an opportunity-centric approach (Boyd and Bright 2007, 1019–1020). The AI process comprises four phases, namely discover, dream, design and destiny. The first relevant question in the discovery phase is: “What gives life to this community?”, and this is asked with the aim of identifying the best of what is already present in the community (Boyd and Bright 2007, 1025–1028).

The second task is to develop a vision of what might be (Boyd and Bright 2007, 1027, 1029). The process of vision weaving is implemented and the participants are encouraged to visualise their dream for the community; the aim at this juncture is to create hope and impetus for action.

The third task is to design a plan or course of action to realise the vision. This plan is co-constructed by the partners, community leaders and members (Boyd and Bright 2007, 1030–1031).

The fourth task is to implement the designed plan to move towards the destiny of the community. The focus is on what will empower the community members and on what will be, or the future of the community (Boyd and Bright 2007, 1032).

### **Action Research**

Action research is implemented to study systems through active participation. Observation and assessment of the effects of the participation and the new dynamics that develop take place. Action learning is participatory and aligns well with the new emerging participatory worldviews.

### **Action Research Steps**

Action research starts with a description of a challenge, concern or problem. The first step consists of the identification of a concern, supported by an illustration of this with problematic cases and problem-

solving attempts (Pistorius and Katabua 2015, 22; Swart and Bowman 2007, 438–443). An analysis of the assumptions that the community associates with their problematic situation – with a particular focus on the assumptions underlying the explanations of their problem situation and the values and inferences on which problem-solving attempts are based – is done to gain a deeper understanding of how the community as a whole interprets the challenge. This could be facilitated through group discussion, and by exploring how personal and community histories are linked with the concern identified. Mutual knowledge acquisition takes place as action researchers apply and explain theory (Swart and Bowman, in Duncan, 2007). Researchers reformulate the initial definition of the concern and solutions Swart and Bowman 2007, 433, 442–443; Pistorius and Katabua 2015, 20–24). Alternative strategies for solutions are explored through group discussions with supervisors and others in the field (Pistorius and Katabua 2015, 22–24).

Informed action is likely to follow when the action researchers are able to account for the choices they have made and the values they based them on. The research process thus entails trial and error, as the researchers engage in the spirals of planning, acting, observing, reflecting and re-planning (Pistorius and Katabua 2015, 22–24).

Both careful observation and verification are fundamental to any action research project. Action researchers are advised to observe and verify through different means – personal experience, dialogue and face-to-face discussion – and to use both qualitative and quantitative methods (Pistorius and Katabua 2015, 23).

### **Benefits of Action Research**

The benefits of this type of research include deeper understanding of community dynamics and how this affects individual behaviour. Action research assists in determining how to empower communities and work towards the prevention of pathology rather than its cure. This form of research gives impetus to dealing with contextual issues through social action and social justice. Christian faith-based organisations could well fulfil the call to social justice by participating in action research (Worthington, Miller, and Talley 2011, 212–215).

### **Contextual Issues**

Many contextual issues have been identified as social determinants of physical diseases and mental disorders (Motsoaledi, 2014). Poverty entails

a lack of access to proper nutrition, education and healthcare services. It further leads to the development of social and mental health problems. It also results in a lack of skills and education, engagement in sex work to survive, substance abuse, violence, theft, and other criminal activities. An integrative framework to overcome issues such as poverty, unemployment, gender inequalities and the lack of basic education and life skills is vital for community development and growth. Christian community psychology provides an integrative framework for a partnership between faith communities, non-governmental organisations (NGOs) and community psychologists for the design and implementation of interventions that could improve the level of healthcare in a community.

### **The Value of Applied Christian Community Psychology for Healthcare**

Healthcare presents as a concern of community psychology practitioners in South Africa. Research done by Edwards (2015, 91) indicates that community interventions in South Africa seem more concerned with basic health and education issues, such as access to clean running water, housing, and human immunodeficiency virus/acquired immune deficiency syndrome (HIV/Aids) than those implemented in the United Kingdom.

Duncan et al. (2007, 12) have formulated a working definition for community psychology with emphasis on the *importance of engaging with communities to promote mental health*. These authors define community psychology as:

Understanding people in the context of their communities, using a variety of interventions (including prevention, health promotion and social action), to facilitate change and improved mental health and social conditions for individuals, groups, organisations and communities..

The application of a Christian community psychology integrative framework in different communities demonstrated the value of this approach. Two examples will be briefly discussed.

## Examples of Applied Christian Community Psychology

### *Example 1*

A community project was designed and implemented in collaboration with a Christian non-profit organisation (NPO), EE,<sup>3</sup> in a community identified as being at risk. EE is a **community home-based care centre**, established to care for those rendered frail by HIV/Aids or cancer, and stroke survivors. This facility provides end-of-life support to ensure that patients die with dignity and is managed by a pastor and a team of volunteers who train family members in how best to care for patients. The EE team is also involved in community outreach to inform, educate and support community members.

The vision of the NPO includes a commitment to being a Word-based ministry that touches people through servanthood and prayer. This is supported by their mission, which is to saturate the world with God's love, and to nurture, care for and touch families in a practical way. The mission further entails caring for the whole person: body, mind, emotions and spirit.

The community project is based on the assumptions, values and methodology of community psychology as previously discussed, and includes a variety of interventions aimed at disease prevention; health promotion and social action; identification of risk; and the design of interventions to prevent the development of potential health and mental health problems. Prevention is based primarily on building resilience, creating supportive environments and encouraging collaboration among all members of the community.

The community interventions include voluntary counselling and testing for HIV available seven days a week, thus identifying those at risk of developing Aids and consequent health problems; pre- and post-test counselling, thus engaging in mental health promotion; establishing a support group for people living with HIV/Aids and for those who are HIV positive; building resilience by helping people live positively; providing information on treatment and treatment for infections (thus health promotion) and handing out food parcels (thus engagement in social action).

The intention of this project is to empower community members and thus give them "a personal sense of control over [their] life as well as the

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<sup>3</sup> This is a fictitious name given to the NPO to protect the identity of participants

political control of factors that influence one's life" (Duncan et al. 2007, 69).

### *Example 2*

The second example is a project carried out in collaboration with KB,<sup>4</sup> an NPO in Windhoek, Namibia, which works in partnership with a Christian ministry to offer an eight-week programme for unmarried pregnant girls and women between the ages of fifteen and twenty-five years in the Katutura community.

This community was identified as being at risk owing to the increase in the number of young, unmarried pregnant girls and women. These girls and women tend to become isolated, leading to further risks in terms of their not completing their education and therefore not being able to find good employment later. A further danger is a sense of rejection, leading to low self-worth, loneliness and depression.

The objectives of the intervention are to provide prenatal education; establish a non-judgemental support group; share prenatal experiences; improve the participants' general lifestyle and strengthen their bio/psycho/socio/spiritual level of functioning.

The cultural context is significant in how the community interprets and deals with this risk and health concern. Katutura township is situated in Windhoek and was given to the Damara group as a permanent place to live. The group kept the name Katutura, which means "We have no permanent home." Acknowledging and understanding the socio-political history of this community is relevant for effective community interventions.

Katutura is a vibrant community that accounts for 60% of the population of Windhoek. However, poverty, unemployment, alcoholism, HIV and teenage pregnancy are rife.

Knowledge of the Damara culture is essential to the design of a community project for this context. The language spoken by the community is Khoekhoe, and the group consists of various clans, each under the leadership of a chief. The Damara people are traditionally hunter-gatherers and herders of cattle, goats and sheep. Girls tend to uphold traditional customs, such as wearing certain clothing while giving birth, staying at home for the first three months after a baby is born, eating only porridge and meat without seasoning and offering diluted porridge or tea if the baby is not breastfed.

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<sup>4</sup> This is a fictitious name given to the NPO to protect the identity of participants.

In this project the importance of applying psychology concerned with understanding people in the context of their communities is illustrated. Interventions include a lecture based on Psalm 139: 13–16 to inspire an appreciation of the value of a child; a video showing the growth of a baby; encouragement of the girls to share their story; and education regarding the signs of labour, labour positions and breastfeeding and bottle feeding, ultimately working towards the prevention of unplanned pregnancy. At the end of the eight weeks, a baby shower (an example of social action) is held for the girls.

Both projects started with an AI to ascertain what works best in the community; this was followed by a co-designed project to engage and empower community members to deal with current issues and weave a vision for the future of the community. The dream instils hope, and co-designing interventions ensures participation, which could lead to social transformation.

## **Christian Community Psychology and Healthcare**

Social transformation is a critical factor in the vision for improved healthcare. The social action model of community psychology provides the option for social activism, thus working towards social change (Arumugam, 2001; Swart and Bowman 2007, 435–436). This model allows for the creation of a partnership between community psychologists and faith communities as a means to contribute to social change and transformation in healthcare practices. The aim of a partnership of this kind is to exert a positive influence on all facets of a community: physical, social and spiritual.

The awareness of social determinants as factors leading to or sustaining health is pertinent for an effective approach to healthcare. Christian community psychology upholds the values of social action, social justice and social transformation. These values are underscored by the Christian faith tradition of social justice.

Social transformation is rooted in social justice, and is a worthy objective for Christian community psychology in partnership with Christian faith communities to achieve. Social transformation aligns with the biblical imperative of equity and compassion among all people. Various passages in the Bible refer to God's desire that people will live in such a way that justice and peace will reign in all human relationships and social structures.

Victor (2003, 17–18) states that Christian social activism demands a response to those who are suffering in a community. Activism

could thus be defined as a “practice of vigorous action or involvement as a means of achieving political or other goals”. In Christian social activism, intentional action should be based on Matthew 22:37–39:<sup>5</sup>

And He replied to him, You shall love the Lord your God  
with all your heart, and with all your soul and with all your mind  
[intellect].

This is the great [most important] and first commandment.  
And the second is like it, You shall love your neighbour like  
[you do] yourself.

Christian social activism is grounded in the character of God (Canning 2011, 188–190) and is aimed at social justice as described in Isaiah 58:6–7:<sup>6</sup> “Is this not the fast that I have chosen: to loose the bonds of wickedness, to undo the bands of the yoke, to let the oppressed go free, and that you break every enslaving yoke?”

Social change is described in Isaiah 58:7 as follows: “Is it not to divide your bread with the hungry, and bring the homeless poor into your house? When you see the naked that you cover him, and that you hide not yourself from the needs of your own flesh and blood?”

The context of the early church illustrates the practical expression of social action in the actions of Tabitha (Dorcas) and all she has done for the community: in Acts 9:36–39<sup>7</sup> we read: “She was abounding in good deeds and acts of charity ... All the widows stood around him [Peter] crying, and displaying under-shirts and other garments such as Dorcas was accustomed to make while she was with them.”

Victor (2003, 17–19) asserts that Christian social activism required from the Christian community is an expression of faith, as indicated in James 2:17:<sup>8</sup> “So also faith if it does not have works [deeds and actions of obedience to back it up], by itself is destitute of power – inoperative, dead.”

In obedience to this call for social action based on faith in Christ, Christian community psychologists in partnership with faith communities should do hope, do compassion and do forgiveness.

The social justice stream focuses upon justice and peace in all human relationships and social structures. It emphasises the gospel imperative for equity and compassion among all peoples.

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<sup>5</sup> Holy Bible, The New King James Version, Prophecy Edition.

<sup>6</sup> Ibid.

<sup>7</sup> Ibid.

<sup>8</sup> Ibid.

Matthew 23:23 reads as follows:<sup>9</sup> "Woe to you, scribes and Pharisees, hypocrites! For you tithe mint and dill and cummin, and have neglected the weightier matters of the law, justice and mercy and faith; these you ought to have done, without neglecting the others."

### **Early Church Community and Healing**

The early church adhered closely to the principles of compassion and sharing, and is associated with spiritual life and healing. Venter (2009, 144–146) asserts that although sickness comes through different dimensions, it affects the whole person. The Pauline letters to the early churches represent the church as a community characterised by the awareness and practice of healing (Venter 2009, 144–146). These healings range from the experience of grace or salvation (inner, emotional healing) to physical healings, spiritual experiences influencing thought patterns, reconciliation and healing in relationships, to finding inner peace and meaning in life through resting in God (Venter 2009, 269–276 ). A Christian perspective on health emphasises the expressing of God's glory (Canning 2011, 191–192).

A community can elicit healing through collective participation in social processes leading to social transformation. The spiritual context of health issues pertains to assessment of the spiritual context of the community: how we (the body of Christ) share and deal with the consequences of spiritual inheritance. Spiritual interventions and collective prayer are based on 1 John 5:14:<sup>10</sup> "Now this is the confidence that we have in Him, that if we ask anything according to His will, He hears us."

### **Criticism**

Criticism of the social action model of community psychology focuses on limitations and insufficiency. Arumugam (2001) asserts that this model pays insufficient attention to social inequalities, and that interventions are limited. Furthermore, communities may be taken advantage of for research purposes, with researchers demonstrating a lack of appreciation and respect. Ethical considerations should be a priority in any collaboration and community engagement. The focus on the influence of the system on behavioural and health problems might lead to the abnegation of

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<sup>9</sup> Ibid.

<sup>10</sup> Ibid.

responsibility. Personal choices and individual responsibility should be respected and upheld to prevent individuals from avoiding personal responsibility and to prevent the system from being blamed for every situation.

## Conclusion

The value of applied Christian community psychology and the church as a healing community could be fully utilised to alleviate suffering and facilitate social change to achieve the goals of wellness. Applied Christian community psychology is in harmony with God's plan through the design and implementation of interventions aimed at a God-given destiny. These interventions are planned to prevent physical and mental illnesses, alleviate the burden of suffering and affirm the ontological relevance of the community. The aim is to enhance the well-being of both the individual and the community.

The relevance of Christian community psychology in healthcare lies in the application of an integrated framework that involves partnerships between church communities, NPOs and healthcare workers. Such partnerships would draw on psychological knowledge and expertise, pastoral and spiritual insights and practical and medical advice and care.

Honouring God's plan of salvation and wholeness for all people requires active participation in societies to alleviate suffering and facilitate social transformation. Christian community psychology enables us to obey this call and become true workers in the harvest.

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# SPIRITUALITY AND HOLISTIC PEOPLE-CENTRED HEALTHCARE: A SOUTH AFRICAN MODEL

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## **Abstract**

There is a growing consensus that spirituality is part of a holistic patient-centred approach to healthcare. Research in this field is rapidly expanding and has led to the publication of textbooks on this subject and their inclusion in academic training. It would seem, however, that models are developed based mainly on North American and European contexts. This paper approaches the subject from a resource-poor, and, in particular, a South African context. It is suggested that the non-profit and faith-based sector should play a major role in this regard. Against this background HospiVision, a South African non-profit and faith-based organisation, is presented as a case study. In conclusion a set of principles and practices for spiritual and pastoral work as part of a holistic approach in resource-poor environments is discussed.

## **Keywords**

Healthcare; spiritual care; pastoral counselling; faith-based; non-profit

## **Introduction**

Illness can give rise to an existential and ontological crisis, as it confronts people with the fragility, vulnerability and the finitude of the human condition (Pellegrino 2012, iv). Serious illness and hospitalisation can be a difficult, traumatic, or even life-changing experience, especially when it

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has to be faced with access only to poor resources and/or limited support (De la Porte 2016, 2). Healthcare workers meet patients in this space of disarray, and in resource-poor environments additional strain is placed on human and other resources. In this context, elements such as faith, hope and compassion become crucial (Louw 2015). This emphasises the importance of spirituality as an integral part of a holistic approach to illness and hospitalisation, not only for patients and their families, but also for healthcare workers (Puchalski and Ferrel 2010, 3).

Spirituality is by its very nature a multi-, inter- and cross-disciplinary venture (Rumbold 2012, 178–179). Healthcare workers are often motivated by a sincere calling. They are confronted daily with intense existential suffering which challenges their own frameworks regarding healing. In resource-poor environments there is often also a sense of helplessness, which can lead to hopelessness (Louw 2008, 135–137). Spirituality, then, becomes a source of strength to be drawn upon in both curative and palliative practices (Brown-Haitho 2012, 209–217). From this perspective the spiritual and pastoral worker becomes an indispensable part of the multi-professional team.

This paper explores the role of spirituality and the spiritual and pastoral worker against the background of the South African healthcare landscape, primarily from a practical theological perspective. The realities of the South African healthcare system are explored, and the value of spirituality and the faith-based community (FBC) is indicated. HospiVision, a South African faith-based organisation (FBO) and non-governmental organisation (NGO) is then discussed as a possible model for the incorporation of spirituality in the healthcare system, particularly in a resource-poor context.

## **A Practical Theological Approach**

Lartey (2012, 293–297) has emphasised the need for practical theological reflection in healthcare settings. Heitink (1999, 6) defines practical theology as “the empirically oriented theological theory of the mediation of the Christian faith in the praxis of modern society”. We find the idea of dynamic interaction and mediation reflected in David Tracy’s definition of practical theology, which reads as follows: “Practical theology is the mutually critical correlation of the interpreted theory and praxis of the Christian faith and the interpreted theory and praxis of the contemporary situation” (Tracy 1983, 67). Graham (2006, 845–864) has emphasised the transformational intent of practical theology, and for Louw (2015, 64), practical theology is “the science of the theological, critical and

hermeneutical reflection on the intention and meaning of human actions as expressed in the practical ministry and the art of faithful daily living". All of these authors follow a hermeneutical approach. Practical theology is thus a theological theory of action which includes a hermeneutical, strategic and empirical reflection on the intention and meaning of human actions as expression of the praxis of God as it takes place in faithful daily living, the practice of ministry and the transformation of society (De la Porte 2016, 2).

A consideration of spirituality in healthcare offers unique opportunities for practical theology and pastoral care. First, spirituality is immediately relevant to individuals and communities, as it deals with core issues that relate to other problems such as poverty, HIV and Aids, crime and violence. Second, it is an area where true inter- and cross-disciplinary work can take place, as it involves health, psycho-social, developmental and theological sciences. Third, everybody involved will be engaged in some way on a personal level, because spirituality touches the core of our humanity. Human suffering is one of the central issues in this field. When a person accesses healthcare, it is often with a mixture of hope and trepidation.

## **The South African Healthcare Situation**

Healthcare in South Africa is in crisis. In the 2011 report on reforming healthcare in South Africa, the Centre for Development and Enterprise (2011, 5) states:

A full-blown crisis of health outcomes developed in South Africa during the 1990s and the first decade of this century. This only received proper political recognition from about 2007, when increasingly frequent media exposure of the public health system's failings created an atmosphere of crisis and scandal. This, along with the brave efforts of health professionals and health NGOs, helped silence high-level denialism about HIV and AIDS in particular and the poor condition of public healthcare in general. Since 2007 the government has been much franker in acknowledging shortcomings in both policy and delivery and has promised to tackle them with determination.

According to the World Health Organization (WHO 2010, 1–5), a well-functioning health system responds in a balanced way to a population's needs and expectations by improving the health status of individuals, families and communities, defending the population against what threatens its health, protecting people against the financial

consequences of ill-health, providing equitable access to person-centred care and making it possible for people to participate in decisions affecting their health and health system. For a healthcare system to render quality health services to all people, when and where they need them, a robust financing mechanism, a well-trained and adequately paid workforce, reliable information on which to base decisions and policies, well maintained facilities and logistics to deliver quality medicines to individuals and populations are required (WHO 2010, 3–5). Healthcare includes preventive, curative and palliative services.

The South African National Development Plan 2030 (NDP) declares the overall health system to be poor (NDP 2011, 301). The NDP further states that the public health sector is institutionally fragmented and characterised by a poor standard of infrastructure, skills shortages, poor staff attitudes, low levels of patient satisfaction, incompetent management, continuing human resource and financial crises, and starkly different health outcomes for different socio-economic groups. However, it should be emphasised that there are also many dedicated people working under exceptionally difficult conditions in public health services. Moreover, some notable successes have been achieved. This should be acknowledged along with the failings of the public system.

## **Spirituality and Healthcare**

A WHO report published in 1998 acknowledges the value of elements such as faith, hope and compassion in the healing process. The report advocates a holistic view of health that includes a non-material dimension, and in particular spirituality (WHO 1998).

In the same year Duke University's Centre for Spirituality, Theology and Health (CSTH) was founded.<sup>2</sup> As part of the work of the Centre, Koenig, McCullough, and Larson published the *Handbook of*

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<sup>2</sup> There are now similar centres at New York University ([www.med.nyu.edu/spirituality/](http://www.med.nyu.edu/spirituality/)), the University of Minnesota ([www.csh.umn.edu/](http://www.csh.umn.edu/)), the University of Florida ([www.spiritualityandhealth.ufl.edu/](http://www.spiritualityandhealth.ufl.edu/)), George Washington University ([www.smhs.gwu.edu/gwish/](http://www.smhs.gwu.edu/gwish/)), and Rush Medical University (<http://www.rusch.edu/>). Also deserving of mention are the Institute for Spirituality and Health at the Texas Medical Center ([www.ish-tmc.org/](http://www.ish-tmc.org/)), and Santa Clara University's Ignatian Institute for Spirituality and Health ([www.scu.edu/ignatiancenter/partners/spirituality/](http://www.scu.edu/ignatiancenter/partners/spirituality/)). In Europe, the *Forschungsinstitut für Spiritualität und Gesundheit* was established in 2005 at University Hospital in Bern, Switzerland ([www.fisg.ch](http://www.fisg.ch)).

*Religion and Health* in 2001. Their research covers the whole of medicine and is based on 1200 research studies and 400 reviews. The second edition was published in 2012 and now includes a review of more than 3000 studies (Koenig, King, and Carson 2012). The handbook provides an overview of the effect of religion on health, and contains a section on the relationship between religion and mental health covering subjects such as well-being, depression, suicide, anxiety disorders, and alcohol and drug abuse. The discussion of the relationship between religion and physical health deals with heart disease, hypertension, Alzheimer's disease and dementia, immune functions, cancer and mortality. The positive influence of religion on health behaviours and disease prevention is also considered. In conclusion, Koenig et al. (2012, 600–601) state:

What have all these studies found? While some report that Religion/Spirituality (R/S) people experience worse mental health (4%) and poorer physical health (8.5%) many more studies (over eighteen hundred) find significant positive relationships between R/S involvement and mental or physical health. Indeed, at least two-thirds of these studies report that R/S people experience more positive emotions (well-being, happiness, life satisfaction), fewer emotional disorders (depression, anxiety, suicide, substance abuse), more social connections (social support, marital stability, social capital) and live healthier lifestyles (more exercise, better diet, less risky sexual activity, less cigarette smoking, more diseases screening, better compliance with treatment).

Another title published in 2012 is the *Oxford Textbook on Spirituality in Healthcare* (Cobb, Puchalski, and Rumbold 2012). The textbook is wide ranging and deals with issues such as personhood, belief, hope, meaning making, compassion, dignity, suffering and the role of culture. In the practice section, topics relating to models of spiritual care, nursing, psychiatry, social work, care of children and palliative care are discussed. The textbook also offers sections on research, policy and education.

The International Society for Quality in Healthcare ([www.isqua.org](http://www.isqua.org)), which grants hospitals international accreditation, states that “the hospital has a place for prayers and meets patients’ spiritual and religious needs” (Standard B.7.2.3, 2011, 46). The Planetree *Patient-centred Care Improvement Guide* includes the following in the assessment criteria for spirituality (Planetree 2008, 14):

- Resources are available to educate staff about different religious beliefs and traditions related to health and healing.

- Spiritual assessments look beyond a patient's faith traditions to also capture what comforts and centres them.
- Space is available for both quiet contemplation and communal worship.

Internationally, spirituality is therefore recognised as an important part of holistic patient-centred healthcare. It is also included in the accreditation standards for hospitals. Unfortunately this is not the case in the South African context. Indicative of this is the absence of any mention of spirituality in the following important documents:

- National Development Plan 2030 (National Planning Commission 2013)
- Strategic Plan 2014/2014–2018/19 (National Department of Health 2014)
- South African Health Review 2016 (Health Systems Trust 2016)
- Council for Health Service Accreditation in South Africa: Hospital Standards, Version 6.7 (COHSASA 2015a)

The third edition of the Council for Health Service Accreditation in South Africa (COHSASA) Palliative Care Standards (COHSASA 2015b) does, however, mention the need for a spiritual assessment of patients and the inclusion of spirituality in a holistic approach, and the National Strategic Plan for HIV, STIs and TB (National Department of Health 2012) acknowledges the important role of faith-based organisations (FBOs). In both the palliative care and the HIV and Aids environment the non-profit and the faith-based sectors play an important role. However, in South Africa there is no statutory requirement or official system in place for the accreditation and certification of spiritual and pastoral workers in healthcare.

## **The Faith-Based Sector**

A hallmark of South African society, apart from its diversity and inequalities, is the religious involvement of people and communities. In the 2011 census, questions about religion were not included. However, the 2001 census revealed that more than 80% of South Africans had some religious affiliation (<http://www.statssa.gov.za/>). However, a 2012 Gallup poll indicated a 19% decline in religious affiliation from 83% in 2005 to 64% in 2012. A very interesting trend is that levels of religious affiliation are much higher in low-income groups (66%) than in high-income groups

(49%) (Win-Gallup International 2012).

The important role of FBOs is indicated in a report by Statistics South Africa (2015) on the non-profit sector. This report indicated that FBOs are the third-largest sector (12% = 14517 out of a total of 120268), after social services (34%) and development and housing (21%). This is followed by the health sector (9%). Magezi (2008, 1–6) is therefore correct in emphasising the churches' contribution to national health and well-being. The church is a subsystem of the community, and as such can influence both community and society. Likewise, clinics and hospitals must also be considered a part of the community, and the church can make an important contribution to their function and impact. The church also has access to and can offer physical and human resources to the community, part of which can be health related. The church provides social and community cohesion, and its leaders can play an important role in societal and moral transformation.

De Gruchy (2007) lists the following as potential contributions of religion to health:

- Religion offers presence;
- Religion offers an integration of tangible and intangible health-promoting factors;
- Religion offers relationships and networks;
- Religion offers an interpretive framework.

Neetling conducted a study regarding the relevance of pastoral work in South Africa with specific reference to the Southern African Association for Pastoral Work (SAAP), and concluded that pastoral counselling is a possible national health resource for healthcare, cost effectiveness, spirituality, social change, reconciliation and multi-cultural application (Neetling 2003, 82). Currently, spiritual care and counselling are provided mainly by religious or faith-based and community-based organisations.

It is therefore clear that in resource-poor environments non-profit organisations (NPOs) and FBOs have the potential to play a crucial role in providing spiritual and pastoral care services as part of holistic patient-centred care. A South African case study is now presented to illustrate how these services could be rendered.

## **Introducing HospiVision**

HospiVision is a South African non-profit and faith-based organisation established to provide broad-based social services in healthcare institutions in South Africa. Such services include emotional and spiritual support and counselling as well as the provision of life skills and training to patients, medical staff and communities. These services are aimed at empowering and restoring dignity, integrity and respect for patients, family and staff.

In its 2016 annual report HospiVision (2016, 1) states its positioning as follows:

Hospitals are places of hope and healing, but also of pain, uncertainty and loss. Illness and suffering highlights the vulnerability of people. In situations of illness and trauma the transience of life becomes a stark and undeniable reality. In these circumstances people start to ask “ultimate questions” about their identity and the meaning of life. It is to this reality that HospiVision responds through our ministry to the sick, vulnerable and those closest to them. The dreaded illness, operation and/or trauma become an opportunity for growth. It is transformed from a crisis to a life-changing event. HospiVision is therefore a natural and indispensable part of the hospital landscape.

The organisation states its vision as “touching the lives of sick and vulnerable people and those around them through spiritual and emotional care, counselling and physical support, and giving them hope through developmental empowering programmes”, and its mission as to “facilitate the establishment of sustainable integrated support and developmental programmes that reach out to and are in service of the sick, the vulnerable and the disadvantaged, their families and those who care for them” (HospiVision 2016, 2).

HospiVision traces its roots back to a decision by Christian doctors and ministers to build a chapel in the Pretoria General Hospital in 1945. The chapel was inaugurated in 1956. The management and use of the chapel and the adjacent offices gradually became the responsibility of the pastoral services after the Dutch Reformed Church appointed a full-time hospital minister, Dr (later Professor) Albertus Smuts. He was succeeded by Dr A.G.S. Gouws, who worked in this capacity for 25 years. The church discontinued this position upon his retirement in 1995. However, Dr Gouws continued the work for several years on a voluntary basis. HospiVision was established in 1997 and took over the ministry from Dr Gouws (Van der Walt 2014, 4). At present HospiVision is

responsible for the emotional and spiritual care of patients and the management of the chapel. Van der Walt (2014, 5) quotes Dr Gouws as saying the following on the occasion of the fiftieth anniversary of the chapel:

Thousands of patients, their families and staff members have had great depth of spiritual experiences in this chapel over the years. Some experienced the heartache of terminal illness and their own approaching death, others have experienced the death of loved ones while yet others experienced the joys of healing and the birth of little children. The joyous bells of marriage have also sounded in this historic building. The Good News of Jesus Christ was also preached many times to those who were seeking answers and many found answers. It is also true that the deepest academic knowledge was shared here, while the sounds of praise and worship of the Living God in the chapel also echoed throughout the buildings as in heaven.

Currently HospiVision offers its services in twelve public hospitals in South Africa, of which three are academic hospitals: Steve Biko (Pretoria), Chris Hani Baragwanath (Soweto) and Tygerberg (Cape Town). The organisation renders the following services (HospiVision 2015, 2):

- Spiritual and emotional support, care and counselling to patients, their families and caregivers
- Employee assistance programmes
- Trauma support and counselling
- Hospi-Kids: care and support to sick and vulnerable children, in particular those infected with or affected by HIV and Aids and/or living with a life-threatening illness
- Volunteer recruitment, selection, training and mentoring
- Physical and nutritional support
- Skills training and socio-economic development programmes for people living with HIV and Aids, chronic illness and disability
- University of Pretoria accredited training for volunteer and professional caregivers, companies, as well as community and faith-based leaders
- Community support and engagement
- Marketing, communication and resource mobilisation
- Research and development

## **Guiding Principles for a Non-profit and Faith-based Approach to Spiritual Care in Healthcare**

The North American and European “chaplaincy” model usually presupposes the appointment and funding of chaplains by the hospital. Chaplains require specialised training (Rumbold 2012, 177–179). This model is not feasible in the South African context. It has already been indicated that the healthcare system is under tremendous pressure, and, moreover, hospitals have seldom appointed people to render spiritual care. In private healthcare (which serves approximately 15% of the population, who belong to medical aid schemes), the provision of spiritual care is not part of the business model; private hospitals consider this to be the responsibility of a patient’s own congregation or denomination. Up until the late 1990s some denominations appointed chaplains in some public hospitals, and these hospitals have usually provided space for such services. However, this model has been phased out, primarily as a result of financial pressures experienced by congregations and denominations. The result is that spiritual care is provided in a haphazard, unsustainable way.

As stated on their website ([www.hospivision.org.za/about-us/our-people](http://www.hospivision.org.za/about-us/our-people)), HospiVision has chosen a model in terms of which a suitably trained and experienced spiritual and pastoral coordinator or manager is appointed for a hospital. The term “manager” is applied in the context of larger tertiary and/or specialised institutions and “coordinator” in the case of regional and district hospitals. The main task of the coordinator or manager is to identify and attend to the spiritual needs of patients, families and staff according to their religious and cultural beliefs and values and in line with organisational policies and procedures. A team of employed staff and volunteers supports the coordinator or manager, and their responsibilities include educating staff about the various religions and cultural practices relating to illness, trauma and death.

If spirituality is to be integrated into patient care and spiritual care is seen as essential, and not just an optional extra, the baton must be taken up by the non-profit and faith-based sector. Only through these sectors can services be rendered on a sustainable and consistent basis. The following is a set of principles and practices governing HospiVision’s operations which could be helpful for other organisations working in the same context. These principles could also guide reflection on spirituality as part of a holistic approach to healthcare in resource-poor environments.

## **A Comprehensive and Inclusive View of Spirituality**

In Africa spirituality has a strong interpersonal and relational component. It is not interpreted as a “private” and/or “individual” matter. According to Manala (2016, 103–117) the African worldview is holistic, is characterised by strong community bonds, dynamism and vitalism, has a heightened sense of the sacred, and is anthropocentric. A bio-psychosocial and spiritual approach will therefore fit well within the African worldview. The “bio” component of the approach should also be expanded to include all aspects of the individual’s physical life. It could be said that in African spirituality there is a shift from “person-centrism” to “people-centrism” based on the principles of ubuntu (community) and batho pele (people first).

Puchalski et al. (2014, 648) have formulated an inclusive and now widely accepted definition of spirituality, which reads as follows:

Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature, and the significant or sacred. Spirituality is expressed through beliefs, values, traditions, and practices.

## **Spiritual and Pastoral Work**

Practical theology has been defined as a hermeneutical reflection on the intention and meaning of human actions as expression of the praxis of God, as it takes place *inter alia* in ministry. In essence, spiritual and pastoral work is a hermeneutic activity (Gerkin, 1984; Louw, 1998). Daily, in an environment where suffering and hope meet, it reflects on the meaning of healing and caring human actions as actions of God (Lartey 2012, 293). It also mediates between the person and the healthcare environment, which can be frightening and confusing, helping people to make sense of their treatment (HospiVision 2016, 2). In the same vein it mediates between people, including staff, patients and family (Willard 2012, 120).

The basis of spiritual and pastoral work is the practice of compassionate presence (Louw 2015, 273–379). Being completely present with one who is suffering means being able to be present with the suffering itself. This is the very definition of compassion. True compassionate presence is not about denying someone their experience with the dark realities they are experiencing; instead, it provides illumination that allows them to explore all the aspects of their situation

with clarity (Taylor and Walker 2012, 135–143). Thus, compassion challenges the care worker to move from “doing” to “being”.

In healthcare institutions various levels<sup>3</sup> of pastoral work are distinguished (Clinebell 2011, 441–460; Klein 2009, 37–50; Tan 1991, 82–95), as illustrated below.

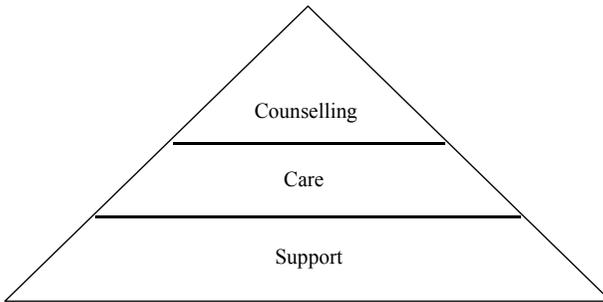


Figure 5.1 Levels of pastoral work

Spiritual and pastoral support entails basic and general support through compassionate presence, conversation and acts of care (Clinebell 2011, 447; Tan 1991, 83). Acts of care can include distribution of books and magazines, assistance with personal grooming, and the provision of clothes and toiletries. A basic orientation regarding the hospital environment and hospital etiquette will be necessary.

Spiritual and pastoral care requires the competence to conduct a conversation based on building a relationship, empathy and empathetic understanding of situations, listening skills and the utilisation of spiritual and religious resources (Clinebell 2011, 448; Tan 1991, 83). It will require basic training in relevant theoretical and practical knowledge and skills as well as practical work, and will be conducted under supervision.

Spiritual and pastoral counselling requires advanced theoretical knowledge and practical experience. It will include all the skills listed under the previous category as well as understanding of medium- to long-term counselling processes (Clinebell 2011, 449; Willard 2012, 119–131; Tan 1991, 84). The counsellor will respond to referrals, interact with and give feedback to other professions, do a spiritual assessment and take a

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<sup>3</sup> These levels also follow the accreditation system of the South African Association of Pastoral Work (<http://www.saap.za.net/>).

spiritual history, when required. Advanced knowledge of the hospital environment will be required.

### **Healthcare Staff Support**

Working in a healthcare context can be challenging, demanding and sometimes confusing. Many people working in this environment have a deep sense of vocational calling and a commitment to service. Brown-Haithco states that “staff support is a way to offer staff a space to regain their sense of balance and meaning” (2012, 209). It is important to emphasise that spiritual care for staff should take place across disciplines: nursing staff, physicians, support staff and administrators. However, spiritual support of staff is often an informal and secondary activity.

Issues that staff struggle with include: complex treatments, high acuity of patients, dealing with death, communication issues, intense involvement with long-term patients and their families, interdisciplinary conflict, ethical issues, workload, role overload and conflict and isolation outside the workplace (Melan, Howard-Ruben, and Whitaker 2004, 4).

Hospivision staff and volunteers are specifically trained to include staff support in their spiritual and pastoral work (Hospivision 2016, 2). When a volunteer visits a ward, a specific inquiry is made regarding how staff members are coping with the issues mentioned above. This might lead to a brief conversation or prayer. Staff members are also referred for counselling. Spiritual and pastoral counsellors are involved in critical incident debriefing, for example after a series of deaths in a ward or in the case of a particularly traumatic event. Other activities include prayer meetings, memorials when a staff member has passed away and involvement in annual days such as the blessing of the hands.

### **Creating a Context and Community to Search for Meaning**

A faith-based approach creates a context for finding meaning in the midst of suffering, and thus mediates hope (Louw 2015, 1–40). Suffering should also be understood as a phenomenon that affects the whole person and his or her relationships and living environment (Ferrel and Del Ferraro 2012, 157–162). Hospitalised individuals often experience a sense of disconnection and isolation from their communities (Louw 2008, 41). This can apply on an emotional level, but it is often the result of being physically far from the community and the family being unable to visit as a result of socio-economic circumstances.

The faith-based community also provides context for care, compassion and hope. Representatives of that community (whether professional or volunteer) build a bridge to the faith community to communicate that we are part of a bigger group, with shared humanity and vulnerability (Marino 2012, 233–239). The faith-based community is also an important resource to support healthcare workers in their commitment to providing compassionate care (Louw 2008, 118–122).

### **Collaborative Partnerships**

In South Africa, “a one size fits all” model of spirituality in healthcare will not work. South Africa has an incredibly diverse society on many different levels: cultural, spiritual, language, social and economic, and there is a distinguishable difference in how healthcare is provided in urban and rural contexts.

Providing spiritual and pastoral care in a complex, resource-poor environment will invariably require a partnership model (Magezi 2012). In this regard the hospital and hospital management must be among the main stakeholders. The formal provision of spiritual care and counselling and the inclusion of this in the multi-professional team must be negotiated with management (Bross 2012, 331).

Furthermore, especially as a result of inadequate resources and a complex system of needs, partnerships with other NGOs and FBOs will be essential. Community-based organisations and in particular faith-based communities and organisations provide a range of services as well as a support network (Klein 2009, 67–78). Volunteers generally come from faith- and community-based organisations (Tan 1991, 188–211).

Particularly in academic hospitals, universities become important stakeholders. It is a continuing lobby process to ensure that spirituality is included in the curriculum for healthcare practitioners. Universities have outreach programmes, which can be utilised to support NPOs working in the healthcare environment.

### **Volunteers**

As stated on the website of the Institute for Volunteering Research ([www.ivr.org.uk](http://www.ivr.org.uk)), extensive literature dealing with volunteer programmes is available. Volunteering is generally considered an altruistic activity where an individual or group (professional or non-professional) provides services for no financial gain to benefit another person, group, organisation or community (Wilson 2002, 215). Volunteers are looking for

meaningful ways to invest their time, expertise and resources to benefit others. However, they are becoming more critical about the work they do (Riddle and Drenth 2002, 33–35). More than before, volunteer work must offer the opportunity for personal development, which entails volunteers assessing what an organisation has to offer them (Mutz and Murray 2006, 68–74).

The role of volunteers is crucial in resource-poor areas. As at 2016 HospiVision had an extensive network of 180 volunteers (2016, 6) covering all three levels of pastoral work, as well as volunteers involved in administration, resource development, physical support and skills training. The volunteer system includes policies and procedures regarding recruiting, screening, training, supervision and mentoring.

### **Training**

Working with staff in a specialised environment and using a network of volunteers requires training on many different levels (Tan 1991, 115–134). All training will be based on a thorough orientation regarding the healthcare environment and the ethical code that is essential for working in this context (Louw 2008, 192–208). Training must be standardised, foundational and continuous across all institutions (De la Porte 2016, 5). A monitoring and evaluation system must therefore be in place.

HospiVision's training is accredited by the Centre for Contextual Ministry at the University of Pretoria (<http://www.up.ac.za/centre-for-contextual-ministry>). It covers aspects such as spiritual care and counselling for the sick, clinical pastoral education, spiritual care and counselling for sick children, trauma counselling in an accident and emergency unit, death and bereavement, HIV and Aids prevention and care, depression, and victim empowerment (HospiVision 2014, 6). This training is presented not only internally but also externally to individuals, FBOs, FBCs and commercial entities.

### **A Multi and Inter-disciplinary Approach**

The principle of including spirituality in a holistic multi-disciplinary approach is no longer disputed. The image that comes to mind in this regard is that of a multi-professional team working closely together to develop a treatment plan in which spirituality is included (Roberts 2012). However, how to achieve this in a resource-poor environment poses a problem. The number of team members available may be limited and their capacity greatly reduced as a result of limited resources. Referrals are

usually based on a bio-medical model. In the South African context spiritual and pastoral counselling is not formally considered part of the treatment plan.

Spiritual and pastoral workers will therefore have to rely on a relational and networking model (Klein, 2009, 67–78). Team members need to be sensitised regarding the availability of these services. Referrals and feedback are also mostly informal in nature, and are not captured in the patient's file. However, this should not detract from the essential role that spiritual and pastoral care and counselling can fulfil in the overall treatment of the patient.

### **Creative Communication and Resource Mobilisation**

If spirituality is seen as among other things a practical theological and mediative activity, then communication and resource mobilisation in the area must also be seen as such. Henri Nouwen is therefore correct in speaking thus about the spirituality of fundraising:

From the perspective of the gospel, fundraising is not a response to a crisis. Fundraising is, first and foremost, a form of ministry. It is a way of announcing our vision and inviting other people into our mission ... Vision brings together needs and resources to meet those needs ... Vision also shows us new directions and opportunities for our mission ... Fundraising is proclaiming what we believe in such a way that we offer other people an opportunity to participate with us in our vision and mission (Nouwen 2004, 3).

In a resource-poor environment creative communication with service users, network partners and the support base is essential. NPOs should develop competence to use all the available communication channels in a networked world (Riddle and Drenth 2002, 157–186). The donor community, whether it is individual, corporate or charitable in nature, should be considered a key stakeholder. This will be one of the vital ways to ensure sustainability (Ritchie 2000, 156–157).

### **Organizational Support and Development**

In the face of overwhelming needs and constant financial pressure governance, management and administrative systems are often neglected, and so a board of directors/trustees that is actively involved is essential (Mutz and Murray 2006, 55–66; Riddle and Drenth 2002, 37–44). Working in a multi-stakeholder environment with funded programmes

also requires systems for monitoring, evaluation and reporting (Bross 2012, 329–341).

Partnerships must, as far as possible, be formalised and partner relationships must be managed (Klein 2009, 67–78). This is of particular importance in the relationships with the hospital as primary stakeholder and the support network, which includes other organisations and in particular the faith-based and volunteer community.

## Conclusion

Spirituality should be considered an essential part of a holistic patient-centred approach to healthcare. In this paper, the problem of providing spiritual and pastoral care in resource-poor environments has been approached from a practical theological, non-profit and faith-based perspective, and the essential role of FBOs and FBCs emphasised. Against this background HospiVision, a South African NGO and FBO, was presented as a case study. From this case study we see that a contextually relevant, faith-based and non-profit approach can draw on principles and practices relating to a comprehensive and inclusive view of spirituality and spiritual and pastoral work, creating a context and community to search for meaning, and involving collaborative partnerships, the utilisation of volunteers, training, marketing, communication, resource mobilisation and organisational support and development.

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# EFFECT OF A FAITH-BASED EDUCATION PROGRAMME ON SELF-ASSESSED PHYSICAL, MENTAL AND SPIRITUAL (RELIGIOUS) HEALTH PARAMETERS<sup>1</sup>

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## Abstract

The aim of the study was to determine the effect of attending a faith-based education program (FBEP) on self-assessed physical, mental and spiritual health parameters. The study was designed as a prospective, observational, cohort study of individuals attending a 5-day FBEP. Out of 2650 sequential online registrants, those previously unexposed to the FBEP received automated invitations to complete 5 sequential Self- Assessment

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<sup>1</sup> Journal of Religion and Health, Published online: 19 September 2015. DOI 10.1007/s10943-015-0129-z. © Springer Science+Business Media New York 2015 – reprinted with permission (LN.3963531110476)

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Questionnaire's (SAQ's) containing: (1) Duke University Religion Index (DUREL); (2) Negative Religious Coping (N-RCOPE); (3) Perceived Stress Scale (PSS); (4) Center for Epidemiology and Statistics-Depression Scale (CES-D); (5) Brief Illness Perception Questionnaire (BIPQ); and the (6) State Trait Anxiety Inventory (STAI). Pre- attendance SAQ (S1) was repeated immediately post-FBEP (S2), at 30 days (S3), 90 days (S4) and after 1 year (S5). Of 655 invited, 274 (42 %) succeeded, 242 (37 %) failed and 139 (21 %) declined to complete S1. Of the 274, 37 (14 %) were excluded at on-site interview; 26 (9 %) never attended the FBEP (i.e., controls: 5#; 21\$; 27–76 years); and 211 (77 %) participated (i.e., cases: 105♂; 106♀; 18–84 years) and were analyzed over time: 211 (S1); 192 (S2); 99 (S3); 52 (S4); 51 (S5). IRB approval was via the Human Research Ethics Committee of Stellenbosch University. DUREL showed significant, sustained changes in Intrinsic Religiosity. N-RCOPE showed significant, lasting improvement. In others, median values dropped significantly immediately after the FBEP (S1:S2) for STAI-State  $p < 0.0001$ ; PSS  $p < 0.0001$ ; BIPQ  $p < 0.0001$ ; CES-D  $p < 0.0001$ ; and at 1 month (S1:S3) for STAI-Trait  $p < 0.001$ . All changes were sustained (S3 through S5). This FBEP produced statistically and clinically significant changes; these lasted in those followed up for  $> 1$  year.

## Keywords

Religion; mental health; spirituality; religion and medicine; religion and psychology.

## Introduction

Faith, religiosity and spirituality (F–R–S) play a significant role in the perception, pre-vention and treatment of disease (Stanley et al. 2011). Collectively, they have *indirect* effects by influencing people's understanding of the nature and etiology of disease; by favoring or prohibiting particular methods of disease management; by influencing utilization of healthcare resources; by affecting patient compliance and satisfaction; and by supporting or impairing recovery (Borras et al. 2007; Grosseohme et al. 2008; Kempainen et al. 2008; Koenig 2007; Kremer et al. 2009; Lyon et al. 2011; Mellins et al. 2009; Parsons et al. 2006; Stewart and Yuen 2011). They may also have *direct* effects by being constituent parts of the therapeutic process, e.g., prayer. As a result, F–R–S and health research tends to fall into two broad categories: (1) *correlation studies* that typically explore psychosocial and behavioral elements of faith and

attempt to identify potential mediators, factors and physiological mechanisms through which the positive or negative health effects may be explained; and (2) *intervention studies* that examine the effect of a specific F–R–S variable and an associated objective health outcome.

This study examined both of these components: In this first paper, we report the out- come of an *intervention*—a standardized faith-based education program (FBEP)—on a set of outcome measures. In a subsequent paper, we will examine the outcome data as *correlates* of morbidity and mortality. Therefore, the chosen outcome measures were all previously validated Self-Assessment Questionnaires (SAQs), some of which have extensive normative data for comparison.

Justification for the study lay in the present paucity of scientific outcome data on health- oriented faith-based instruction on physical, mental and spiritual (religious) health parameters. While many faith-based organizations address health issues at some level, few offer standardized interventions that would permit the analysis of outcomes. Even fewer consider the durability of the results or the possible detrimental effects. Therefore, the objective of this paper was to report the outcomes of a standardized FBEP intervention: Were there effects; were they positive or negative; and did they last?

The FBEP intervention is a 5-day program called For My Life™ (4ML), presented by Be in Health Inc. (BiH) – an international NFP Christian ministry specializing in faith-based teaching on spiritual, psychological and physical health issues. BiH has developed a wide range of biblically based educational materials, ministry approaches and training programs aimed specifically at bio-psycho-socio-spiritual health and disease prevention. The 40-h 4ML program offers the initial, intensive, systematic teaching and ministry components and introduces a framework for ongoing discipleship from a Christian, biblical perspective.

It is estimated that approximately 30,000 people have attended the 4ML program since its inception. A central part of the program is the so-called 8 R's, also called “the walk-out” which include *recognition, responsibility, repentance, renunciation, removal, resistance, rejoicing* and *restoring* in response to negative life experiences, thoughts and emotions. There is a significant amount—approximately 20 h—of Biblically referenced teaching on sickness and health; pathways of disease and “spiritual roots” of disease; as well as the importance of forgiveness, resolving negative religious coping and becoming reconciled with God, others and themselves. Great emphasis is also placed on the effects of fear, stress and anxiety on health. Various opportunities for relational restoration and reconciliation with God, self and others are offered

throughout the program—in the form of collective prayers of confession and repentance—to facilitate resolving unforgiveness and receiving God’s love. The program concludes with a final 30-min individual “wrap-up” ministry session at the end to deal with any residual or outstanding issues. Negative Religious Coping and disempowerment issues are dealt with specifically throughout the program. Negative spiritual and emotional influences are externalized and objectified for the purpose of ensuring a functional internal *locus* of control in partnership with God and self. The negative influences and thoughts are categorized by means of descriptive names, like ‘bitterness’, ‘accusation’, ‘envy & jealousy’, ‘rejection’, ‘unloving’, and ‘fear’, to allow the participants to more readily identify them; to take authority over their impact on their lives and relationships; and to constructively pursue and manifest positive emotions, behavior and relational skills in return (analogous to Cognitive Behavioral Training). The emphasis is on empowering individuals to accept responsibility for their lives and to realize that reconciliation with God and others is the primary objective. This, in turn, will facilitate removal of existing barriers to spiritual, mental and physical health recovery. The goal, therefore, is not primarily healing but relational restoration; healing is presented as the by-product of restored relationships.

## **Methods**

### **Study Design**

The study was designed as a prospective, observational, cohort study of individuals attending a 5-day FBEP called “For My Life™” (4ML) with IRB approval. The FBEP was presented by Be in Health Inc. ([www.beinhealth.com](http://www.beinhealth.com)), a 501(c)3 organization in Thomaston, GA. During FBEP online registration, all individuals who indicated their age as  $\geq 18$  years and had no prior exposure to the FBEP (or its associated materials) received an automated online invitation to participate in the study; no other methods of solicitation were employed, and no other subjects were recruited. The only incentive to participate was a complimentary book related to the program material; there were no other benefits to participating. Sample size calculations were performed using Stata/IC 10.1 for Windows (StataCorp LP, 4905 Lakeway Drive, College Station, TX 77845, USA). The study required 44 cases for a power of 0.9 and an alpha of 0.05. To allow for on-site exclusion and attrition over time, a target of 250 subjects was selected. Enrollment was from February 1, 2011, to November 21, 2012 (21 months). Between 1 and 9 subjects (out of a class

of 16–95 attendees; average 41) enrolled over 63 consecutive 4ML programs (see Fig. 6.1).

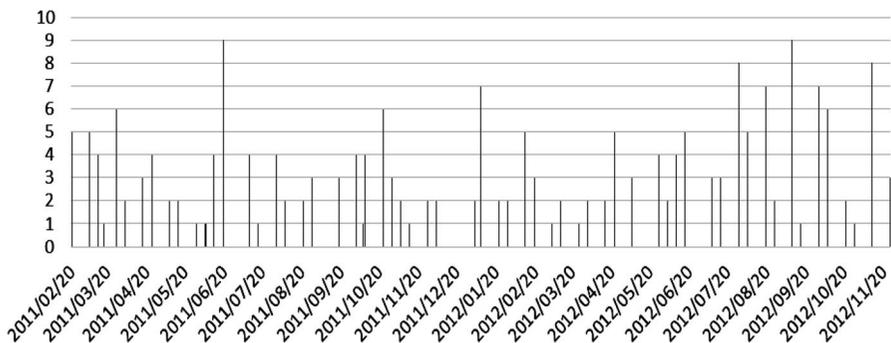


Figure 6.1 Subject enrollment over 21-month study period and 63 consecutive FBEPs

The FBEP director and teachers were blinded to who the subjects were. Apart from the initial, brief on-site eligibility interview with the on-site research coordinator, contact with subjects was limited to e-mailed instructions to complete the follow-up SAQ's. Long-term follow-up continued until January 15, 2014. The 91-item SAQ was offered online via Survey Monkey ([www.surveymonkey](http://www.surveymonkey)) using a personal e-mailed link. All data were entered directly into the survey. The results were de-identified and exported for analysis with subject numbers allocated to permit collation. No alterations were made to the data entries. All incomplete surveys were excluded from analysis. Scoring and reverse scoring configurations were verified meticulously to assure validity of the SAQ results. The SAQ was completed once before and four times after the FBEP: SAQ 1 (S1) was taken during FBEP online registration; SAQ 2 (S2) was immediately after the FBEP (with a 7-day cutoff period); SAQ 3 (S3) was at 30 days after S2; SAQ 4 (S4) was at 60 days after S3; and SAQ 5 (S5) was taken at the end of the study period, more than 1 year after S1. Participants received two e-mail prompts, 7 days apart, to complete SAQ's S2, S3, S4. If they failed to respond within 7 days of the second e-mail, they were excluded from further surveys other than S5, which all subjects (cases and controls) were again invited to complete. See Fig. 6.2. A brief telephone interview was performed within 30 days of S4 to determine whether the participants had received any additional or alternative interventions, and to obtain qualitative information about their

experiences during and following the program. The S5 questionnaire was also accompanied by an introductory set of questions to determine whether participants had received any interventions between S4 and S5. No participants reported any additional interventions other than routine religious involvement and medical care.

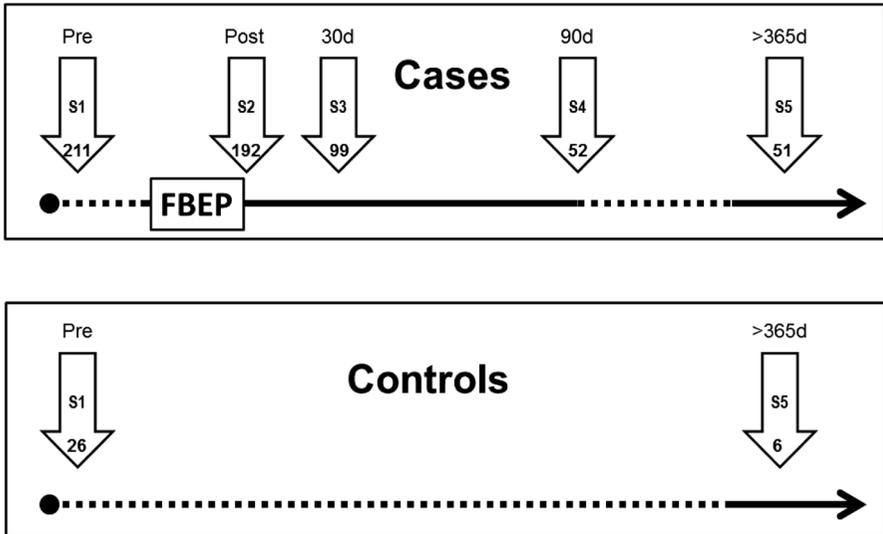


Figure 6.2 Study timeline for cases and controls

### Participants

Out of 2650 sequential online registrants during the enrollment period, 655 indicated they were of eligible age and had no prior exposure; these were invited to participate. Of these, 274 (42 %) were successful in submitting S1; 242 (37 %) were unsuccessful; and 139 (21 %) were unwilling to participate. Of the 274, 26 never attended the FBEP (i.e., controls: 5♂; 21♀; 27–76 years); 211 met the eligibility criteria (i.e., cases: 105♂; 106♀; 18–84 years); and 37 were excluded during the on-site interview. Reasons for exclusion were: age <18 years; any prior exposure to the program or its material before the first day of the FBEP; not personally completing the SAQ's; and lack of English and basic computer proficiency for proper comprehension of the FBEP material and valid

completion of the questionnaires. The derivation of the study sample is depicted in Fig. 6.3.

Age and gender distribution are shown in Fig. 6.4 in 5-year intervals. All the participants were US citizens, thereby permitting comparison to US normative data.

### Research Instruments

The 91-item SAQ was made up of 6 components: (1) Duke University Religion Index (DUREL); (2) Negative Religious Coping (N-RCOPE); (3) Perceived Stress Scale (PSS); (4) Center for Epidemiology and Statistics-Depression Scale (CES-D); (5) Brief Illness Perception Questionnaire (BIPQ); and (6) State Trait Anxiety Inventory (STAI).

The *DUREL* is a 5-item questionnaire that measures Organizational and Non-Organizational Religious Activity (i.e., ORA and NORA—also classified collectively as Extrinsic Religiosity); and private or Intrinsic Religiosity (IR) (Harold G. Koenig and Bussing 2010): the higher the score the greater the involvement in religious activities.

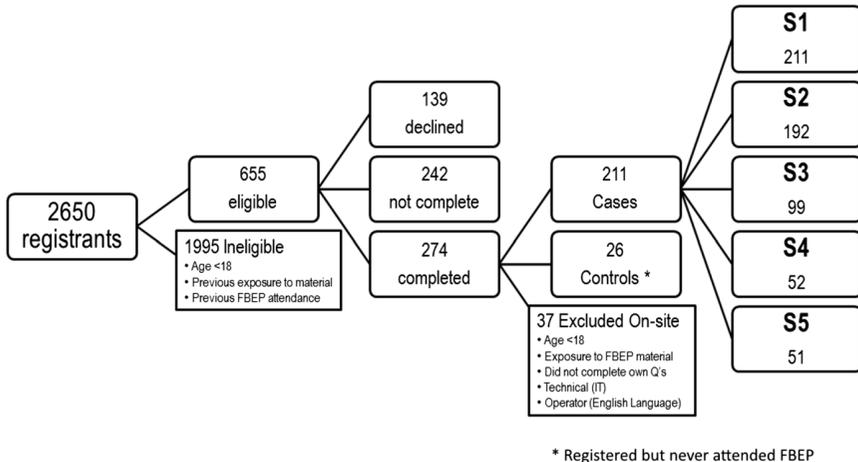


Figure 6.3 Derivation of the study sample

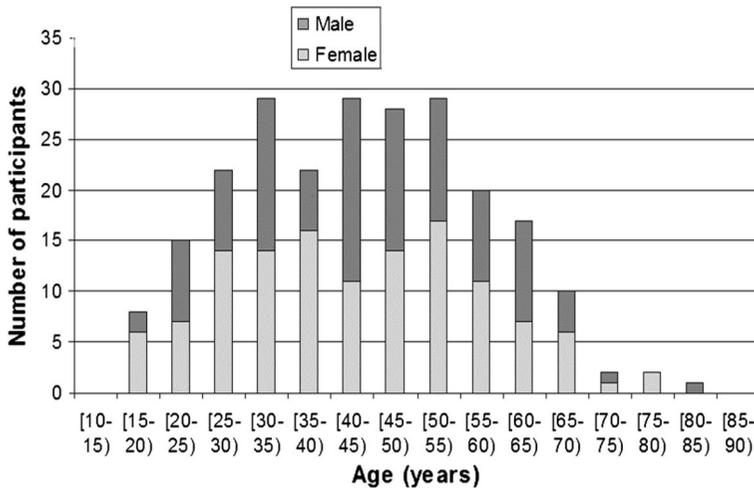


Figure 6.4 Age and gender distribution of subjects—in 5-year increments

The questionnaire has been used extensively in regression analyses linking religious activity and health outcomes. It had good test-retest reliability (Koenig and Bussing 2010; Storch et al. 2004).

The *N-RCOPE* is a 7-item questionnaire. It assesses spiritual discontent, perceived spiritual punishment and harmful spiritual influences related to illness (Pargament et al. 2000). Scores are from 0 to 21. The higher the score the greater the ability to cope in a positive religious way to life's stressors. The questionnaire has good test-retest reliability and identifies important negative religious factors that have been associated with poor mental and physical health outcomes (Pargament et al. 2011).

The *PSS* is a 10-item questionnaire that assesses perceived stress (Cohen 1983; Cohen et al. 1995). Scores range from 0 to 40. It measures the extent to which a person perceives that life's demands exceed their ability to cope: the higher the number, the greater perceived stress in the individual's life. The PSS has established associations with physical symptoms and abnormal health parameters (Burns et al. 2002; Carpenter et al. 2004; Cohen et al. 1993; Cruess et al. 1999; Culhane et al. 2001; Ebrecht et al. 2004; Epel et al. 2004; Holzel et al. 2010; Kramer et al. 2000; Leon et al. 2007; Malarkey et al. 1995; McAlonan et al. 2007; Stone et al. 1999).

The *CES-D* is a 20-item questionnaire that assesses depressive symptoms in the past week (Radloff 1977). It is well recognized in depression research for a general population (Choi et al. 2014; Radloff

1977; Schein and Koenig 1997). Scores range from 0 to 60. The higher the score the more depression there is. It also correlates with abnormal EEG findings associated with depression (Diego et al. 2001).

The *BIPQ* is an 8-item questionnaire that offers high-yield information on perception of an individual's illness as a threat (Broadbent et al. 2006; Leventhal 1984). Scores range from 0 to 80. A higher score indicates a more threatening view of illness. It has been validated over a large spectrum of illnesses relevant to the study population (Broadbent et al. 2008).

The *STAI* has 40 items and is made up of 2 parts (Bergua et al. 2012; Kvaal et al. 2005; Oei et al. 1990; Tenenbaum et al. 1985): Part One (State Anxiety or STAI-S) has 20 items measuring current anxiety; the higher the number the more anxious the individual feels *right now* (Spielberger 1983). Part Two (Trait Anxiety or STAI-T) has 20 items measuring long-term anxiety; the higher the number the more anxious the person feels *generally* (Spielberger 1983). Both parts have scores ranging from 20 to 80.

At the conclusion of the study period, all valid SAQ's were analyzed: (1) *cases* S1: 211; S2: 192; S3: 99; S4: 52; and S5: 51; (2) *controls* S1: 26; S5: 6 (female only). Twenty cases completed all 5 SAQ's; then, to increase the number of S50 s a second invitation was sent to the remaining 218 participants. Cases who did not complete all 5 surveys were categorized as lost to follow-up (LTFU) as opposed to those cases who completed (CMPL) all of them; these two groups were compared at baseline (S1) and immediately after the FBEP (S2) to assess bias and possible predictors of attrition (Fewtrell et al. 2008)—see Table 2.

Scale	Norms S1			S2			S3			S4			S5		
	M (SD)	MD (SD)	p	M (SD)	MD (SD)	p	M (SD)	MD (SD)	p	M (SD)	MD (SD)	p	M (SD)	MD (SD)	p
PSS (women) (Cohen and Janicki-Deverts	16.14 (7.56)	25.07 (8.16)	<0.001*	16.56 (9.29)	70.4 (9.29)	0.89	13.80 (6.27)	-2.3 (6.44)	<0.01#	14.30 (6.44)	-1.8 (8.84)	0.14	15.87 (8.84)	-0.3 (8.84)	0.61
PSS (men) (Cohen and Janicki-Deverts	15.52 (7.44)	20.87 (8.57)	<0.001*	14.16 (8.60)	-1.4 (8.60)	0.06	10.22 (6.31)	-5.3 (5.93)	<0.001#	10.28 (5.93)	-5.2 (9.15)	<0.001#	13.82 (9.15)	-1.7 (9.15)	0.10
CES-D (Crawford et al. 2011)	10.24 (9.67)	23.87 (15.95)	<0.001*	12.54 (11.89)	72.3 (11.89)	0.79	8.91 (8.31)	-1.3 (10.98)	<0.01#	9.13 (10.98)	-1.1 (12.86)	<0.05#	9.80 (12.86)	-0.4 (12.86)	0.14
CES-D (Radloff 1977)	9.25 (8.58)	23.87 (15.95)	<0.001*	12.54 (11.89)	73.3 (11.89)	0.11	8.91 (8.31)	-0.3 (10.98)	0.07	9.13 (10.98)	-0.1 (12.86)	0.09	9.80 (12.86)	70.6 (12.86)	0.26
STAI-S (women) (Spielberger 1983)	35.20 (10.61)	50.79 (16.29)	<0.001*	31.31 (11.24)	-3.9 (11.24)	<0.001#	33.61 (11.24)	-1.6 (12.86)	0.13	34.48 (12.86)	-0.7 (17.26)	0.26	35.96 (17.26)	70.8 (17.26)	0.43
STAI-S (men) (Spielberger 1983)	35.72 (10.40)	44.53 (16.62)	<0.001*	32.75 (13.85)	-3.0 (13.85)	<0.01#	29.52 (13.85)	-6.2 (13.85)	<0.001#	28.72 (13.85)	-7.0 (13.07)	<0.01#	32.57 (13.07)	-3.2 (13.07)	0.08
STAI-T (women) (Spielberger 1983)	34.79 (9.22)	51.77 (15.02)	<0.001*	39.94 (13.17)	75.2 (13.17)	<0.001*	37.12 (13.17)	22.3 (13.17)	0.19	38.26 (13.17)	73.5 (13.17)	0.48	37.52 (16.91)	22.7 (16.91)	0.98
STAI-T (men) (Spielberger 1983)	34.89 (9.19)	46.77 (15.25)	<0.001*	37.35 (13.14)	72.5 (13.14)	<0.01*	31.60 (13.14)	-3.3 (13.14)	<0.001#	31.17 (13.14)	-3.7 (13.01)	<0.01#	34.29 (13.01)	-0.6 (13.01)	0.08

\* Significantly higher than population mean

# Significantly lower than population mean

**Table 6.1 Comparison of mean scores of the study population and general population norms for PSS, CES-D and STAI over time**

## **Biostatistics**

Statistical analyses were performed using STATGRAPHICS® Sigma Express for Micro- soft Excel® (Statpoint Technologies, Inc, USA; [www.statgraphics.com](http://www.statgraphics.com)). Wilcoxon rank-sum tests were performed to determine the level of significance between the means of the subscales of the respective SAQ's. Kruskal–Wallis rank tests were used for determining differences in medians. The reference groups were derived from the original scale publications or from the most appropriate recent population data available online (Cohen and Janicki-Deverts 2012; Crawford et al. 2011; Radloff 1977; Spielberger 1983); *p*-values in Table 1 were obtained using the Wilcoxon signed-rank test; and for Table 2. Fischer's exact test was used after confirming equal variances.

Metrics	LTFU ( $n = 181$ )	CMPL ( $n = 0$ )	$p$ value
Comparison at baseline (S1)—mean ( $\pm$ SD)			
Age	43.0 ( $\pm$ 14.1)	43.8 ( $\pm$ 13.1)	0.767
Gender (male/female)	88/93	17/13	0.4373
N-RCOPE	16.42 ( $\pm$ 4.18)	17.33 ( $\pm$ 4.32)	0.258
BIPQ	41.91 ( $\pm$ 17.39)	44.43 ( $\pm$ 15.67)	0.457
PSS	23.24 ( $\pm$ 8.56)	21.4 ( $\pm$ 8.90)	0.28
CES-D	24.05 ( $\pm$ 15.66)	22.8 ( $\pm$ 17.82)	0.692
STAI-S	47.94 ( $\pm$ 16.66)	46.1 ( $\pm$ 17.27)	0.578
STAI-T	49.67 ( $\pm$ 15.16)	46.93 ( $\pm$ 16.24)	0.365
Comparison of changes S1 vs. S2 [mean (SD)]			
N-RCOPE	0.975 ( $\pm$ 3.61)	0.3 ( $\pm$ 3.075)	0.337
BIPQ	-13.37 ( $\pm$ 17.0)	-23.767 ( $\pm$ 17.9)	0.003*
PSS	-7.05 ( $\pm$ 8.5)	-8.6 ( $\pm$ 10.3)	0.376
CES-D	-10.66 ( $\pm$ 10.7)	-12.87 ( $\pm$ 12.64)	0.414
STAI-S	-14.31 ( $\pm$ 15.8)	-19.83 ( $\pm$ 16.6)	0.082
STAI-T	-9.82 ( $\pm$ 5.1)	-13.133 ( $\pm$ 14.10)	0.266

\* Significantly greater improvement in CMPL

**Table 6.2 Attrition analysis—comparison between those completing all 5 surveys (completers or CMPL;  $n = 30$ ) and those with less than 5 surveys (lost to follow-up or LTFU;  $n = 181$ )**

## Results

Of the 211 cases, 190 (90 %) attended the FBEP within 1 month and 134 (64 %) attended within 2 weeks (range 1–213 days), of completing S1. Compliance with the time-sensitive points for S2, S3 and S4 was excellent (see Fig. 6.5) with minor variability due to response time to the e-mail prompts. Personal qualitative telephone interviews were scheduled within 30 days of completing S4; none of the participants reported receiving any additional interventions of a medical, psychiatric, counselling or faith-based nature, other than routine follow-up and religious activities since attending the FBEP. Responses to specific introductory questions on S5 confirmed no additional interventions between S4 and S5.

Changes in the DUREL scale are depicted in Fig. 6.6: Because the FBEP included ORA, NORA and IR activities, changes between S1 and S2 would be expected to reflect the *content* of the FBEP program relative to the individual's baseline religiosity: There was no statistically significant change between median ORA scores at S1 vs. S4 ( $p = 0.06$ ) or S1 vs. S5 ( $p = 0.09$ ). Median and mean NORA scores did increase statistically between S1 vs. S3, S4 and S5 ( $p < 0.001$  for each, respectively), whereas S3, S4 and S5 did not differ statistically. Median and mean IR scores also increased significantly between S1 vs. S3, S4 and S5 ( $p < 0.001$ , respectively) without statistically significant differences between S3, S4 and S5.

The median N-RCOPE scores improved after the FBEP (see Fig. 6.7); differences between S1 vs. S2, S3, S4 were all significant ( $p < 0.0001$ , respectively); S3 was also statistically higher than S2 ( $p < 0.001$ ), whereas S3, S4 and S5 did not differ statistically from each other. Confidence intervals did not overlap between S1 and S2 and narrowed over 3 years, with homogenization of the group.

The CES-D changes are depicted in Fig. 6.8. The initial values showed a wide distribution from S2 onwards, with a homogenization of values; the changes were preserved over the remainder of the study period. The median and 95 % confidence intervals of S2, S3, S4 and S5 did not overlap with S1.

Based on epidemiological studies, CES-D scores were grouped as follows: low ( $<15$ ); mild-to-moderate depression (16–21); and possible major depressive illness ( $>21$ ) (Radloff 1977; Schein and Koenig 1997; Stansbury et al. 2006). Using these criteria, there was a significant redistribution of the possible major toward low-grade depression (see Fig. 6.9)

In these figures, the embedded tables show the application of a multiple comparison procedure to determine which means are significantly different from which others. The output shows the estimated difference between each pair of means. The *asterisk* indicates statistically significant differences at the 95.0 % confidence level ( $p < 0.0001$ ). The ratio between low-grade and major depression continued to improve between S1 vs. S3 ( $p < 0.0001$ ), and the relative proportions were maintained through S5. The BIPQ scores dropped significantly after the FBEP with a decrease in median and mean values between S1 vs. S2 ( $p < 0.0001$ ); a gradual homogenization of the population; and no statistically significant difference between S2, S3, S4 and S5. See Fig. 6.10.

Median and mean PSS scores also dropped with statistical significance between S1 vs. S2 ( $p < 0.0001$ ) and S2 vs. S3 ( $p < 0.001$ ) with no further significant changes from S3 through S5. See Fig. 6.11.

State Anxiety (STAI-S) median and mean scores showed a prompt drop at S2 ( $p < 0.0001$ ) and no further significant changes between S2 through S5—see Fig. 6.12.

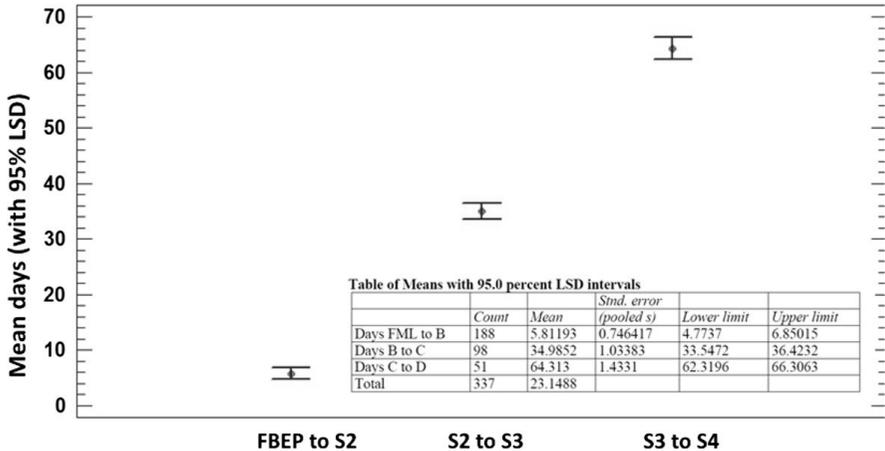


Figure 6.5 Period between FBEP and time-sensitive SAQ's (S2, S3 and S4)

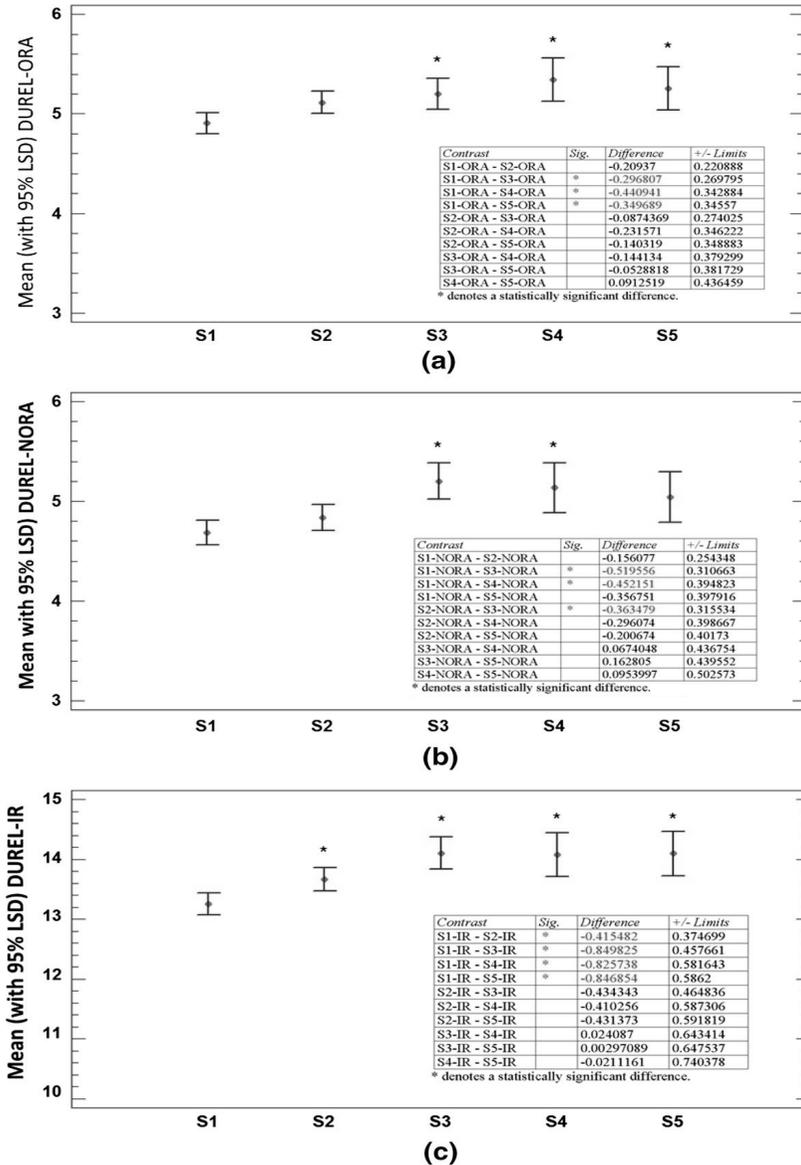


Figure 6.6 DUREL score changes over time. a. Organizational Religious Activity (ORA). b. Non-Organizational Religious Activity (NORA). c. Intrinsic Religiosity (IR).

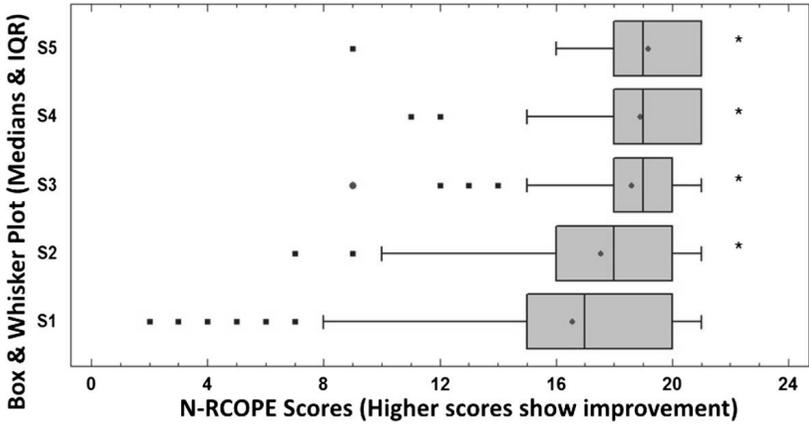


Figure 6.7 Negative RCOPE changes over time

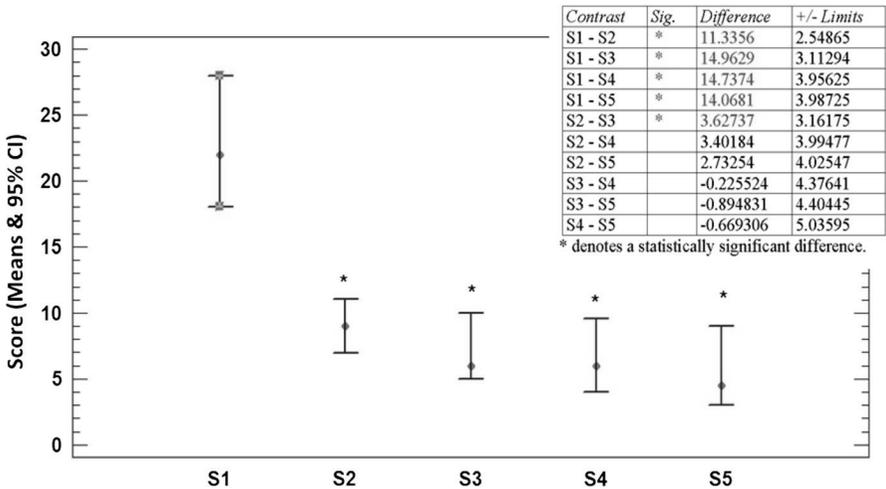


Figure 6.8 CES-D changes over time.

In this figure, the embedded table shows the application of a multiple comparison procedure to determine which means are significantly different from which others. The output shows the estimated difference between each pair of means. The *asterisk* indicates statistically significant differences at the 95.0 % confidence level.

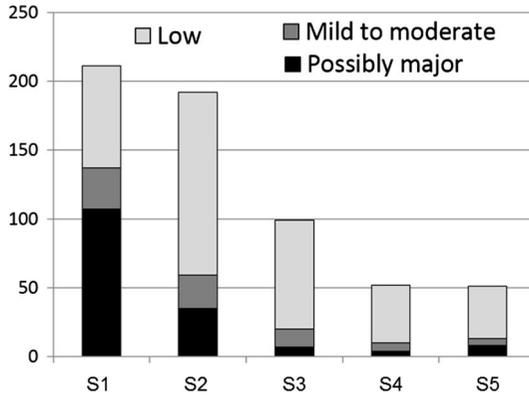


Figure 6.9 CES-D changes over time—by category.

The *bar graph* shows the CES-D scores for all cases grouped as low (<15); mild to moderate (15–21); and possibly major ([21) depression

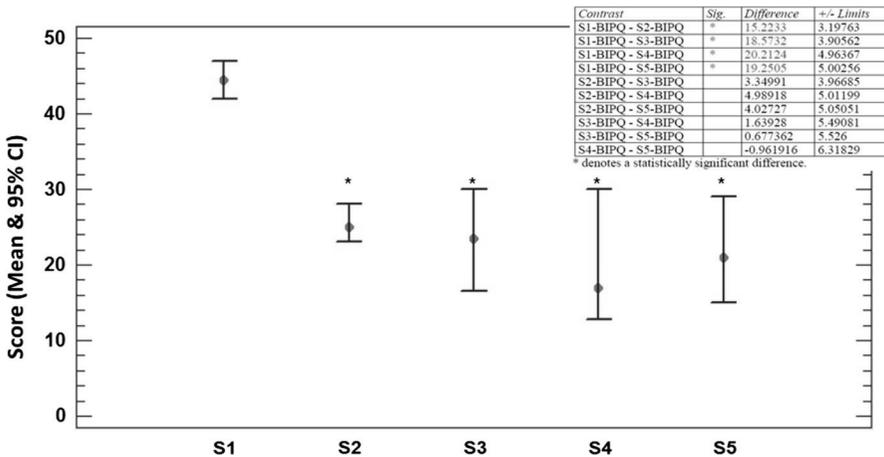


Figure 6.10 BIPQ changes over time.

In this figure, the embedded table shows the application of a multiple comparison procedure to determine which means are significantly different from which others. The output shows the estimated difference between each pair of means. The *asterisk* indicates statistically significant differences at the 95.0 % confidence level.

Lastly, as would be expected, STAI-T dropped more slowly than STAI-S; as such, significant statistical differences were recorded between median and mean values for S1 vs. S2 and between S2 and S3 ( $p < 0.002$ ). There was no statistical difference between S3, S4 and S5—see Fig. 6.12. The box and whisker plot shows a homogenization of the population—Fig. 6.13.

### Discussion

The vast majority (90 %) of the subjects attended the FBEP within a month of online registration. As such, the changes immediately following the program are more likely to be the result of the FBEP than a time-based deviation towards the mean. This is also supported by the fact that the measures did not revert to the baseline values over time.

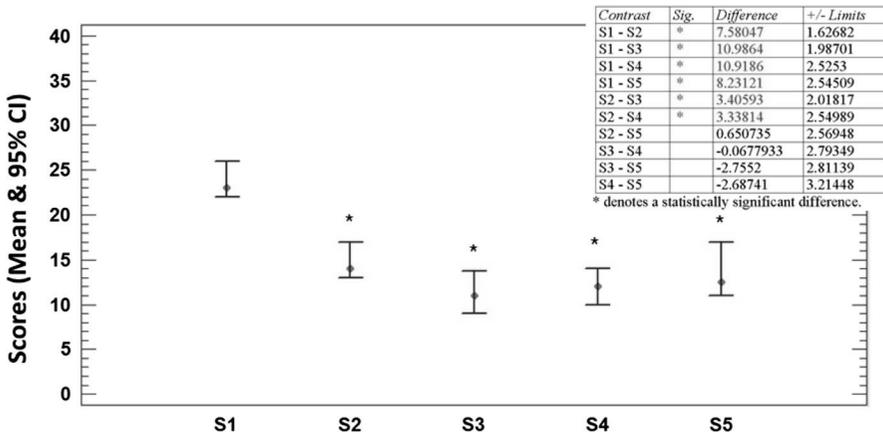


Figure 6.11 PSS changes over time.

In this figure, the embedded table shows the application of a multiple comparison procedure to determine which means are significantly different from which others. The output shows the estimated difference between each pair of means. The *asterisk* indicates statistically significant differences at the 95.0 % confidence level.

To reflect the changes in more absolute terms, the CES-D, PSS and STAI data from the sample were compared to population norms (see Table 1). The study population scored significantly *higher* at baseline (S1): PSS women & 1 SD, PSS men & 1.5 SD; CES-D & 1.5 SD; STAI-S women & 1.5 SD; STAI-S men & 1 SD; STAI-T women & 2 SD; and

STAI-T men & 1 SD. This suggests poorer mental health on entry into the study (Cohen and Janicki-Deverts 2012; Radloff 1977; Spielberger 1983). Immediately after the FBEP program, S2 scores were reduced by C1 SD on all scales. PSS and CES-D scores were now comparable with population means, whereas STAI-S scores were significantly below population means. STAI-T also underwent a highly significant change at S2, relative to S1, but was still significantly above population norms. By 90 days (S3) the STAI-T for males approached population norms; for women it was still slightly above normal mean scores.

The attrition analysis is shown in Table 2. When comparing those completing less than 5 surveys (lost to follow-up [LTFU]) vs. all 5 surveys (completers [CMPL]), no significant differences were found for age ( $p = 0.767$ ), gender ( $p = 0.437$ ), N-RCOPE ( $p = 0.258$ ), BIPQ ( $p = 0.258$ ), PSS ( $p = 0.28$ ), CES-D ( $p = 0.692$ ), STAI-S ( $p = 0.578$ ) or STAI-T ( $p = 0.365$ ).

Similarly, when comparing LTFU and CMPL according to recorded changes in scores between S1 and S2 (excluding DUREL—as explained previously), only the BIPQ changes were significantly different between the groups; this suggests that cases who experienced positive changes in BIPQ may have been more likely to complete all 5 surveys, whereas changes in the other measures were not significantly associated with attrition.

In general, the FBEP had a remarkably prompt, statistically and clinically significant ‘normalizing’ and homogenizing effect on the respective parameters by S2. Interestingly, by 30 days (S3), most of the scores were still decreasing from the S2 values with PSS, CES-D and STAI (men) reaching levels significantly below population means. The observed changes were largely maintained by 90 days (S4), with STAI (women) now approaching population means. After a year (S5), all mean scores had returned to population means which, as noted previously, were significantly different from S1 scores:

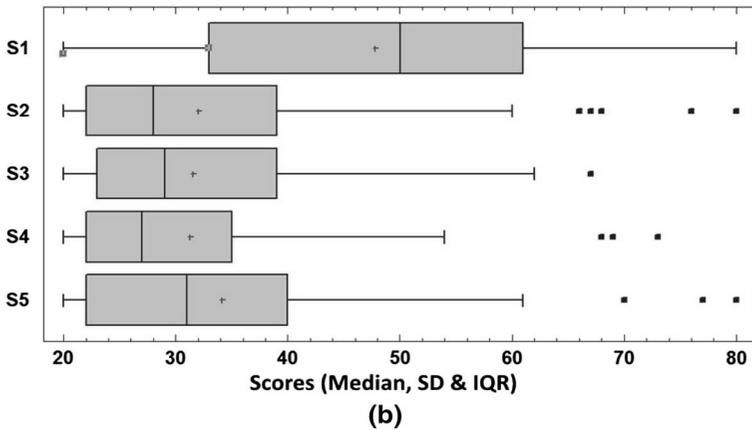
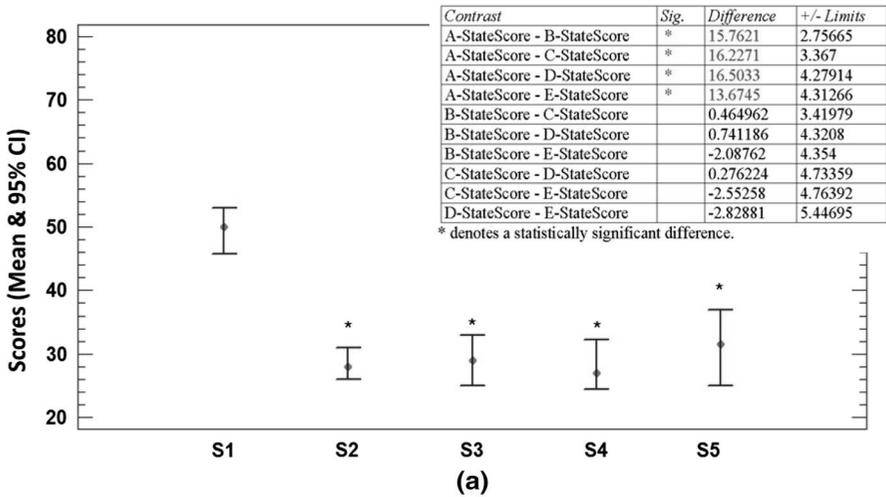


Figure 6.12 A STAI-S changes over time, b STAI-S changes over time.

In this figure, the embedded table shows the application of a multiple comparison procedure to determine which means are significantly different from which others. The output shows the estimated difference between each pair of means. The *asterisk* indicates statistically significant differences at the 95.0 % confidence level.

For each index, the difference was &1 SD below the baseline scores and on par with the general population. Thus, the FBEP appeared to

improve the study population's mental health parameters (as measured by these scales and compared to population norms), and this continued to improve in the period of follow-up after the program and was maintained for >1 year.

It is important to state that not everybody benefited equally from program. However: When reviewing the 211 individual scores, some individuals experienced an initial increase in scores (i.e., defined as any increase in score, irrespective of magnitude) between S1 and S2 for N-RCOPE ( $n = 81$ ; 38 %); BIPQ ( $n = 34$ ; 16 %); PSS ( $n = 34$ ; 16 %); CES-D ( $n = 33$ ; 16 %); STAI-S ( $n = 24$ ; 11 %) and STAI-T ( $n = 40$ ; 19 %).

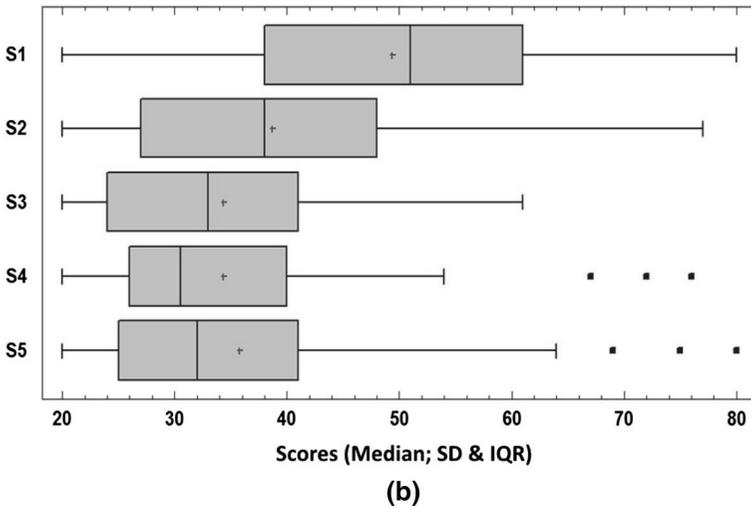
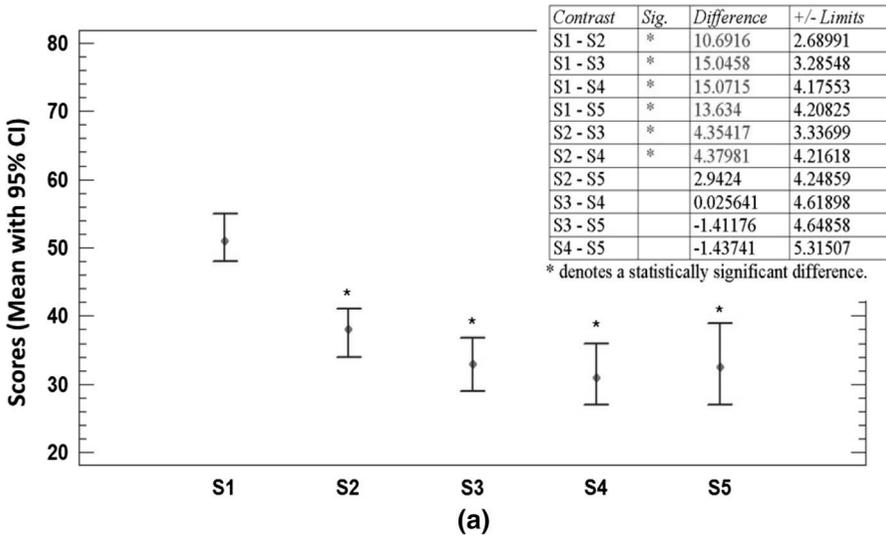


Figure 6.13 a STAI-T changes over time, b STAI-T changes over time

In this figure, the embedded table shows the application of a multiple comparison procedure to determine which means are significantly different from which others. The output shows the estimated difference

between each pair of means. The *asterisk* indicates statistically significant differences at the 95.0 % confidence level.

However, the vast majority of these were minor increases. The majority of the participants followed the general trend of significantly lowered scores or improved significantly by S3.

The FBEP improved N-RCOPE scores significantly, suggesting a more constructive religious perspective on the circumstances or the condition that brought participants to the FBEP. The DUREL Extrinsic Religiosity scores were not affected over time, whereas IR scores—which correlate more closely with better health outcomes—did show a significant increase from baseline.

### Limitations

As is not unusual for these studies, there was a 75 % attrition over the full study period. With 92 % completing S2, however, the evidence supporting the initial impact of the FBEP is strong. The evidence for enduring effects is weakened by the attrition over time, although those who completed all 5 surveys (CMPL) did show lasting changes. The attrition analysis did show that, with the exception of BIPQ changes from S1 to S2, the LTFU and CMPL groups did not differ significantly from each other (Table 2). However, it is obviously impossible to determine whether the LTFU group ( $n = 181$ ) retained the recorded changes through to S5, even though some did complete S3 ( $n = 69$ ; 38 %) and S4 ( $n = 22$ ; 12 %), respectively, and changes in their respective scores were maintained until their last completed survey.

It is unfortunate that the small number of female-only controls at S5 did not allow for a meaningful case-control analysis. Comparisons between cases and controls at S1 did not show any significant differences, however.

In addition, all the general strengths and weaknesses inherent to SAQ's in assessing health status apply to this study (Smith and Goldman 2011) and specifically for each of the respective SAQ scales employed (Bergua et al. 2012; Broadbent et al. 2006; Choi et al. 2014; Cohen 1983; Cohen et al. 1995; Koenig and Büssing 2010; Kvaal et al. 2005; Leventhal 1984; Oei et al. 1990; Pargament et al. 2000, 2011; Radloff 1977; Schein and Koenig 1997; Tenenbaum et al. 1985).

The following potential biases were also identified, assessed and mitigated where possible:

*Volunteer bias:* For various reasons, persons who chose to enroll for the FBEP may have differed from general population, thereby limiting

the extent to which the data can be extrapolated. Reassuringly, baseline SAQ data showed significant heterogeneity, whereas demographic data analysis reflected a near-normal distribution by age and gender.

*Self-selection bias:* Persons opting to complete the survey may have differed from those who chose not to. However, after the a priori exclusion of underage and previously exposed individuals, only 21 % opted out of the study. As such, the study was able to capture 79 % of the eligible participants during the study period.

*Computer-literacy bias:* Thirty-seven percent of the subjects enrolling for the study failed to complete and submit the first SAQ successfully. Recent polls state that more than 50 % of US citizens above the age of 65 years use the internet regularly, whereas more than 75 % under 65 years do. Moreover, it is normative for approximately 97 % of all regular program registrations for the FBEP to be received online. We were therefore surprised by the relatively high “failure” rate; a bias toward higher levels of computer literacy cannot be excluded.

*Language bias:* For practical reasons, and to ensure validity of the SAQ’s, the study was limited to subjects with English language proficiency. As such, the results cannot be generalized to non-English-speaking subjects.

*Vested interest bias:* The primary investigator, co-investigator and two other co-authors had neither organizational affiliations to Be in Health Inc., nor any vested interests in the outcome of the study. However, by practical necessity, the on-site Research Coordinator and an administrative assistant were employees of Be in Health Inc. at the time of the study. As such, every effort was made to minimize vested interest bias by limiting personal interactions with subjects to the initial, brief and carefully scripted on-site interview by the Research Coordinator and by providing online access for direct entry of data by subjects. Further measures included: blinding of the teachers and staff of the FBEP to avoid any differential attention being given to the study participants; limiting all communication to generic, electronic and merely instructional media; and forwarding any program-related enquiries from the participants directly to the Program Director without any interaction, or revealing their participation in the study.

*Religious bias:* The FBEP is explicitly Christian in its religious orientation. Gallup polls indicate that 77 % of US citizens identify as Christian (Newport 2012). Nevertheless, the program is more likely to attract individuals with higher levels of F–R–S, and this probability is supported by the participants’ high DUREL scores. Accordingly, the

response to the program should not be extrapolated to individuals with low levels of religiosity or to other persuasions of faith.

## Conclusion

This study is important because it is a *prospective intervention study*. Conceptually, the FBEP represents, as a standardized, short-term, intensive exposure, what might otherwise be addressed within a conventional Faith-Based Community context by means of deliberate and specific emphasis on health and disease, emotional awareness and well-being, relational competence, social support, and trauma- and health-oriented counselling and prayer.

The findings of this study support the conclusion that attendance of this FBEP is associated with prompt, mostly positive, and statistically and clinically significant changes on the assessed spiritual, mental and physical health parameters, within a self-selected group of participants, who were eligible, able and willing to complete all the surveys. For them the changes also appeared to last over the full study period; only limited conclusions are possible for those who did not.

Further analyses are planned to evaluate the differential impact on the various SAQ parameters; to perform projected calculations of lowered morbidity and mortality as a result of the observed changes; and to explore mechanisms for the observed changes. The findings also support the conclusion that self-selected individuals attending the FBEP are more likely to benefit than to be harmed by doing so.

The authors hope that this work will encourage more intervention studies of this nature.

Source of Funding: None. However, two co-authors are employees of Be in Health Inc. Thomaston, GA, USA.

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# RESPONSIBLE WHOLENESS IN HEALTHCARE: A SOCIAL WORK CONTRIBUTION TO GUIDE SPIRITUAL SUPPORT TO HEALTHCARE SERVICE USERS<sup>1</sup>

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## **Abstract**

Healthcare represents environments of healing, dying and rehabilitation. Psychosocial and biopsychosocial theory forms part of whole-person approaches to healthcare, and various authors further suggest the inclusion of spirituality in healthcare provision. There is, however, a lack of scientific knowledge of professionals' understanding of spirituality and its praxis. The discipline of social work can significantly contribute to whole-person care provision.

The aim of this paper is to explore the various models informing social work on whole-person care and to focus on the role that social workers can play as part of the multi-professional team. The implications for further research and practice are explored.

## **Keywords**

Spirituality; healthcare; psychosocial; biopsychosocial; inter-disciplinary; social work; whole-person; spiritual support; healthcare service users

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<sup>1</sup>Based on doctoral work in progress: "Developing Guidelines for Social Workers and other Care Providers to Render Spiritual Support to Healthcare Service Users."

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## Introduction

Life experiences consist of both pleasurable moments and stressors such as crisis, disease, healing, dying and rehabilitation. Homeostatic regulation and behavioural responses serve as adaptive natural mechanisms and the human organism presents its own “wisdoms” which aim to preserve the person as a whole (Cacioppo and Freberg 2016, 567, 620; Kent, Rivers, and Wrenn 2015, 265). When their survival is threatened people engage in physical and psychological goal-directed behaviours, and some of these strategies could present as unproductive behavioural tendencies (Dickinson and Balleine 1994, 1–18; Kent et al. 2015, 264–304). Goal-directed survival strategies are compromised by symptoms of physiological and psychological responses which could contribute to mental health issues or general health complications (Olf et al. 2014, 114–121).

Life stressors affect people on biological, psychological and social levels; the person’s environment, mind and body are interconnected, and pain in one dimension could result in physical or mental health complications in the others (Cacioppo and Freberg 2016, 620–622, 629–632). The person as a whole responds to crisis. In healthcare environments, people in crisis “become a diagnosis,” and this focus on diagnosis leaves little room for whole-person needs (Ayinde 2013, 114; Puchalski et al. 2014, 650). Service users often present with the need to seek answers to questions complicated by biological, psychological, socio-cultural and existential dimensions (Puchalski et al. 2014, 642–656).

Religion and spirituality are not similar concepts, but people consider both to be important, and both should be sensitively appreciated by healthcare practitioners, as both construct a sense of well-being, purpose and meaning (Puchalski and Ferrell 2010, 22). When existential meaning and purpose are being sought, spirituality presents with potential for meaning construction as a conscious activity “in the project of life-integration through self-transcendence toward the ultimate value one perceives” (Koenig 2014, 1162,1163). Spirituality could be understood as a human effort to make sense of the self, others and the world, and which also leads to experiences of awe and wonder (Waaijman 2002, 59).

The doctoral work in progress seeks to understand spirituality in relation to the healthcare environment as experienced and described by healthcare professionals and other care providers. The authors are of the opinion that social work seeks to satisfy whole-person needs through the levels of intervention as well as through the theoretical approaches informing practice.

## **Psychosocial and Biopsychosocial Approaches and the Inclusion of Spirituality**

Health is a state of “complete physical, mental and social wellbeing,” and not simply the absence of frailty, illness, a medical condition or pathology (World Health Organization (WHO) 2003, para.1). Mental health is the condition of accepted psychological well-being and, in this light, whole-person approaches to mental health aim to facilitate the well-being of the biological, psychological and social person (American Psychiatric Association (APA) 2013, 20; Cacioppo and Freberg 2016, 639, 640).

In environments of healing, dying and rehabilitation, relationships between the mind and body exist; multi-dimensional aspects such as psychotherapy, social connectedness, spirituality and religious activities contribute to improved well-being (Cacioppo and Freberg 2016, 635, 636; Dezutter et al. 2008, 74–90).

Psychosocial approaches and theory are closely linked with the human potential and ecological systems perspectives and provide a theoretical context for mental healthcare provision (Rogers 1942; Teater 2010, 6). Erik Erikson introduced psychosocial theory, describing human development as a sequence of stages where unique challenges or crises need to be resolved, and his theory aims to provide explanations concerning the essence of personality development (Louw and Louw 2014, 22, 23). Psychosocial approaches aim to comprehend the person as a whole being; the person is seen as the result of interaction between the social and psychological person. People often present with lifestyle, physical and psychosocial difficulties associated with chronic diagnosis, and service users report the need for social and emotional support in treatment programmes (Willems et al. 2015, 1, 2).

Psychosocial approaches would consider socio-cultural and historical aspects to be of importance, and also take the relationships with self, environment and significant others – as well as the outcomes of these relationships – into account (Fioritti, Peloso, and Percudani 2016, 51,52,57; Rogers 1951, 486, 497, 498; Teater 2010, 6). Persons receiving a chronic diagnosis regularly present with fatigue, fear of reoccurrence, depression and anxiety, together with unemployment, sexual dysfunction and limited cognition. Adherence to treatment, diagnosis acceptance and adaption is successfully managed through psychosocial approaches that deal with whole-person reactions to disease (Willems et al. 2015, 1, 2). Sensitivity to psychological, physical, historical, socio-cultural and developmental needs requires adaption of interventions according to the person’s changing needs (Ayinde 2013, 133). Psychosocial facilitation

contributes positively to personality development, even in the presence of physical disability (Ayinde 2013, 107).

Humanistic psychology best responds to providing the ideal conditions within a psychosocial framework for personal growth (Ayinde 2013, 114, 133). Interventions become a collaborative effort and entail tailored person-centred need assessment, clear problem identification and outcome evaluation (Coulter, Roberts, and Dixon 2013, 6, 14; Willems et al. 2015, 2–6). Psychosocial interventions are multi-disciplinary in providing whole-person care; they embrace a positive view of human beings as having the potential to strive towards becoming fully functional and to grow in a self-actualising direction (Cacioppo and Freberg 2016, 595; Rogers 1951, 488).

Biopsychosocial approaches combine elements of psychosocial and medical therapies to deal with the biological, psychological and social dimensions of a person. The origins of the biopsychosocial approach can be traced back to the works of psychiatrists Adolf Meyer (1952), George Engel (1977, 1980) and others who aimed to develop novel medical interventions (Pilgrim 2015, 168). Engel and early theorists argued that biological, psychological and social processes are responsible for certain states of health (Pilgrim 2015, 166–170). Medical students specialising in psychiatry are trained from the perspective of Engel's biopsychosocial model of assessment and care provision, and psychiatry has a long history of being practised within the multi-professional team consisting of social workers, nursing professionals, occupational therapists and psychologists (Janse van Rensburg et al. 2014, 40).

Biopsychosocial understandings provide explanations of the emergence of disease and health, but should guard against bio-medical reductionism to diagnosis and medicalisation (Pilgrim 2015, 164). To guard against medicalisation or diagnosis and symptomatic focused treatments, the uniqueness and individualism of the person is the focus in a whole-person approach (Cacioppo and Freberg 2016, 595; Coulter et al. 2013, 8, 9; Kent et al. 2015, 273). Biopsychosocial theory aims to bridge gaps that might exist between biological, psychological and socio-cultural sources that contribute to whole-person well-being (Kent et al. 2015, 264; Rodgers, Paxton, and McLean 2014, 816, 820).

Recent biopsychosocial interventions include resilience and mindfulness training, behavioural, cognitive and humanistic therapies to facilitate diagnosis acceptance, activation of therapy and commitment to treatment (Kent et al. 2015, 273). Improved resilience, self-regulation, cognitive functioning and personal growth are reported as productive outcomes for persons living with chronic pain and mental health

complications (Kent et al. 2015, 264). For this reason, the importance of biological and psychosocial variables contributes significantly in prevention, intervention and adherence programmes (Rodgers et al. 2014, 823).

Human beings react constantly to the environment and to their experiences. Biopsychosocial approaches are therefore interested in the relationship between cognitive, emotional, socio-cultural and environmental effects on the physiology of the person (Rith-Najarian et al. 2014, 194, 195, 196). A biopsychosocial approach views health as the outcome of the interaction between the environment and both the psychosocial and biological person, and is aimed at disease prevention, enhanced recovery and strategies for coping with biological and psychosocial pain, chronic conditions and adjustment (Cacioppo and Freberg 2016, 639, 640; Coulter et al. 2013, 1, 8, 9, 14).

Human developmental stages are also recognised by significant neurological, cognitive, physiological and environmental changes and adjustments. At times, these changes present as life stressors resulting in medical diagnosis (Rith-Najarian et al. 2014, 193). Diagnosis, statistical analysis, medical intervention, psychosocial counselling and patient education are directed towards whole-person care (Valenzuela-Pascual et al. 2015, 1). Biopsychosocial treatment is a mixed-method approach that deals with physical and psychological pain, dysfunction and cognitions and aims to restore whole-person functionality (Rith-Najarian et al. 2014, 194–196; Valenzuela-Pascual et al. 2015, 1–9).

The inclusion of spirituality in the biopsychosocial approach (“biopsychosocial-spiritual”) that recognises human spirituality is advocated by authors (Anye et al. 2013, 414–421; Puchalski and Ferrell 2010, 22). Spirituality implies a lived experience that is reality to the person as perceived, a conscious and ongoing approach to life; instead of connecting with an external almighty power, people are searching for some internalised connection between themselves and the divine (De Jager Meezenbroek et al. 2012, 388). Spirituality could be broadly described as a person’s striving and experience of a connectedness with oneself, others, nature and the transcendent (De Jager Meezenbroek et al. 2012, 388).

Spirituality cannot be ignored, as it forms part of the human developmental cycle, behaviours, universal values and social contexts; spirituality is often associated with positive mental health outcomes and, further, provides emotional protection against life’s stressors (Louw and Louw 2014, 10, 32, 294). Within whole-person approaches, all dimensions of the service user’s life are of importance, including knowledge of a service user’s spiritual needs (Hunt 2014, 375; Nkomo 2013, 4).

Considerable research is currently being done with regard to spiritual care in healthcare; it is universally acknowledged that people reach towards religious practices and spiritual teachings when confronted with life stressors, disease, healing, dying or rehabilitation (Abu-Raiya and Pargament 2015, 24–32; Ganga and Kutty 2013, 442).

However, the study of spirituality in healthcare seems to be relatively new in South Africa. A study among hospice workers in KwaZulu-Natal found that patients and nursing staff considered spirituality to be relevant in healthcare, and that spirituality involves a strong existential factor for nursing staff. Further, it indicated the benefits of advanced training in spirituality in healthcare (Maharaj 2006, iv, 43, 67). Exploring the concept of spirituality at Chris Hani Baragwanath Hospital, Nkomo (2013, 83) indicated that people present the need to be fully understood. This would include the understanding of their spirituality and relevant socio-cultural systems.

Some South African psychiatrists view the process of developing an appropriate norm for the inclusion of spirituality in healthcare as a relationship that requires formalisation between healthcare professionals and different spiritual, cultural or religious practitioners, and this formalised relationship still has to undertake a developmental journey (Janse van Rensburg et al. 2014, 40–45). In South African hospitals, pastoral care is usually provided by ministers of religion and volunteers. However, the role of the clergy in healthcare seems to be controversial, as pastors' practices are often founded on personal experience and charismatic teaching (Martin 2013, 6). It can be argued that spiritual support should be provided by healthcare personnel who are not working from any particular religious frame of reference. Ideally, services in healthcare environments should be rendered by regulated and trained personnel who advocate social justice for service users.

## **Research and Practice**

As interest in spirituality is increasing, the medical sector suggests that scholars investigate the inclusion of spirituality in healthcare provision (Puchalski, Dorff, and Hendi 2004, 690–710). Systematic intra-professional theoretical communication, education and its praxis will support comprehensive whole-person healthcare (Baldacchino 2015, 594). Future research should inform the advancement of healthcare provision and neutralise professional biases towards the existential and spiritual needs of service users (Baumann and Pajonk 2014, 873; Eunmi, Zahn, and Baumann 2015, 930). An inter-disciplinary understanding would ensure

“anthropological, bodily and material character” in understanding spirituality (Kourie and Ruthenberg 2008, 310).

Healthcare practitioners need to provide evidence-based practice that supports the all-inclusive psychosocial and spiritual needs of service users (Sulmasy in Puchalski and Ferrell 2010, 6, 12). The multi-dimensionality of the person should be approached through cooperation between professions and disciplines (Landman 2009, 6). Social work acknowledges the link between spirituality and mental, relational and physical health, and therefore social workers should be theoretically equipped in spiritual support provision (Baldacchino 2015, 594; Hunt 2014, 374–380; Phillips 2014, 65–74).

## **Social Work**

Social workers as professionals efficiently assist healthcare service users and their relevant systems, as they are positioned at the frontline of healthcare and are theoretically equipped to contribute to whole-person care policy, identify service user-focused needs and participate in healthcare review teams (Liechty 2013, 123, 130, 143; International Federation of Social Workers (IFSW) 2014). Social workers centre attention on service users’ psychosocial needs and form part of the multi-disciplinary team of mental health practitioners (Bailey and Liyanage 2012, 1121; Frauenholtz 2014, 158; Mental Health Care Act 17 of 2002 in South Africa 2016, 6, 7). Insights from the discipline’s conceptual models, value-oriented perspective, theory and language advocate whole-person care, and social work constructs the bridge between psychosocial and medicalised diagnosis-focused healthcare (Allen 2012, 183–185).

In South Africa, social work is understood as a “practice-based profession and an academic discipline that promotes social change and development, social cohesion and the empowerment and liberation of people underpinned by theories of social work, social sciences, humanities and indigenous knowledge” (South Africa 2016, 7). With the anticipated focus on the specialisation of clinical social work, a clinical social worker would be a registered professional and specialist with sophisticated therapeutic proficiency to intervene in psychosocial, psychiatric, health, mental health and other life challenges (South Africa 2016, 6).

Although the literature advocates the utilisation of spiritual care by social workers, there is some difficulty in defining spirituality in relation to the profession (Senreich 2013, 548–563). Social work needs to formulate a generative theory of spirituality that will inform the discipline and its praxis on the incorporation of spirituality in clinical approaches

(Baldacchino 2015, 594; Liechty 2013, 140). Consensus on the inclusion of spirituality in healthcare would be beneficial because practitioners are often willing to integrate spirituality in interventions, but fear ethical dilemmas and report a lack of theoretical knowledge and clinical confidence (Furness and Gilligan 2014, 763, 778; Phillips 2014, 69). There is a need to prepare mental health and healthcare professionals to acknowledge human spirituality in healthcare interventions (Allen 2012, 183–185; Landman 2009, 6; Nkomo 2013, 3).

## **Implications for Further Research and Inter-professional Practice**

Inter-professional education on whole-person approaches will promote all-embracing care provision, and improved treatment interventions will result from biopsychosocial and spiritual understandings (Cheawchanwattana et al. 2015, 14; Koenig 2014, 1161, 1171; Rith-Najarian et al. 2014, 194, 195, 196). Understanding is needed to inform an emerging body of knowledge and practice to provide whole-person healthcare inclusive of spiritual support (Wood and Ross-Kerr 2010, 1).

The changing psychological, social and cultural environments provide the opportunity for social work to reformulate its role in healthcare (Gass and Bezold 2013, 686–690; Rubin and Babbie 2011, 55, 8). Scientifically generated knowledge would ensure unique educational progress and enhance evidence-based praxis of social work (Barker and Fioersch 2010, 359; Furness and Gilligan 2014, 763).

The South African healthcare landscape consists of a colourful range of differing discourses. These internalised frames of reference are in interaction with psychosocial, medical and biochemical practices and, accordingly, healthcare service users' internal worlds should be empathetically understood by healthcare providers (Landman 2009, 3). Such an understanding will facilitate the provision of comprehensive person-centred care and provide guidelines for future development.

It is against this background that the doctoral study in progress focuses on the lack of research-based knowledge of social workers' and other care providers' understanding of spirituality and how to render appropriate spiritual support as part of whole-person healthcare. In order to answer the research question: *What would guidelines for the training of social workers and other care providers, with regards to rendering spiritual support as part of whole-person care to healthcare service users, comprise?* a qualitative research approach and an explorative, descriptive, contextual and phenomenological research design will be undertaken.

## Research in Progress

Various research sites serving as representative environments of *healing, dying and rehabilitation* were chosen as part of the population:

- Home nursing and care providers: Registered nurses and pastoral counsellors render services in environments of dying.
- Brain injury rehabilitation: Social workers, and occupational and speech therapists assist people with brain injuries and their significant others in an environment of healing and rehabilitation.
- Treatment centres for substance dependence: General medical practitioners, psychiatrists, registered nurses, psychologists, social workers, occupational therapists and pastoral consultants function within environments of healing and rehabilitation.
- Counselling and pastoral care service providers in public healthcare: Ministers of religion, psychology students, social workers and volunteers work in environments of healing, dying and rehabilitation.
- Community-based trauma support organisations: Volunteers provide victim empowerment services as well as emotional support to emergency services personnel and hospitalised persons; they function within environments of trauma, healing and dying.

Purposive sampling will be utilised, drawing a sample of registered professionals, including social workers employed in healthcare as well as volunteers and ministers of religion rendering services at a registered facility as determined by the population of this study.

Face-to-face interviews, guided by a semi-structured interview guide, will serve as the method of data collection. Interpretive data analysis will be implemented and data will be verified through the use of Guba's model of data verification (Lietz and Zayas 2010). Ethical considerations: *obtaining informed consent, treating the information confidentially and managing information in a responsible manner* will be considered (Silverman 2011, 418).

## Conclusion

The authors presented psychosocial and biopsychosocial theory as part of whole-person approaches and further considered the inclusion of spirituality in healthcare provision. Improved psychological and physical

well-being with the inclusion of spirituality in healthcare is evident. There is, however, a lack of scientific knowledge on the understanding of spirituality in healthcare practices. The risk of not understanding the human construct in totality could result in partial treatment or interventions, unscientific practice that is not evidence-based, unprofessional conduct and malpractice (Allen 2012, 183; Gass and Bezold 2013, 285). Further understanding will inform an emerging body of knowledge on theory and praxis of whole-person interventions (Wood and Ross-Kerr 2010, 1).

Social work research informs practice on the micro, meso and macro levels to improve interventions through scientific findings and recommendations (Furness and Gilligan 2014, 763–778; Rubin and Babbie 2011, 6–8, 55, 56). Social work could significantly formulate clinical definitions and contribute to inter-disciplinary communication on human spirituality in healthcare provision (Allen 2012, 183–185; Liechty 2013, 123, 130, 143). The discipline needs to be anticipatory in training practitioners to engage with matters such as human spirituality; education on spirituality is essential for ethical, respectful and comprehensive training for practice (Furness and Gilligan 2014, 763, 778; Hunt 2014, 376).

Understanding human spirituality and spiritual support in healthcare environments will inform the social work discipline, other care providers and practice. Through intra- and inter-disciplinary communication, the researcher aspires to inform practice and education on ethically responsible healthcare provision within the environments of healing, dying and rehabilitation, where spirituality is included in treatment approaches.

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# THE SPIRITUAL JOURNEYS OF A GROUP OF HEALTHCARE PROFESSIONALS AT A SOUTH AFRICAN PROVINCIAL HOSPITAL<sup>1</sup>

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## Abstract

Individual enactments of the concept of spirituality vary widely. For some, spirituality is about participating in organised religion, for instance by going to a church, synagogue or mosque. For others it is a more personal experience that entails private prayer, yoga, meditation, quiet reflection, or even long walks. This paper reports and discusses some of the findings from a broader study, entitled “An Exploration of Understandings of Spirituality among Patients and Staff at the Chris Hani Baragwanath Hospital.” A total of 48 respondents, representing various healthcare professions, participated in the part of the qualitative study presented in this paper. Data were collected from discussions in focus group interviews and from participants’ drawings of their spiritual life journeys. Thematic content analysis revealed the following themes: spiritual beliefs, spiritual role models, spiritual rituals, activities and spiritual choices; life experiences; and coping mechanisms in the work environment. A key finding is that healthcare professionals experience their spirituality as a

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<sup>1</sup> This paper is based on my PhD in Social Work titled “An Exploration of Understandings of Spirituality among Patients and Staff at the Chris Hani Baragwanath Hospital”, which was awarded in 2014.

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source of support and as an aid to coping with the challenges of daily and work life.

## **Keywords**

Spiritual journey; healthcare professionals; spiritual beliefs; life experiences

## **Introduction**

The spiritual domain is an important but relatively unexplored area in most helping professions on the African continent. However, social work academics have recently shown increasing interest in this area of religion and spirituality. Asher (2001) suggests that the main reason for this sudden surge of interest in spirituality may be that the demands of modern African society are psychologically and emotionally overwhelming. The presence of religion and/or spirituality is widespread, and is one of the longest-standing phenomena known to humankind (Berry and York 2011). From a more analytic perspective, it can be argued that religion and spirituality have featured prominently in human history and that in nearly all societies they have played a significant role in human life since the beginning of time. Consequently, they have featured in literature related to mental health (Ameling and Povilonis 2001; Hill and Pargament 2003), psychotherapy Peres, Simao, and Nasello 2007; Breitbart et al. 2004), and nursing and social work (Canada 1999; Sheridan 2010; Asher 2001; Berry and York 2011). There can be no doubt that the religious and spiritual discourse of social work is well researched and acknowledged in other countries such as the United States (McClain, Rosenfield, and Breitbart 2003; Sheridan 2010), New Zealand (Phillips 2010; Baskin 2002; Beatch and Stewart 2002; Potahu 2003) and Canada (Coates et al. 2007). It nevertheless remains an underexplored area in South Africa. The body of social work literature in South Africa is vast, and much of it focuses on social security, social development and social work education; however, little has been written about social work, religion and spirituality. Sheridan (2002) states that social work services that incorporate spirituality and religion may help clients deal with a sense of alienation, hopelessness, grief and a range of other issues. The existence of centres of social work and spirituality, and journals dedicated to religion and spirituality in European and American countries has inspired me to seek a platform to highlight the importance of a spiritual journey in human life.

## **Conceptualising Spirituality and Religion**

In the healthcare literature, the terms “religion” and “spirituality” are usually used interchangeably, although they have quite different meanings (Miller and Thoresen 2003, 27). Miller and Thoresen, as well as Pesut et al. (2008, 8) define spirituality in terms of individual experiences involving meaning, connectedness, and transcendence; however, they define religion in communal terms, the key characteristics being institutionalised practices and beliefs, membership and modes of organisation. Thus, for these authors, spirituality is understood as being at the level of the individual, with religion being more of a social phenomenon. However, religion can also be conceptualised as an individual phenomenon, characterised by the adherence by an individual to specific beliefs and practices (Miller and Thoresen 2003). This latter conceptualisation of religion enables further distinctions to be made relating to an individual’s beliefs and practices – for example, unspiritual religiousness (e.g., observing some practices for the social benefits), or unreligious spirituality (e.g., mystical experiences without a religious context). Of course, a definition of spirituality and religion has to be broad enough to include all individuals and be applicable to all religious denominations (Miller and Thoresen 2003): Puchalski et al. (2014) define religion as an expression of spirituality for individuals. Therefore, in this paper, spirituality is taken to signify the universal aspect of human existence, a search for meaning and purpose, and the striving towards fulfilling relationships and connections with other people and a higher power.

## **Research Question and Goal**

A research question is often used to focus exploratory studies, as it refers to the problem that is to be investigated (Babbie 2007, 88–89). The study was guided by the following research question: “What are the spiritual journeys of a group of healthcare professionals in a South African provincial hospital?”; the goal of the study was therefore to explore the spiritual journeys of a group of healthcare professionals in a South African provincial hospital. Religion and spirituality play a crucial role in social work practice and in the lives of people, and healthcare practitioners are encouraged to be religiously and spiritually sensitive when executing their duties. Much has been written by historians, religionists, missionaries and anthropologists about the role of African traditional religion and spirituality Mpofo 2001; Shizha and Charema 2012; Shoko and Burck

2010; Machinga 2011; Kazembe 2009; Chavunduka 2001; Gelfand et al. 1985), but little is known about it from a social work perspective. Despite the importance of aspects of religion and spirituality such as resilience and meditation in social work practice, this is an area which has received little research attention, and South Africa is still behind when it comes to critical studies of the religious and spiritual discourse of social work. This gap makes the present paper important, in that it seeks to consider some of the issues by providing empirical evidence relating to the spiritual journeys of a group of healthcare professionals at a South African provincial hospital, in that way enabling social workers and other healthcare professionals to find ways of incorporating religious and spiritual aspects in their practice. This paper will, therefore, contribute to the foundation for spirituality and social work research and education in South Africa.

### **Research Methodology**

According to Greenstein, Roberts, and Sitas (2003, 3), qualitative research is a broad approach in social research that is based on the need to understand human and social interaction from the perspective of insiders and participants in the interaction. An exploratory research design was adopted for the study reported on in this paper. The exploratory research design does not aim to provide final and conclusive answers to the research questions, but rather explores the research topic in varying levels of depth (Reiter 2013). It has been noted that exploratory research is the initial research, which forms the basis of more conclusive research. It can even help in determining the research design, sampling and data collection methods. Exploration demands more from the researcher than confirmatory research, in terms of both preparation and willingness and ability to expose oneself to foreign cultures and languages, as well as the courage to engage in critical and honest self-reflection and critique (Reiter 2013). Exploratory research is used when the topic or issue is new and when data is difficult to collect. Exploratory research is flexible and can be used to seek answers to research questions of all types (what, why, how).

Purposive sampling enabled me to explore the spiritual journeys of a group of healthcare professionals in a South African provincial hospital (Babbie 2007, 184). The sampling process had inclusion and exclusion criteria: included were 24 participants (which included social workers, nurses, speech therapists and physiotherapists) at the Chris Hani Baragwanath Academic Hospital (CHBAH). The healthcare professional experience in the outpatient department of the participants ranged from

junior to managerial and all had worked at CHBAH for more than two years. Healthcare professionals who worked exclusively in inpatient wards were excluded.

<b>Groups of respondents</b>	<b>Designation</b>	<b>Total number of respondents</b>
<b>Nursing personnel</b>	Nursing manager Professional nurses Nursing auxiliary Enrolled nurses Student nurses	<b>12</b>
<b>Social workers</b>	Social work manager Grade 3 social workers Grade 2 social workers Grade 1 social workers	<b>16</b>
<b>Physiotherapists</b>	Physiotherapist intern Senior physiotherapist Chief physiotherapist Junior physiotherapist	<b>10</b>
<b>Occupational therapists</b>	Chief physiotherapist Senior occupational therapist Junior occupation therapist Occupational therapist intern	<b>10</b>
<b>Total number of respondents</b>		<b>48</b>

**Table 8.1 Profile of participants**

Data were collected through semi-structured interviews with open-ended questions, and two focus groups guided by an interview schedule. According to Greenstein et al. (2003, 56), semi-structured interviews involve a clear list of issues to be considered and questions to be answered, but there is more flexibility relating to the sequence in which they are asked. The interviews were then transcribed and the data were content (thematically) analysed according to the nine steps of Creswell's process for qualitative data analysis (Schurink, Fouché, and De Vos 2011, 403–419). Thematic analysis is performed through the process of coding in six phases to create established, meaningful patterns. These phases are:

familiarisation with data, generating initial codes, searching for themes among codes, reviewing themes, defining and naming themes. The trustworthiness of the findings was ensured through member checking and reflection (Lietz, Langer, and Furman 2006). Data saturation was reached after 12 interviews.

Ethical considerations, specifically the avoidance of harm, informed consent, non-violation of research participants' privacy, as well as anonymity and confidentiality, were taken into account (Babbie and Mouton 2001, 524; Strydom 2011, 115–126; Welman, Kruger, and Mitchell 2005, 201). Before the commencement of the empirical study, the authors obtained approval from the Research Ethics Committee of North-West University.

## **Presentation of Results and Discussion**

“The goal of a spiritual journey is not the completion of the journey, but the full engagement with the path along the way” ([www.Kellesparts.com](http://www.Kellesparts.com)). The research findings are presented in this section according to the profile of the participants and the main themes that emerged. For the purpose of this paper verbatim responses of participants are presented, and responses given in an indigenous language were translated into English.

### **Spiritual Journeys Drawn by Participants**

A phenomenology research design was adopted for the study. Phenomenology seeks to illuminate the specific, to identify phenomena through the way in which they are perceived by the actors in a situation. This translates into gathering “deep” information and perceptions through inductive, qualitative methods such as interviews, discussions and participant observation, and presenting these from the perspective of the research participant(s). Epistemologically, phenomenological approaches have their foundation in a paradigm of personal knowledge and subjectivity, and emphasise the importance of personal perspective (Conal and Sinclair 2010). They are powerful for understanding subjective experience, gaining insights into people's motivations and actions, and cutting through the clutter of taken-for-granted assumptions and conventional wisdom.

Conal and Sinclair (2010) propose that phenomenological study designs follow a four-step process comprising bracketing, intuiting, analysing and describing. According to Crotty (1996), bracketing is the process of identifying and holding in abeyance any preconceived beliefs

and opinions that one may have about the phenomenon that is being researched. Intuiting occurs when the researcher remains open to the meaning attributed to the phenomenon by those who have experienced it. This process of intuition results in a common understanding of the phenomenon that is being studied. Analysis involves processes such as coding, categorising and making sense of the essential meanings of the phenomenon. As I worked with rich descriptive data, common themes or essences began to emerge. This stage of analysis basically involved total immersion for as long as necessary in order to ensure a pure and thorough description of the phenomenon. At the descriptive stage, I came to understand and to define the phenomenon. The aims of this final step are to communicate and to offer distinct, critical descriptions in written and verbal form.

I formulated the interview questions for the purposes of gathering data from each participant's demographic information relating to experiences involving spirituality, religion, developmental phases and work experience. Data were collected through the plotting of a spiritual journey. Conversations during interviews did not follow a uniform question-and-answer pattern; rather, participants were guided in terms of context in the process of plotting their spiritual journey. This process was achieved by giving the participants an interview schedule and also conducting focus groups.

A thematic analysis following the data analysis steps was used to analyse the data from plots as well as the focus group discussions. My judgement as a researcher was crucial in determining what constituted a theme, since there is no definitive answer to what proportion of data constitutes a theme. This process involved searching across a data set to find repeated patterns of meaning. Below examples and descriptions of the plotted spiritual journeys by healthcare professionals are given.

**Spiritual journey 1:** This diagram captures the spiritual journey of one of the respondents, incorporating her developmental life phases from childhood to adulthood. The roots of the plant represent the respondent's birth, first spiritual event, which took the form of her naming ceremony, and her primary school experience. During this period, she was completely under her parents' guidance. The next part, including the leaf growing from the stem, represents the respondent's teenage life, high school life and her first intimate relationship, which did not last long. The breakup left her heartbroken, but during this experience prayer sustained her. The last part represents university experience and early adulthood, serving in the community, getting married, and working experience in a healthcare

setting, which the respondent described as emotionally taxing. However, support from family, church and community sustained her.

**SPIRITUAL JOURNEY 1**

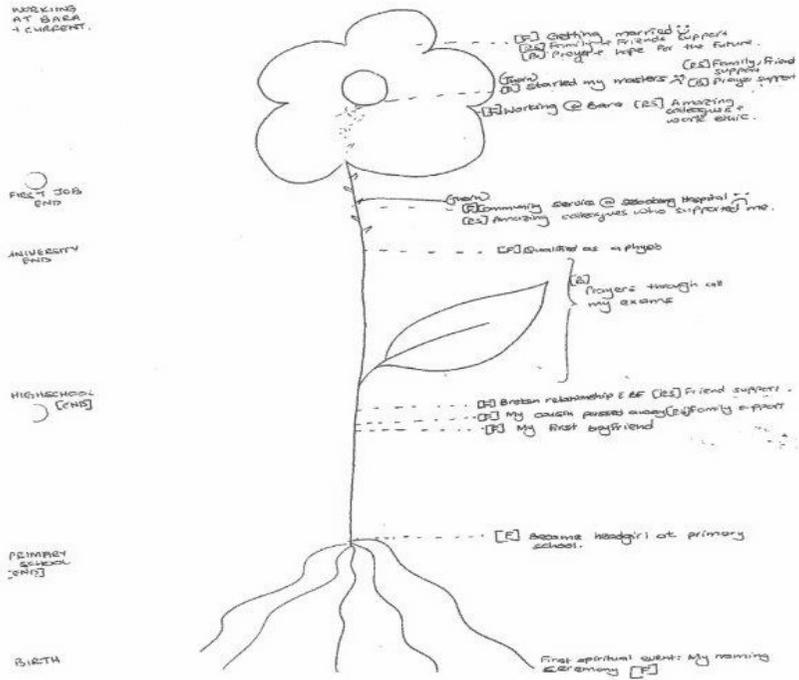
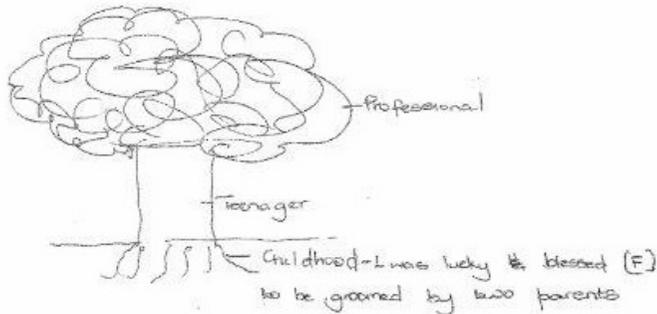


Figure 8.1 Spiritual journey 1

**Spiritual journey 2:** This diagram depicts a respondent’s imagination road as he grew from childhood to attain professional status. His source of spiritual support came from both his parents, which he considers to be a blessing, as he learnt the importance of prayer. In his professional life, his spirit was lifted by patients’ acknowledgement of his work, and spiritual conversations. Support from friends played a significant role.

## SPIRITUAL JOURNEY 2

IMAGINATION BOARD

Childhood	Teenager	Professional
<ul style="list-style-type: none"> <li>① lived with both parents</li> <li>② Being thought the importance of going to church.</li> </ul>	<ul style="list-style-type: none"> <li>① Passing my matric which allowed me to do nursing.</li> <li>② Prayer &amp; family always helped when I'm in stressful situations.</li> <li>③ When I lost my father whom was a cardiac patient my family &amp; friends &amp; church members were there to help me.</li> <li>④ I prayed to god to keep my heart as good as it ever after being professional.</li> </ul>	<ul style="list-style-type: none"> <li>① My spirit being lifted up by patients acknowledging what I do.</li> <li>② Being heart broken by losing a patient.</li> <li>③ Giving God any problem that I come across at work helps.</li> <li>④ Talking to a close friend about what's troubling me.</li> <li>⑤ I needed friends &amp; spiritual guidance when I had a fight with the colleague.</li> </ul>

Figure 8.2 Spiritual journey 2

**Spiritual journey 3:** The diagram captures the respondent’s developmental phases coupled with life experiences and the roles played by different sources. In early childhood, the respondent illustrates that her faith and spirituality were moulded mainly by her parents. While in her teenage years there was minimal guidance from parents, as she believes she took ownership of her faith, which was also influenced by her community and society. Her interactions with friends, the church and her active involvement in community activities and programmes exposed her to interfaith and spiritual dimensions.

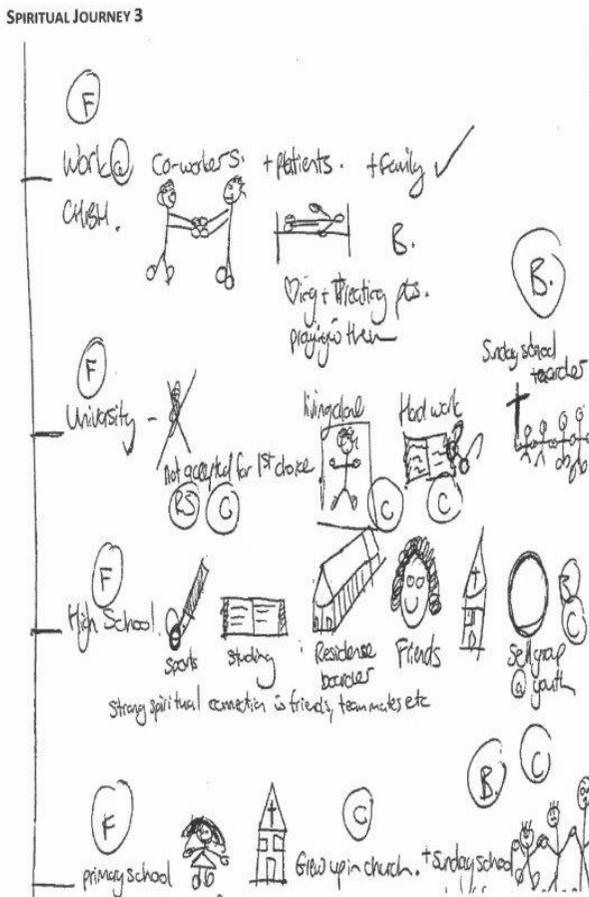


Figure 8.3 Spiritual journey 3

From the analysis of the spiritual journeys, the following themes were identified:

### **Theme 1: Spiritual Beliefs are Associated with Human Development Stages**

Results related to spiritual beliefs indicated sub-themes associated with three developmental phases, namely childhood, adolescence and adulthood.

#### ***Sub-theme 1.1: Spiritual beliefs during childhood***

The participants reported that during this developmental phase they adopted the religious belief of the family. During this stage, biological parents, grandparents and Sunday school teachers (for those who were Christians) were the significant role models. Therefore, the spiritual decisions were made by parents, and included a number of prominent spiritual rituals and activities such as baptism and traditional ceremonies.

#### ***Sub-theme 1.2: Spiritual beliefs during adolescence***

Participants mentioned that during this stage spiritual beliefs were influenced by family members, friends and personal experiences. Biological parents and godparents, friends, youth pastors and youth spiritual leaders played a significant role in their understanding of spiritual beliefs. Spiritual rituals or activities included *ukuthomba* or *intonjane* (the process of welcoming a girl child into womanhood) and confirmation.

#### ***Sub-theme 1.3: Spiritual beliefs during adulthood***

Spiritual belief during adulthood was reported as being solely the individual's decision. For those who were married, it was also influenced by marital status. Partners, pastors or ministers of religion also played an important role in terms of spiritual beliefs. Comparing these stages with the literature was an enlightening activity.

**Theme 2: Spirituality as Emotional Coping Mechanism during Various Life Experiences**

Data analysed from plotted journeys and focus group discussions illustrated a link to emotions and life experience and determined the role of spirituality as a coping mechanism.

Emotions	Life experiences	Coping tendencies
Sadness	Loss of a loved one	Family, friends, church community support An opportunity to connect with ancestors
Anxiety	Writing examinations Dealing with a critically or chronically ill patient Difficult life situations	Keeping calm Acknowledging that there is one above
Sense of being overwhelmed	Adulthood Professional pressures	Prayer Parental spiritual support keeps me grounded (firm foundation)
Depression	Losing a patient Realising I am HIV positive	Reflection Rituals Sharing life stories revitalised my energy
Excitement	Achieving a professional goal	Understanding who I am; inner strength kept me determined
Stress	Professional and parental pressures	To be kept grounded (rooted in my culture and professional belief)
Frustration	Not getting along with relatives Financial constraints	Having hope for the future The courage to keep going

**Table 8.2 Spirituality as emotional coping mechanism during various life experiences**

Traditionally, the concept of coping has been associated with focusing on strategies that have to do with emotions and problems. Jacinta (2004) attests to this, as she states that spirituality as a coping mechanism can be observed to be a powerful resource in the provision of comfort, peace and resolution for patients confronted with critical illness. Healthcare professionals who work with patients need to equip themselves with knowledge about patients' reactions and the coping strategies they choose to apply in order to deal with this harmful phenomenon. Thus, how spirituality helps healthcare workers to cope is influenced by their understanding of spirituality (Hobfoll 2001). These authors suggest that individuals who believe that they are able to control their painful situation and that they are not severely disabled appear to function better than individuals who do not have those beliefs. Louw and Edwards (2008, 9) are of the opinion that coping with illness is an art when the patient sees his or her illness as a very special opportunity for growth. Louw and Edwards (2008, 10) emphasise that the task of pastoral care is not only to sustain the sick, but also to prepare the healthy for crisis and the possibility of illness. Feelings of emptiness and despair characterise spiritual distress (Ross 2006, 46). These feelings are frequently encountered in situations involving physical or mental illness. However, through spirituality, people are liberated from despair (Puchalski 2001, 289).

### **Theme 3: Spirituality and Coping with the Work Environment**

As work and family demands grow, our personal life needs more nourishment than ever if we are to cope. In this regard, spirituality has appeared to be the best coping mechanism, as the decision to cope must come from deep inside a person's value system. Love, truth, patience and kindness are strong spiritual principles that could form strong pillars in one's daily struggles for balance. A respondent shared: "When I lost my mom, the love, kindness and patience I received from my friends, colleagues and prayers sustained me." The Joint Commission for Accreditation of Pastoral Services commissioned Van de Creeck and Burton (2001, 81) to draw up a white paper on the role and importance of professional spiritual healthcare. This tool has been of great significance for professionals who apply it in their working environment.

## **Conclusions**

Every healthcare professional comes from a specific spiritual background; therefore, the therapeutic intervention calls for understanding in treating human beings holistically.

### **Spiritual beliefs develop over the human life span**

From birth onward, as one is trying to make sense of the everyday world, one's spiritual awareness grows as meaning forms. Insight will evolve as one develops a willingness to explore questions and change personal attitudes. Fowler (1988) attests to this notion, as described in the stages of faith development.

From one's early days until the present, the ordinary world has offered endless opportunities to mature through a process of discovery leading to deeper insight into the mystery of life. Because these experiences occur every day in the context of personal history, one's interpretation of them plays a large part in the direction one takes. Exploring the emotional history of one's life can reveal the unresolved issues that might be delaying, distorting or misdirecting the natural desire to grow in spirit. Problems, pain, and human suffering of all kinds will strengthen a person's inner life if these are grounded in an attitude of personal accountability. Without honest self-evaluation, one's spiritual path can seem to go around in circles.

One may choose a specific belief system within a religion as guidance, or one may rely upon own insight and personal experiences to deepen one's spiritual journey, or even seek out life lessons found in literature, art, music and philosophy. There are many religions, many teachers, many spiritual disciplines to inspire, guide and inform a person's spiritual journey, and these should be seen as vehicles to carry a process of developing awareness leading to your inner wisdom. The most important tools needed on a spiritual journey will be a person's interest, openness to discovery and willingness to discard fixed interpretations.

### **Spirituality is a coping mechanism for general life experiences**

Religion and spirituality are important in explaining one's life experiences and understanding. Without religion and spirituality, it would be difficult for healthcare professionals to explain the coping ability in their life experiences. Spirituality can assist healthcare professionals and their patients in terms of coping with daily work demands and stress. The study

conducted by Breitbart (2002) on spirituality and meaning in supportive care for cancer patients proved to be a success and raised awareness of the importance of the spiritual dimension during therapy.

## Recommendations

- Spiritual self-awareness should be nurtured in healthcare.
- Healthcare professionals should be encouraged to search for strengths and positive aspects in their own spirituality.
- Healthcare professionals can be empowered through in-service training opportunities to be sensitive towards predominant socio-cultural and spiritual beliefs.

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# PROMOTING CARING PRESENCE IN NURSING: INITIAL FINDINGS

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## Abstract

Caring Presence forms an integral part of spiritual care in nursing. There is a need to gain deeper understanding of Caring Presence in nursing in South Africa, and we therefore envisage developing, implementing and evaluating a programme for its promotion in this context. This paper reports on an initial phase, executed in two rural hospitals in the North West Province of South Africa, namely the discovery phase of an appreciative inquiry. The population consisted of nurses of all categories working at these hospitals; 22 nurses participated in individual interviews and 26 nurses participated in World Café workshops to gather data on how and why nurses practise Caring Presence. Thematic data analysis resulted in Caring Presence practices, abbreviated to the acronym DREAM. Participants shared that they practise Caring Presence through dedication, respect, relationship, health education, the art of nursing, a positive attitude, advocacy and motivation. These results tie in closely with the

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literature on Caring Presence. In this research study, however, the nurses emphasised “health education,” providing nursing in a caring manner, and that a rural context plays a role in how nurses view and practise Caring Presence. The views of nurses on how to implement and sustain Caring Presence practices should be explored further. The preliminary Caring Presence practices should be refined and validated. The findings of this phase of the research can be integrated in the subsequent phases of the overall research programme, entailing the development of a programme to promote Caring Presence in nursing.

### **Keywords**

Caring Presence; nursing presence; therapeutic presence; healing presence; nursing; appreciative inquiry; World Café workshops

### **Caring Presence**

Spirituality can be integrated into nursing through the encouragement of Caring Presence, leading to depth and quality in healthcare and to transformation in both nurses and patients (Covington 2003, 302). Madeleine Clemence Vaillot was the first nurse to define Caring Presence, and she eloquently described this concept as “being with the patient with the whole self when that patient is in need” (Bright 2012, 14).

The comprehensive definition formulated by Covington (2003, 312) further illuminates this concept:

An interpersonal, intersubjective human experience of connection within a nurse–patient relationship that makes it safe for sharing oneself with another. The nurse brings conscious awareness (intentionality) and is available and attentive in the moment to provide opportunity for deep connection between the nurse and patient in the relationship. Deep connection within the relationship provides an important bond between participants that gives them a sense of safety as both nurse and patient attempt to discover meaning in the human experience of health and illness. Although not necessarily part of the experience, transformation of the nurse, the patient, or both, may be one outcome.

The landscape of Caring Presence is coloured with a number of assumptions, which help us understand this concept at an even deeper level. We agree with the assumptions stated by Stanley (2002, 936–939): Caring Presence is a mode of “being” rather than “doing”, Caring Presence acknowledges vulnerability, and Caring Presence can be transcendent.

Furthermore, Caring Presence requires knowing and being comfortable with oneself, knowing the other person, connection, affirmation and valuing, intuition, empathy and a willingness to be vulnerable, being in the moment, serenity and silence.

## **Research Problem**

Although international literature provides an inclusive view of Caring Presence, this concept is not yet explicitly articulated in South African nursing. South African nurses are more acquainted with closely related concepts such as ubuntu (compassion and humanity) as a philosophical approach to nursing, the therapeutic use of self or caring attitudes and values as core standards to improve quality in healthcare. It is, however, not known how, when or to what extent Caring Presence is practised by South African nurses. There is therefore a need to gain a deeper understanding of Caring Presence in the South African context, and to develop ways to promote it.

This prompted us to ask: How can Caring Presence be promoted in nursing in the South African context? How, when and to what extent do nurses practise Caring Presence? What Caring Presence practices can be developed? In answering these questions, we hope to be pointed in the right direction to develop a programme to promote Caring Presence in nursing.

## **Research Purpose and Design**

The purpose of our research in this area is to promote Caring Presence in nursing in the South African context. We envisage the development, implementation and evaluation of a programme to promote Caring Presence in nursing. We believe that although Caring Presence may not be a well-known *theoretical* concept in South Africa, nurses nevertheless do practise it, and we can learn much from nurses about how, when and to what extent they do so. For this reason, we chose an appreciative inquiry as described by Cooperrider and Whitney (1999) as the design for this research. During phase 1 of our research – the discovery phase – we aimed to establish what works well or best in terms of Caring Presence in nursing through exploring and describing how, when and to what extent nurses use Caring Presence. Based on these new insights, we aimed to develop Caring Presence practices. During subsequent phases – the dream, design and destiny phases – we hope to develop, implement and evaluate a programme to promote Caring Presence in nursing. In this paper, we

report on the discovery phase as carried out in two rural district hospitals in the North West Province of South Africa.

## **Research Method**

### **Population**

The decision was made to include nurses of all categories, namely professional nurses, enrolled nurses and enrolled nursing auxiliaries, as we believe that we can learn from all nurses. We focused on one of the nine South African provinces, namely North West, as this is a predominantly rural province and nurses have to rely a great deal on themselves as therapeutic instruments to render quality healthcare. During the process of obtaining permission from the relevant authorities – the North West provincial department of health – we were guided to choose two of the most remote and rural district hospitals in the province. The first of these is a 60-bed hospital, which serves 21 clinics and surrounding areas. The second has 290 beds, and serves 28 clinics and 78 mobile health points.

### **Sample**

We used purposive sampling as explained by Botma et al. (2010, 201) to select participants. To ensure that information-rich participants were included, the inclusion criteria entailed all categories of nurses (professional nurses, enrolled nurses and auxiliary nurses) with at least six months' working experience who work at the above-mentioned district hospitals in North West. We also set an inclusion criterion to include nurses who were willing to participate and to be audio-recorded. Although student nurses are present at the hospitals and have expertise in Caring Presence, they are viewed as a vulnerable group and were therefore not expected to participate. Data sufficiency and saturation determined the sample size – we collected data until adequate, quality and rich data were generated, and until repetition of data was apparent.

### **Data Collection**

The participants were asked to provide demographic information (age, gender, nurse category). Tables 9.1 and 9.2 reflect the demographic information relating to the participants.

We conducted and audio-recorded in-depth individual interviews with nurses at the two rural public hospitals (n = 22) to explore and

describe how, when and to what extent they practise Caring Presence. To achieve our aim, we used a broad, open-ended question in the interview, namely: Tell me of times when you practised Caring Presence. The interviews were facilitated through the use of communication techniques such as paraphrasing, summarising, minimal verbal responses and reflections. Underlying meanings were discovered together with the participants through interactive probes, such as amplificatory probes (“Tell me more about...”), exploratory probes (“How did you respond when...”), explanatory probes (“What is it that made you...”) and clarificatory probes (“In what way was it...”) (Kvale 1996, 133–135).

Nursing category	Gender	Age group			
		25–30 years	30–40 years	40–50 years	50–60 years
8 Professional nurses	3 Males 19 Females	25–30 years	30–40 years	40–50 years	50–60 years
8 Enrolled nurses 6 Auxiliary nurses		1	6	11	4

**Table 9.1 Demographic information of the participants who participated in individual interviews**

Following the individual interviews, we conducted two World Café workshops in which 26 nurses participated to further explore and describe: “What works well in Caring Presence?”, “What helps nurses to practise Caring Presence?” and “What is the impact of practising Caring Presence?” During the workshops, we also explored “Caring Presence is practised best through/by/when ...”

The World Café method was originally developed as a tool to appreciate the strengths of a group and to facilitate change in groups, and was therefore an appropriate approach in our research. Seven design principles are used in the World Café method, namely setting the context, creating a hospitable space, exploring questions that matter, encouraging everyone’s participation, connecting diverse perspectives, listening together for patterns and insights, and sharing collective discoveries (World Café 2008).

The participants were involved as co-researchers and experts on the topic, and were divided into smaller groups of four to six participants to discuss the above-mentioned questions. Each of the small groups was provided with sheets of paper and coloured pens to write down their

contributions. After a discussion lasting about 20 minutes, the groups each moved to another table, where a different set of questions was discussed. This was done until all the groups had visited all the tables, and answered all of the questions.

Each group appointed a host (one of the participants) who remained at the table to welcome and orient the new group concerning the answers supplied by the previous group, and to invite the contributions of the new group. After several rounds of small group discussions, a discussion with the whole group was facilitated to summarise and further clarify data generated in the small group discussions.

Nursing category	Gender	Age group		
12 Professional nurses 10 Enrolled nurses 4 Auxiliary nurses	5 Males 21 Females	30–40 years	40–50 years	50–60 years
		8	14	4

**Table 9.2 Demographic information of the participants who participated in the two World Café workshops**

Directly after the individual in-depth interviews and the World Café workshops the research team took field notes in the form of methodological notes (reflections on the method and strategies), theoretical notes (own thoughts and reflections on the meaning of “what is going on”) and personal notes (notes on own feelings). These notes were used during the data analysis to enrich and confirm the findings.

### **Data Analysis**

The data analysis was done concurrently with data collection. Directly after the individual interviews, the team met and reflected on our impressions of the participants, the context and repetitive themes from the interviews. We made reflective notes, which we shared with the participants the next day during a World Café workshop, as a way of providing feedback on our early view on the findings from the individual interviews in order to build rapport and to stimulate further discussions.

A thematic analysis as described by Creswell (2013) followed the initial reflective discussions. The initial thematic analysis was performed by one of the research team members, and the remaining team members acted as co-coders.

The team reflections gave rise to themes, which were categorised as the acronym DREAM. This acronym is particularly appropriate, as it is in line with appreciative inquiry terminology. The themes and the categorisation of themes as DREAM were confirmed during the thematic analysis, and will be discussed under “Findings”.

## **Rigour**

The framework of Guba and Lincoln (2005) was used to ensure rigour. Truth value and neutrality were ensured through triangulation of the data collection methods, prolonged engagement with the participants and reflexivity in the form of field notes and reflective discussions. Applicability was ensured through selecting the most appropriate population and sample, through data saturation and thick descriptions of the results. Consistency was achieved through co-coding the data, and also through a thick description of the research process and findings. A thick description also contributed to transferability.

## **Ethical Considerations**

Ethical clearance was obtained from the Health Research Ethics Committee of the Faculty of Health Sciences at the Potchefstroom Campus of North-West University.<sup>6</sup> We also sought permission from the North West Department of Health and the management of the two rural public hospitals.

Ethical principles, norms and standards, as formulated by the Department of Health (2015, 14–17), were followed. These encompass the principles of beneficence and non-maleficence, equality and respect for persons. The research team respected the participants and their research interests and the research project was therefore secondary to the safety and dignity of the participants.

The participants were recruited via mediators, namely nursing service managers of the two hospitals. Informed consent was obtained. Before data collection commenced, an extensive discussion about the research and what was expected from the participants was facilitated by

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<sup>6</sup> Reference number NWU-00179-15-A1.

both the mediator and the research team, and informed consent was confirmed. During this discussion, the participants were given the opportunity to ask questions. The participants were free to withdraw from the study without penalty. Data were collected at the hospitals at venues conducive to individual interviews and workshops, such as offices, and training and/or boardroom facilities. Safe, comfortable and private venues were used for data collection.

## **Findings**

### **Impressions of the Team Regarding the Context**

We were touched by the positive attitude and dedication of the nurses at both rural district hospitals. The hospitals are clean and tidy. Furthermore, it was apparent that the nurses work in difficult circumstances. These hospitals are overcrowded, and resources are restricted: for instance, there is limited patient transport, and a lack of specialised equipment.

### **Impressions of Some of the Participants regarding the Research**

We asked the participants about their experience of the research, and they indicated that they would appreciate feedback on the findings, as well as a follow-up. They also expressed a sense of being valued and refreshed through their participation in the research. One of the participants expressed this experience in the following way:

“It’s a wake-up call, you know, when you are used to doing something, we are like wipers, we come to work, we go home, you are not aware that you are so special, you are really saving lives. You feel like that when you come from school, this is my first month, I am a professional nurse, I am going to make a difference, I am going to make sure my community is helped in a certain way until after 6 months it becomes a norm, it becomes like household duties, you come, you do vital signs, you give injection, you go. But with something like this, it shows, it gives you a home work, yesterday when I went home, I thought you know, it’s not only about the patients as well, it also involves me, it involved what I am doing, you know, if people can come from the university, lecturers, it’s exciting for me.”

## **DREAM**

The broad themes that repeated throughout the in-depth individual interviews and the World Café workshops were the following:

- D – Dedication
- R – Respect, Relationship
- E – Education, Environment
- A – Art of nursing, Attitude, Advocacy
- M – Motivation

These themes are discussed by means of a short description of each. Sub-themes were identified within these themes, and these sub-themes were formulated as preliminary Caring Presence practices. This is followed by quotes from the in-depth individual interviews and World Café workshops as confirmation of the findings.

### ***D – Dedication***

The nurses shared that they are dedicated to being nurses. This dedication and passion motivates them to continue practising Caring Presence, even in difficult circumstances. They shared that they “go the extra mile,” as they are there for their patients.

Caring Presence practices:

- I practise Caring Presence, because I am dedicated and passionate about nursing.
- I practise Caring Presence when I practise nursing according to prescribed standards, and sometimes even beyond what is expected.
- Practising Caring Presence and caring for others strengthens me and brings fulfilment.

These findings are confirmed through the following quote:

“You have to have passion for what you do, it can also include commitment, it has to do with end result that I’m imagining, for every patient you want to see them better, so you have a focus for each and every patient.” (World Café workshop 1)

### ***R – Respect***

The nurses emphasised that they practise Caring Presence through demonstrating respect towards patients. They behave respectfully to convey their high regard for patients, and also to build rapport with patients.

Caring Presence practice:

- I practise Caring Presence when I show respect to patients.

The following quotes and paraphrases support this finding:

“I address the patient respectfully (‘Ntate ...’ (Father)), showing respect for older people.” (Interviews 8, 9, 14)

“I call the patient ‘chief’, as a sign of respect, to connect with patient.” (Interview 11)

“Kind manner in talking to the patient, not in a harsh manner.” (Interview 8)

Identify self, ask patient’s name, ask patient’s feelings, confirm that patient can ask when he/she needs something, then explain reasons why I am here and what I am doing, to nurse in totality, because I am not working with an object, I have to explain what I am doing, get permission to do, patient feels welcomed, accepted, honoured (ubuntu). (Interviews 8, 11, 12)

### ***R - Relationship***

The nurses shared that they practise Caring Presence through building trusting relationships with patients. They emphasised the importance of introducing themselves, having patience and communicating in a way that enables them to connect with patients. Their trusting relationships have an impact on the community – relatives in the village inform them of the health status of their discharged patients.

Caring Presence practices:

- I practise Caring Presence through building trust relationships with patients.
- I connect with patients through introducing myself, and getting to know patients and their needs.
- I am patient when communicating with difficult patients.
- I communicate at a level that patients understand.
- I use non-verbal communication to connect with patients.

The following paraphrases from the data confirm these results:

Reconnect, build relationship, introduce yourself, identify patient, be friendly, confidentiality, call patient by a specific name, know who I am talking to, therefore understand what type of patient it is, e.g. moody patient, responding differently today, identifying if the patient has pain. (Interview 14)

The result: the patient feels free: not to have fear, being open to talk to nurse about anything. (Interviews 13, 14)

### ***E – Education***

This theme seems to be unique in terms of a rural South African context. The nurses in this study stated that they provide “health education” to patients as a way of practising Caring Practice. The uniqueness of this lies in their explanation of “health education”, namely providing information about what patients can expect in hospital and what the procedures entail. Traditionally, this is referred to as “orientation and informing”. In addition, the nurses emphasised that by providing health education with regard to the condition of patients and prescribed medication, they contribute to the adherence to medication and the prevention of defaulting from treatment. They furthermore emphasised that family members should also receive health education.

Caring Presence practices:

- I practise Caring Presence by providing health education.
- I inform patients about what to expect in hospital, to put them at ease and to build trust relationships.
- I provide health education in order to prevent defaulting and readmissions.
- I explain their condition to patients to promote acceptance and hope.
- I provide health education to family members to involve and reassure them.

The following quote supports these findings:

“Health education is very important, the patient will explain to you what he knows, you will be able to communicate with the patient, make him understand about his condition.” (World Café workshop 2)

### ***E – Environment***

The nurses in this research referred to two facets of their environment in relation to Caring Presence, namely the hospital environment and the rural nature of their community. They mentioned that the environment in which they work and live has an impact on how they practise Caring Presence. In the first place, the hospital environment places demands on them. They have to attend to large numbers of patients in a setting with limited resources. These demands were identified as a difficulty experienced by the nurses in both hospitals. However, they shared that they still feel passionate about nursing and that they remain dedicated. They also mentioned that appreciation from management lifts their morale.

Second, they shared that they had grown up in the community they now serve as nurses, and their role as a nurse stretches far beyond the walls of a hospital. They fulfil a caring role in their community through attending to neighbours in need, and they are touched by their patients as they are known to them as neighbours and community members.

Caring Presence practice:

- The environment in which I work and live has an impact on how I practise Caring Presence.

The following quotes and paraphrases reflect this finding:

Having to attend to a large number of patients affects my work (don't get chance to eat), but I love nursing. (Interview 1, 2 and 6)

“Being appreciated by our managers helps us to practice Caring Presence.” (Interview 8)

“This is a rural community, I know the community very well and I therefore practise Caring Presence not only in hospital but at home as well.” (Interview 7)

“Community members come to my house for assistance, ask for transport, advice at home, I do help, beyond duty times, I grew up here, my patients were my teachers, family. I'm affected by the patients because I know them since childhood, admitting a girl the same age as my daughter, become emotionally attached, it is personal for me.” (Interview 10)

With regard to a challenging nursing environment, one of the participants concluded with the following:

“There is no open road without challenges, but we thrive despite these.” (Interview 6)

### *A – Art of nursing*

This theme can be viewed as carrying added depth, as it was repeated many times during the interviews and the World Café workshops. It is also the theme that most closely mirrors international literature on Caring Presence, namely that Caring Presence is demonstrated through the art of nursing.

Caring Presence practice:

- I practise Caring Presence through practising the art of nursing.
- I welcome patients and identify the needs of patients.
- I provide for the basic needs of patients.
- I provide nursing care in an unhurried, calm, confident and caring manner; I am there next to my patients.
- I provide holistic nursing care.
- I care beyond the obvious.

The following quotes support these findings:

“Listening is very important, if you don’t listen to what the patient is saying you are going to miss the key story of the patient, when you assess the patient you try to get the main complaint, you are trying to treat the cause, you don’t treat the outcomes, it goes with assessment.”  
(World Café workshop 2)

Psychologically, going beyond physical care, be somebody the patient can talk to, sit down with them, smile, then patient able to talk and open up about their problems, build relationship, connection. (Interviews 5, 14)

### *A – Attitude*

The nurses shared that having a positive and kind attitude is also a way they practise Caring Presence.

Caring Presence practice:

- I practise Caring Presence by displaying a friendly, positive and approachable attitude.
- I practise Caring Presence by offering myself wholeheartedly to patients.

The following quotes confirm this finding:

“When patient is crying with pain, if the patient is emotional, as a nurse, you can see the signs (that the patient is emotional) you can see with your eyes, then you must come with a smile, that you welcome the patient, they will have trust for you, and talk everything that they want to become relieved.” (Interview 7)

“Always assist the patient when he or she needs help, not even complaining, you must always commit yourself, don’t tell the patient I’m tired, you must always be concerned about the patient, having patience, when busy in unit nurses get frustrated: ‘No you ask too many questions’, thus patience is important, and even if you are busy, you can still tell them let me just do this and this and this, I’ll be with you.” (World Café workshop 1)

### ***A – Advocacy***

The nurses found it very important to advocate for patients as part of practising Caring Presence.

Caring Presence practice:

- I advocate for the patients to ensure they receive the best possible care.

Quotes that support this finding include the following:

Advocate for the patient (Interviews 5, 8 actively following up on complaints), “refer to social worker if patient does not have anything to eat at home, and is therefore defaulting” (Interview 7), “talk to the multi-professional team.” (Interview 9)

“We are almost 24 hours with the patient, then we can say if you do this to the patient, it will be better than that, I talk on behalf of the patient.” (World Café workshop 2)

### ***M – Motivation***

The nurses were of the opinion that another way of practising Caring Presence is through motivating and encouraging patients.

Caring Presence practice:

- I practise Caring Presence by motivating patients.

The following quotes confirm this finding:

Encourage the patient, singing for the patient, reassuring the patient, giving hope, can cure the patient by singing and touching, it is part of nursing. (Interviews 4, 6, 7, 12)

“I motivate patients, by grooming them, guiding them to pray, I believe that prayer ‘puts strength’.” (Interview 10)

## **The Impact of Caring Presence**

The nurses shared that Caring Presence has a positive impact on patients and on their morale. The following quotes illustrate this last identified theme:

“Patients heal more better ... someone they can trust, if you are that kind of Caring Presence, it helps them to understand, and accept their conditions, it even helps them relax in a strange place, where sometimes if they are not comfortable, they are like, I want to go home, if they feel more at home, they heal better, they heal faster, they take their treatment properly, you even find some of them passing here, just popping in, just to say ‘Hi, you helped me’.” (World Café workshop 1)

Harmonious relationship in the unit, happiness [patient and nurse], achievement [nurse]. (World Café workshops 1 and 2)

## **Limitations**

The research team acknowledges that language barriers can limit the expression of the participants, even though some of the team members are fluent in the indigenous language spoken by the participants. In spite of this limitation, rich and in-depth data were generated.

## **Discussion**

The findings were categorised into the mentioned themes and sub-themes, but it was also quite evident that Caring Presence is a comprehensive and in-depth concept and that these themes overlapped. This is supported by the literature, in which it is stated that the concept of Caring Presence “is a complex whole” (Doona, Haggerty, and Chase 1997, 57; Finfgeld-Connett 2006).

In addition, the findings closely follow the literature on Caring Presence (Covington 2003, Finfgeld-Connett 2006, Kostovich 2012). Kostovich (2012, 69) explains, for example, that Caring Presence is evident through direct and indirect physical availability, empathetic attention, physical and emotional comfort, competent performance of

nursing procedures, patient education, and coordination of care with other healthcare providers. She further explains that “such actions create a therapeutic healing experience, thereby improving quality of life and engendering a psychospiritual peace” (Kostovich 2012, 69). In this research study, the nurses emphasised “health education” and providing nursing in a caring manner (the art of nursing). Another important aspect that was highlighted is that a rural context plays a role in how nurses view and practise Caring Presence.

Finally, it is concluded that these findings can be used as preliminary Caring Presence practices for nurses working in rural public hospitals.

## Recommendations

It is recommended that the research team give feedback to the management and nurses of the participating hospitals in the form of meetings and through the distribution of posters and handouts containing the preliminary Caring Presence practices (DREAM). In addition, it is recommended that the views of nurses on how to implement and sustain Caring Presence practices should be explored. It is also recommended that these preliminary Caring Presence practices be refined and validated. The findings of this phase of the research can be integrated in the subsequent phases of the overall research programme to develop a programme to promote Caring Presence in nursing.

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# ETHICAL DILEMMAS AND PASTORAL COUNSELLING IN THE HEALTHCARE ENVIRONMENT

NICOLENE L. JOUBERT<sup>1</sup>

## **Abstract**

Ethical dilemmas in the healthcare environment are embedded in conflict between the values, interests, professional ethical principles, personal beliefs and religious systems of various role-players. Role-players include patients, family members, faith communities, nurses, doctors, psychiatrists, psychologists, clergy, counsellors, financial systems and institutional staff. Dilemmas arise on various levels, causing moral distress. Institutional constraints often add to conflicts and moral distress. This paper explores ethical dilemmas that could arise for pastoral counsellors in the healthcare context. A practical ethical-decision making process, applicable to diverse settings, is proposed.

## **Keywords**

Bioethics; pastoral counselling; ethical dilemmas; institutional constraints; spirituality; whole-person treatment; moral reasoning; ethical-decision making process

## **Introduction**

The purpose of this paper is to explore ethical dilemmas experienced by pastoral counsellors in the healthcare environment.

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Pastoral counselling is interpreted in different ways, depending on the context. Most commonly, it designates counselling by clergy, or counselling performed within a broad religious framework or offered by a faith community (Lartey 2002, 104). For the purpose of this paper, pastoral counselling is used as a broad term to refer to a whole-person approach to healing in the healthcare environment, focusing on the spiritual needs of patients.

Whole-person care refers to a bio/psycho/socio-spiritual approach to healthcare that acknowledges that illness not only disrupts the biological functioning of patients, but also affects relationships, leads to spiritual concerns, and affects the patient's relationship with the transcendent (Sulmasy 2002, 24–32). Internationally there appears to be agreement concerning the spiritual dimension of whole-person care (Puchalski et al. 2014, 644–650), with Puchalski et al. (2014, 642–643) stating that a focus on spirituality could improve patients' health and quality of life.

Healthcare settings must satisfy the need for compassionate care and respect patients' dignity and spirituality (Puchalski et al. 2014, 642–643). In terms of whole-person treatment, physicians face complex challenges relating to issues such as blood transfusions, palliative care, euthanasia and organ transplants. Pastoral counsellors find that the healthcare environment poses unique challenges, which often pertain to intricate bioethical questions and dilemmas. Life events that involve serious illnesses elicit intense emotional reactions and questions about the right course of action. A clear, practical decision-making process is imperative for all role-players to prevent confusion and moral distress. Pastoral counsellors need knowledge about the healthcare environment and well-developed moral reasoning skills to provide compassionate, viable options in cases of ethical dilemmas.

## **The Healthcare Environment**

The healthcare environment comprises multiple complex systems. Garman (2006, 152–153) outlines four stakeholder groups: the customers or patients, staff, health systems and the community. Competency and knowledge of the healthcare context requires understanding of all of these groups. Whole-person treatment can best be pursued when there is dialogue and cooperation between various layers of decision-making that influence treatment protocols. Koubel (2011, 111–112) states that the transformation of the role of patient to that of customer has numerous implications for liability and ethical decisions, one of which is that

patients/customers should be thoroughly informed about treatment choices. Healthcare facilities operate according to policies and procedures aligned with national health laws, which form an overarching system for designing and structuring healthcare practices. Health bodies are responsible for the allocation of resources (Koubel 2011, 113). Financial management structures and medical insurance aim at the sustainability of healthcare. The interconnectedness of these systems, illustrated in Figure 10.1, should be acknowledged, as each one has the potential to influence the health of the patient as well as affect families and communities.

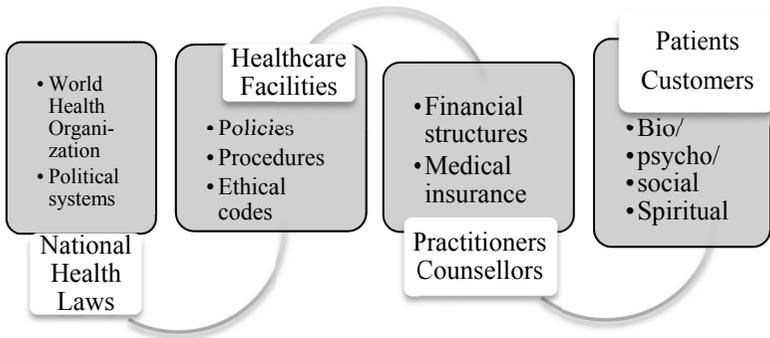


Figure 10.1 Healthcare environment

## Pastoral Counselling

According to Streets (2014, 1–2) pastoral counselling evolved from religious counselling and pastoral psychotherapy, and is currently viewed as a notable area of practice for clergy and other religious professionals practising in various contexts, including hospitals and mental health clinics (Streets 2014, 1–2; Lyall 1995, 1, 19–22; McCann 1962, 52). Pastoral counselling takes an interest in how a patient’s spiritual or religious beliefs and values influence their view of illness, identity, the world, life, death and afterlife (Streets 2014, 3–5). The pastoral counsellor explores the meaning-making component embedded in a patient’s religious beliefs and values, and thus cares for the whole person (Agbiji and Landman, 2014, 2–3).

In the Christian context, a pastor's role is compared with that of a shepherd (Lartey 2002, 23). A shepherd protects, nourishes and guides his sheep; the pastoral counsellor has a comparable goal, which is achieved by means of spiritual direction and applying counselling knowledge and skills. The latter could be obtained from contemporary secular scientific fields focusing on helping people.

Pastoral care, although often viewed as being interchangeable with pastoral counselling, refers to a broad ministry of care, mutual healing and growth within a congregation (Magezi 2007, 655–657). Pastoral care has been embedded in Christian thought for centuries, and is also referred to as soul care (Agbiji and Landman 2014, 2–3). It involves spiritual and emotional love and concern for people. Pastoral counselling is an expression of this caring through therapeutically oriented dialogue and storytelling aimed at alleviating distress (Magezi 2007, 658–663; Streets 2014, 4–6).

Christian pastoral counsellors often see their role as applying biblical knowledge and counselling expertise to fulfil Luke 4:18–19: “He has sent me to heal the broken-hearted, to proclaim release to the captives, recovering of sight to the blind, to deliver those who are crushed.” These verses are an expression of God's grace to those who are suffering. It is a good message to those who are deeply afflicted emotionally (the broken-hearted) as well as those who are suffering physically. The message pertains to all aspects of human existence: biological, psychological and spiritual. In order to effectively fulfil such a calling, pastoral counsellors should be able to integrate spiritual, religious and psychological understanding of health concerns and challenges with the aim of enhancing health and faith maturity.

## **Ethics in Healthcare**

Ethics in healthcare, or bioethics, is a broad term referring to ethical considerations in biomedical science (Braunack-Mayer 2001, 98–100). It stems from a sense of right and wrong with specific reference to our convictions about our rights and beliefs about our duty to others regarding life and death situations. An ethical dilemma occurs when the “right” decision is not clear in a particular incidence of conflict and the choices at hand (Braunack-Mayer 2001, 98–100). Research findings indicate that ethical problems are complex and entail more than an application of a prescribed professional ethical code or a moral choice by an agent (Hopia, Lottes, and Kanne 2016, 660–661).

Professional ethics deals with what ought to be, and not with what is. It is defined as a set of moral principles, beliefs and values that relate to a specific culture or group (including religious groups). These principles are implemented to decide what is the right as opposed to the wrong course of action for a particular situation (Chung and Wickham 2015, 525–526). Chung and Wickham (2015, 526) point out that ethical issues are subjective, and as a result, there is the potential for differences in interpretation among role-players. Ethical dilemmas also occur when different laws are in conflict with each other or when a law is ambiguous in itself. It is often not possible to agree on one accepted answer. These authors argue, for example, in the context of social work and child protection, that therapeutic work entails too narrow an approach, and that this should be broadened to include the protective and legal system (Chung and Wickham 2015, 525).

### **Ethics in Pastoral Counselling**

Pastoral counsellors are generally guided by a set of ethical codes aligned with the beliefs of the religious groups they represent. Different religious traditions in fact share many core values pertaining to life and death. Mackler (2003, 1) argues that the Roman Catholic tradition and the Jewish faith tradition adhere to the same fundamental values pertaining to bioethics, although they differ in how they balance these values. At the core of these traditions is a life-affirming view that life is precious, as a person is created in the image of God (Mackler 2003, 3–5). Beliefs regarding health, life and death might lead to different opinions and interpretation of health ethics as prescribed by health laws. This could lead to potential conflict between pastoral counselling services and healthcare providers.

Many countries do not have clear policies on the role of spirituality and faith in healthcare, which increases the risk of ethical conflict (Agbiji and Landman 2014, 1–2). Opposing assumptions and values held by the scientific community and a faith community could result in conflict between the spiritual views and the biomedical scientific approach. Ignorance of the differences, absence of guidelines, a lack of dialogue and misunderstandings between the biomedical scientific context and spiritual/faith community are probable reasons for ethical dilemmas. Hanford (2002, 137–141, 175–184) argues that it is essential to obtain a faith perspective on bioethics from pastors to illuminate the theological dimensions of bioethics. This would also ensure a balanced, whole-person approach to healthcare.

Christian bioethics follows a deontological rather than teleological approach, centres on the Bible as a directive for right and wrong, and is based on the value of love (Geisler 2005, 17). Love encompasses loving God above all else and loving your neighbour as yourself. The deontological approach focuses on right norms and right actions (Geisler 2006, 17; Slosar, 2006, 140–141). This implies that the rule, which is good, determines the result and forms the basis for action. In contrast to this approach the teleological approach focuses on good goals and consequences (Slosar 2006, 140–141; Rowson 2001, 9). This approach states that the result determines the rule, forms the basis for the action and could sometimes be invoked to justify breaking the rule.

According to Hanford, Christian bioethics should be therapeutic, meaning that it should entail a caring Christian faith-based ethic as well as a scientifically-based cure ethic (Hanford and Koenig 2013, 43). The overarching aim in Christian bioethics is to transcend the current situation and reach out to the Presence of God.

Key beliefs in Christian thought inform the moral reasoning process that take place in order to make an ethical decision. The core beliefs that influence Christian bio-ethical decisions are as follows: The existence and sovereignty of God is paramount in Christian thought (Geisler 2005, 185–187); God is the creator of all and controls life and death (Geisler 2005, 185); Christian ontology claims that God exists as a personal God and that humans are created in the image of God as conscious and self-conscious beings and have inborn awareness of God's moral will (Davis 2004, 24); Christian epistemology holds that the foundation of knowledge lies in our knowledge of and relationship with God (Van Til 2011, 11–13). Knowledge is gained through senses, science, Scriptures and mystical encounters with God.

Christian anthropology forms the basis for Christian moral reasoning and accountability. Human beings are created in God's image as body and soul/spirit; they beings have moral, social and mental capacities. Human beings have fallen into sin, and need salvation. Through Christ we gain true self-knowledge (Van Til 2011, 14–15).

## **Ethical Dilemmas**

An ethical dilemma is defined as a logical incompatibility between two ethical principles or laws in a moral situation in which different ethical principles or laws could be applied and one principle or law violates the other principle or law. A situation could lead to a moral problem when an agent believes that they ought to perform or not perform a certain action

based on moral grounds or when institutional and financial constraints prevent the desired ethical course of action (Braunack-Mayer 2001, 100–102; Beauchamp and Childress 2001, 10–12; Ganz, Wagner, and Torren 2015, 43–44; Holm and Severinsson 2014, 403). Beauchamp and Childress (2001, 10–11) argue that in the case of an ethical dilemma one aspect might become more important than another, which would determine the choice of action: for example, when there is a conflict between the professional ethic of patient confidentiality and the danger of violence, the latter takes precedence.

Various authors and research findings support the notion that ethical dilemmas arise from conflicting norms, values, interests, financial resources and institutional constraints, which could thwart the desired ethical course of action congruent with one's conscience and values (Ganz, Wagner, and Torren 2015, 43–44; Holm and Severinsson 2014, 403; Braunack-Mayer 2001, 98–102; Oddo 2001, 125–127). This could cause frustration, anger, feelings of powerlessness and moral distress for doctors, nursing staff and other role-players (Holm and Severinsson 2014, 403; Ganz, Wagner, and Torren 2015, 43–44).

Controversial ethical issues often emerge from new advances in biology and medicine. These relate to biological, psychological, social and spiritual problems, concerns and decisions relating to issues such as procreation, abortion, assisted suicide and euthanasia, treatment refusal, organ donation and embryos as research subjects. Oddo (2001, 125–127) correctly points out that the various role-players in healthcare mentioned above could influence the ethical decision-making process, as they represent different values, interests, knowledge, expertise and involvement.

It is possible to distinguish three forms of ethical dilemmas, namely ethical problems to which an immediate solution is not apparent, but to which the solution becomes clear after ethical guidelines have been consulted; ethical conflict where two or more interests collide and the solution becomes apparent after a compromise between them is reached; and ethical conflict where the appropriate course of action is not given and does not include one solution only. A way to achieve a resolution is to apply a moral reasoning process involving all role-players.

Beauchamp and Childress (2001, 2–4, 12–14) argue in favour of a secular common morality, shared by all morally serious people, that is not based on a particular philosophy or doctrine. These authors are of the view that common morality could give rise to universally acceptable principles to guide bioethics and prevent dilemmas. There are four such bioethical principles, namely autonomy and self-determination; beneficence; non-maleficence; and justice.

- Respect for autonomy and self-determination emphasises that a patient's own perspective about benefit and harm needs to be assessed (Beauchamp and Childress 2001, 12).
- Beneficence emphasises the quality of doing good and helping others, and that one ought to carry out action that benefits others (Beauchamp and Childress 2001, 12; Summers 2008, 49–50).
- Non-maleficence invokes the obligation not to harm others (Beauchamp and Childress 2001, 12).
- Justice refers to equality in healthcare, for example, consideration for research subjects to prevent the exploitation of subjects from vulnerable population groups, and fair distribution of resources (Summers 2008, 52–54).

Macaleer (2014, 79–80, 245–278) argues that Christian faith values such as love, the importance of God's will, and views on life, personhood, responsibility, family, the law and flourishing could enhance bioethical principles.

A critical reflection on ethical dilemmas while observing the values of the patient, their family as well as professional codes, is advised as a means to assess the validity of ethical decisions (Chung and Wickham 2015, 526). Oddo (2001, 125–127) emphasises that each role-player in the healthcare context should contribute to the ethical decision by adding knowledge and expertise, keeping the patient in the centre.

Moral reasoning is described as a practical decision-making process to determine the best ethical course of action for a particular situation by figuring out how to apply the moral truths at stake (Richardson 2013, section 1.1). A systemic, holistic moral reasoning process would consider the needs of patients and other roleplayers in the healthcare environment, including concern for bio/psycho/socio/spiritual dimensions of existence, professional conduct ethics and institutional constraints.

### **Observation and Illustration**

The following two examples illustrate the occurrence of ethical conflict in relation to religious beliefs.

#### **Example 1:**

Recently, I observed a conflict that took place at the intensive care unit (ICU) of a reputable hospital. The family of the patient, an aged and dying man, summoned the rabbi, as they did not expect their father (at that stage

in a coma) to live through the night. Due to the hospital's policy of allowing only two visitors per patient in ICU, the security guard insisted that one of the two brothers at their father's side leave the ICU ward before the rabbi could enter. This caused family members waiting outside the ICU door considerable distress. The son who had to leave his father's side lost his temper and threatened the security guard.

Ethics has always been central in Jewish thought, being related to the belief that the individual and the Jewish community have a covenant with God (Mackler 2003, 20, 46, 52). In terms of the Jewish faith, ministering to the dying and their family is crucial, as these moments of suffering, death and loss could be a time of growth (Mackler 2003, 69–70). In Judaism, death is viewed as a passing over to another life, and although the loss is grieved, there is a strong belief that the opportunity for psychological and spiritual growth should be seized.

The rigid implementation of the hospital's policy in the above illustration shows how the curing ethic of healthcare organisations could conflict with the caring ethic and spiritual values of religious patients and their pastoral caregivers.

This illustration highlights the difficulty in deciding what is right. Did the security guard do the right thing by ignoring the pleas of the family members to allow three people instead of two at the bedside of their dying father for a time of ministry? Did the son do the right thing by losing his temper and shouting insults at the security guard? Did the rabbi do the right thing by keeping quiet instead of explaining the importance of the moment to the security guard? Or was there another course of action that could have prevented this painful event for the family?

ICU policies in many hospitals restrict the number of visitors per patient. This policy could cause an ethical conflict if not understood correctly and applied with sensitivity.

### **Example 2:**

Jehovah's Witnesses base their moral code on the Bible, emphasising that worshipping God means living a clean and sober life (BBC website 2009a). Their convictions do not allow patients to undergo a blood transfusion (Clough 2006; Schaffer 2015; JAMA 1985). The life of a patient who is a Jehovah's Witness could be in danger, which will cause a conflict for a physician attempting to save lives (JAMA 1985). This gives rise to an ethical dilemma and moral distress for nursing staff, and many surgeons are not willing to operate on patients if blood transfusions are not allowed – although the church no longer takes action against a member who receives a transfusion (Clough 2006; BBC website 2009a; Schaffer

2015). The medical practitioner must choose whether to respect the autonomy of the patient or obtain a legal intervention to save a life. The same dilemma arises for family members of Jehovah's Witnesses (Clough 2006; BBC website 2009a). The conflict rests on the decision whether to save a life (a bio/psycho/social issue) or to obey a religious conviction (a spiritual issue).

### **A Practical Moral-Reasoning Process**

A practical-moral reasoning process is required to resolve ethical dilemmas and alleviate moral distress. Such a process should comprehend moral truths adhered to by the patient, respect professional ethical guidelines and consider institutional constraints. Moral truths would generally include the view of the person, God, love, respect for others, healing, life, death and afterlife.

In this section, a practical moral-reasoning process, drawing from Christian, other faith and non-faith models is proposed to aid pastoral counsellors faced with bioethical dilemmas. Kilner (2011, 11–12) asserts that a method is required by all Christians to aid bioethical decision-making. He further argues that obtaining and applying wisdom is vital in such a method. The church has many outstanding sources of wisdom that could cast valuable spiritual light on bioethical challenges. Christians should draw on these biblical and theological resources to find wisdom, as a way of travelling, rather than a destination (Kilner 2011, 11–12). This implies sifting, organising and interpreting information to enable informed engagement with bioethical dilemmas. Kilner (2011, 13–14) asserts that wisdom should also be drawn from other applicable resources, such as medical information, financial systems, the law, and political, intercultural and social resources. Charter (2011, 292–294) proposes problem-based learning as an approach to bioethical ethical-decision making. This entails the acquisition of knowledge, adopting an interpretive framework based on Scripture, implementing critical exploration of bioethical challenges and developing transferable skills. Examples of this approach are provided in three areas of bioethical concern: a better birth, the quest for a better life and a better death (Averbeck 2011, 24–26; Greggo and Parent 2011, 60–64).

The above-mentioned method could aid pastoral counsellors in fulfilling the overarching moral obligation of a pastoral counsellor, namely to cast spiritual light on the issue at hand. Drawing from biblical, theological and ministerial sources of wisdom would make it possible to critically explore the bioethical dilemma and formulate a spiritual

perspective (Averbeck 2011, 26–34; Greggo and Parent 2011, 64–68). A critical exploration is based on questions such as, “Why does the dilemma arise?” “Who is involved?” and “What are possible solutions?” Kretzschmar (2009, 14–18) highlights that the critical exploration and evaluation of ethical decisions should include virtue ethics (what does this decision say about my character?) and choosing a good life (a life with God).

Cunningham (2011, 127) argues that Christians have a moral imperative to obey the law that does not necessarily apply to a non-believer, and thus proposes an approach that considers paying attention to moral questions and legal concerns. This author proposes a decision-making flow chart that includes both dimensions (Cunningham 2011, 127–128).

Kretzschmar (2009, 21–26) postulates that the Christian faith community should be involved in the decision-making process. Kilner (2011, 11–20) warns against ignorance of medical or legal matters that could lead to harm rather than health. A Christian community can contribute meaningfully only if procedures are put in place to ensure a thorough understanding of medical factors and to enhance bioethical principles. Faith communities could serve to support, nurture and affirm patients struggling with bioethical dilemmas.

Once the ethical decision is made, action should follow. The outcomes of the action should be carefully considered by means of reflection (Chung and Wickham 2015, 525; Kretzschmar, 2009, 26–33). Reflection in healthcare is paramount and entails an awareness of actions and consequences as well as seeing inside and behind our decisions (Jasper, Elliot, and Koubel 2011, 40–43; Holmes 2001, xvi). Reflection leads to a deeper understanding of ethical aspects involved and the impact of decisions on the self and others. Reflective learning entails the inner exploration of the experience and issues triggered by the action. This could alter the decision, and there should be space in the process for a different decision.

Open communication channels and constructive dialogue between pastoral counsellors and healthcare organisations and practitioners could prevent or help to resolve these conflicts. Pastoral counsellors should receive training that includes how to apply a well-thought-out and legally informed ethical decision-making process when faced with ethical conflict in a healthcare context. Cognisance of health laws and health ethics is imperative, and pastoral counsellors should reflect on their own belief system and values to gain deeper understanding of ethical dilemmas. The aim of the decision should be to get the patient to flourish.

Lastly, a commitment towards increased communication and understanding between all the role-players in the healthcare environment is recommended. The pastoral counsellor should take time to connect with the healthcare providers, be they the doctor, nursing staff, psychiatrist or psychologists, administrative staff or security guards. Dialogue between the role-players should be encouraged to inform all parties of the religious values and spiritual beliefs that might play a role in the situation.

Based on the discussion, the following practical moral reasoning process is proposed that could be applied by pastoral counsellors.

- Phase One: Formulation of a spiritual/theological perspective on the issue at hand.
- Phase Two: Identification and exploration of ethical dilemmas.
- Phase Three: Decision regarding a proposed best ethical course of action.
- Phase Four: An evaluation of this decision in the light of various ethical approaches with core role-players.
- Phase Five: Dialogue with other role-players in the healthcare environment.
- Phase Six: Implementation of the decision.
- Phase Seven: Reflection.

## **Application**

A 12-year-old girl, Helen, confides in you, a pastoral counsellor, that she is pregnant. She plans to go for an abortion and has already contacted a clinic and made an appointment for the procedure. She wants you to promise not to tell her parents, as she is afraid of her father's anger. She is also afraid that both her parents will reject her, force her to leave the house or force her to keep the baby. Helen is distraught and threatens to commit suicide if you try to prevent the abortion. She asks you to pray for her that everything will go well.

The implementation of the practical moral reasoning process could aid in a meaningful moral decision.

### **Phase one: A spiritual/religious perspective**

The Christian spiritual perspective on abortion spans a conservative, a moderate and a liberal approach (Geisler 2010, 131). The Catholic Church states that every human being, also the unborn child, is afforded to right to life by God (Schiff 2002). Giles (2011, 58–61) concurs with this viewpoint

from a reformed theological position, in terms of which the right to dignified life is seen as extending from the moment of conception to the moment of death. Giles (2011, 64–69) observes that the universal dimensions of dignity and love include love for the unborn, and imply the duty and responsibility to protect and care for the unborn.

In Judaism a normative approach is adopted, with the rabbis stating that abortion is allowed to save the life of the mother, but that it is not justified for maternal needs or a threat to the life of the fetus (Schiff 2002, 227–229). The Church of England shares the view of the Catholic church that the termination of life is a moral evil, but makes provision for exceptions (BBC website 2009b). A more liberal Christian perspective in favour of pro-choice is expressed by several denominations, for example the Presbyterian Church USA, the Metropolitan Community Church and the Evangelical Lutheran Church (Newsmax 2015).

A pastoral counsellor would consider the perspective on abortion upheld by the faith community of Helen and her parents, but also discuss other Christian perspective with them to shed light on the issue of abortion.

### **Phase two: Identification and analysis of ethical dilemmas**

A number of ethical dilemmas are presented, stemming from spiritual beliefs and medical and legal aspects pertaining to sexual abuse and statutory rape and abortion and professional ethics pertaining to the autonomy of the patient and confidentiality. The legal examples are from South African law.

Dilemma 1: The Christian perspective on abortion versus the law on abortion.

Giles (2011, 62) concurs with the position taken in South African law that the embryo is human life, and further states that life is God-given and that only God has the right to take life away (Giles 2011, 58). This author argues that the Bill of Rights, which states that everyone has the right to life, and therefore has the same rights to legal protection as any other person, is in conflict with the law on abortion, which allows the mother the choice to end the life of the embryo (Giles 2011, 61–62). In South Africa, the Choice on Termination of Pregnancy Act 92 of 1996 provides abortion on demand for any woman if she is less than 13 weeks pregnant. A woman under 18 may obtain an abortion without informing or consulting her parents. Certain conditions apply if the pregnancy is between 13 and 20 weeks.

Dilemma 2: Confidentiality versus the age of consent and statutory sexual offences laws.

Confidentiality has limits, and any counsellor is compelled by law to report actions that are illegal. The age of consent in South Africa is 16 years. Below this, participants in sexual activity are legally not old enough to give consent, which compels a counsellor to report the disclosure of sexual activity in children 15 years and younger. In Helen's case, a statutory rape case would be investigated.

Dilemma 3: Full-term pregnancy versus medical implications for a minor.

A full-term pregnancy in a minor could lead to serious medical consequences for the mother and the baby. Child mortality is 50% higher in the case of babies born to adolescent mothers than those born to mothers in their early twenties (Loaiza and Liang 2013, 4). Mothers could suffer a variety of physical difficulties, for example, cardio-vascular problems and damage to the pelvic floor, bladder and rectum.

Dilemma 4: Family values and beliefs versus protection of a minor.

Family values, which might entail viewing children as a gift from God or viewing large families as a blessing, should be considered in the light of medical facts regarding a full-term pregnancy in a minor. The protection of an underaged child takes priority, although family values should be explored and respected.

Dilemma 5: Pastoral counselling and care (obedience to God) versus obedience to the state.

Obedience to God is the highest moral obligation of a pastoral counsellor, but it does not exclude obedience to the state. In this case the law on abortion serves to protect the minor from the potentially damaging medical consequences of a full-term pregnancy. Reporting the disclosure of the pregnancy is obligatory in light of the age of consent and sexual offences legislation and takes priority over confidentiality. Lastly, the pastoral counsellor's obedience to God is fulfilled by supporting and caring for Helen and her parents throughout the process. It is imperative to encourage the Christian community to care for Helen and her family post-abortion and support them through moral and spiritual distress.

### **Phase three: Determining the best ethical course of action**

The proposed best ethical course of action would then be debated in light of the core Christian beliefs, convictions and values as outlined above. The purpose is to enhance the secular bioethical principles of confidentiality,

autonomy, beneficence and non-maleficence within the framework of medical facts regarding full-term pregnancy in a minor, the law on abortion and legislation governing children.

This process takes into account Christian thought regarding the sovereignty of God, dignity of humanity, sanctity of life and the principle of the greater good, which includes higher and lower moral laws (in a dilemma the highest moral law should be followed: for example, obey the government and love God above all else). It further acknowledges the principle of double effect, meaning that an act has both good and bad consequences – for example, some treatments have side effects. The process also recognises human mortality, and lastly charity towards human life, referring to the fact that love should be applied in all ethical dilemmas (Geisler 2005, 187–188). Arguments in support of an abortion for Helen, notwithstanding the most important moral obligation of a pastoral counsellor, are based on Helen's age and moral obligations of a Christian community towards its members.

The fact that Helen is so young has serious medical implications for a full-term pregnancy and consequent motherhood; she is a minor, and this compels the pastoral counsellor to report the case, as it implies statutory rape. Serious medical and psychological implications of a full-term pregnancy in a minor are highly possible (Guggenheim 2005, 216). The risk of maternal death is 60% higher for a teenager under the age of 15 than for a woman in her early twenties (Loaiza and Liang 2013, 4). Thus, an abortion, as a preventive measure, would be the best ethical course of action.

Further to this, it is argued that the Christian community has a moral obligation to love and care for women suffering post-abortion emotional and spiritual distress (Jeal and West 2003, 53–55). The best ethical course of action would thus include continual pastoral care and acceptance, respect and support from the Christian community.

#### **Phase four: Evaluation of ethical decision**

In this phase, the course of action is evaluated in light of various ethical approaches (deontological, teleological and virtue ethics) by the core role-players (the pastoral counsellor, Helen, her parents and the doctor). The evaluation should assess to what degree the action is aimed at seeing the patient flourish and not just survive.

The deontological approach claims that the rule or principle is good, regardless of the outcome (Slosar 2016, 140–141). The teleological approach focuses on the outcome of the action in terms of the principle of

good that states that those actions that are morally valuable are those that maximise good consequences (Slosar 2016, 140–141). The application of virtue ethics would lead the question of whether this choice makes me a good person. The choice that is considered would be evaluated in terms of what it says about the character of the healthcare worker, patient, faith community and pastoral counsellor.

A further question is: “How could a sense of coherence be enhanced?” A sense of coherence refers to comprehensibility, manageability and meaningfulness. These factors, which stem from a salutogenic framework, support the notion of flourishing, which extends beyond a decision about right and wrong and reaches to an experience of inner peace and meaning. The matter to consider is how to help the patient to flourish and sustain well-being.

### **Phase five: Dialogue with other healthcare role-players**

Shared decision-making in healthcare practice supports a whole-person approach to health by honouring the patient’s choice and values. Dialogue between all the role-players (clinic personnel and nursing staff) about differences in personal values and views and ethical conflict should be encouraged by the pastoral counsellor. Values and health risks drive the healthcare environment, whereas spiritual and moral inner peace drives the input of a pastoral counsellor. Whole-person care requires sensitivity to all dimensions of functions. Dialogue and cooperation between all role-players would result in the best outcome for the patient.

### **Phase six: Implementation of decision**

The decision entails supporting the termination of the pregnancy and meeting Helen’s need for prayer. Furthermore, it involves explaining to Helen the limitations of confidentiality and the legal obligation to disclose the pregnancy to her parents and report the situation to the child protection services. Continuous pastoral counselling for Helen and her parents, which should include dialogue with the healthcare services, accompanying Helen and her parents to the clinic, and providing support during post-abortion moral and spiritual distress, is imperative. Further to this, referrals to and cooperation with other professionals, such as a social worker to deal with court procedures and a child psychologist for mental health assessment and therapy, should be included.

### **Phase seven: Reflection**

The pastoral counsellor, Helen and the significant others should reflect on the moral reasoning process and outcomes so as to create awareness of the external process and the issues and reactions. Reflection further includes becoming aware of inner processes, and looking beyond what happened to inner feelings, thoughts and motivations. Moral and spiritual distress before, during and after the abortion should be noted. Reflection serves as a learning process for all role-players, and new insights and lessons learnt should be highlighted.

### **Conclusion**

The proposed ethical decision-making process for pastoral counsellors is based on core beliefs and principles that acknowledge God's sovereignty over life and death. God created human beings in His image as conscious, self-conscious and moral beings. His will should ultimately be sought in every ethical dilemma. His will is based on His unchanging moral character, which includes aspects such as justice, love, truthfulness, and mercy. Our moral obligations are part of God's commandments and the highest moral obligation is to glorify Him. Pastoral counsellors should consider health and other laws, personal beliefs of patients and institutional constraints. Dialogue with all relevant role-players in the healthcare environment to increase reciprocal understanding of ethical principles at stake should be part of the process. Reflection on the process, the action taken and the consequences should be undertaken in order to deepen pastoral counsellors' understanding of bio/psycho/socio/spiritual dynamics and the meaning it has for patients. Pastoral counsellors should guide a patient to a place of flourishing and inner peace.

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# THE ETHICAL INTEGRATION OF RELIGION AND SPIRITUALITY IN MENTAL HEALTH WITHIN A SOUTH AFRICAN CONTEXT, WITH EMPHASIS ON CHRISTIANITY<sup>1</sup>

WENDY-LEIGH GREYVENSTEYN<sup>2</sup>

## **Abstract**

As research continues to evaluate the fields of religion, spirituality, and psychology, it becomes imperative to gain further insight into the interface between and integration of these fields. The relationship among professionals in these fields, as well as the perceptions of the legitimacy of one another's expertise, influence the extent to which integration takes place. This study examines these perceptions and their effects by interviewing both church leaders and psychologists, after which themes are then drawn from the data.

## **Keywords**

Spirituality; ethics; religion; psychology; church; mental health

## **Introduction and Rationale for the Study**

The need for this study arises from the fact that the consideration of religion and spirituality in the field of psychology and counselling has gained momentum over the past few decades, and has therefore become imperative for the general field of mental health (Brown et al. 2013, 107).

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<sup>1</sup> This article is based on the literature survey and pilot study components of a PhD study in Psychology that the author is currently completing. The findings are preliminary and form part of ongoing research and analysis.

<sup>2</sup> The author of this paper is a PhD: Psychology student at the University of South Africa and is in private practice as a clinical psychologist.

This has resulted in numerous publications on the necessity of integrating a client's spirituality and religion into an effective psychotherapeutic process (Shafranske 1996; McMinn 2011; McMinn and Campbell 2010; Tan 2011; Pargament 2013). The relationship of spirituality and religion to health has also been well established through research (Puchalski et al. 2014, 10).

According to Tan (2011, 325–363), the integration of religion or spirituality and psychotherapy is one of the main areas in which the field of counselling and psychotherapy has seen substantial development in recent years. However, Johnson (2010, 7) notes that there is a lack of theoretical agreement both within and between the two fields of religion and spirituality, and psychology, with many divergent views and contradictory opinions across the professional boundaries. Zinnbauer, Pargament, and Scott (1999, 890–891) state that there is considerable disagreement among social scientists as to the meaning of religion and spirituality, and that there is an increasingly biased and polarised perception of religion among psychologists. Furthermore, some people continue to view psychologists with extreme mistrust. This is due to the perceived “religiosity gap”, with religiously minded clients being concerned that the professionals from whom they receive treatment may not be like-minded, and therefore unable to assist them effectively (Greenridge and Baker 2012, 211–212).

Johnson (2010, 10) explains that, in order to understand the developments in the fields of psychology and Christianity and the integration of the two, we need a better understanding of the relationship between these fields. Much of the tension that exists between the fields of theology and psychology can be understood as a battle for epistemic authority (Porter 2010, 3). While arguments exist for the field of theology to have a regulatory and governing role above that of psychology in any integration of the two fields (Porter 2010, 4), similar arguments are made for egalitarian integration in which hierarchical relationships are dissuaded (Sandage and Brown 2010, 20).

Within the discipline of psychology, there has also been debate as to the extent to which religion and spirituality should be scientifically considered (Wulff 1996, 43–70). There has been much research, therefore, into the determination of whether or not religion and spirituality are harmful, neutral or beneficial to psychological health (Hackney and Sanders 2003, 43). However, Pargament (2013, 7) states that arguments which assess religion and spirituality purely in terms of benefit or harm are intrinsically flawed, because they assume a categorical and generalisable answer. Instead, it is far more useful to consider the

“multivalence” of psychology, religion and spirituality by asking when, how and why they become either destructive or constructive, and in what contexts this takes place.

Considering that the field of psychology has the study of the human condition as its primary focus (Sternberg 1998, 3), it is essential to understand how to apply the knowledge of religion and spirituality to practice. To ensure the ethical, constructive treatment of clients accordingly, the American Psychological Association has recently published a handbook of guidelines for treating clients in a religiously sensitive manner (*APA Handbook of Psychology, Spirituality, and Religion* 2013). The APA’s ethical guidelines for proper professional conduct also state that professional psychologists are expected to uphold the following five general principles of professional practice, summarised by Tan (2011, 24–35) as follows:

- Beneficence and non-maleficence
- Fidelity and responsibility
- Integrity
- Justice
- Respect for people’s rights and dignity

To consider the ethical guidelines for the practice of psychology and other health professions within the South African context, we must understand the statutory regulations as stipulated by the Professional Board for Psychology as well as the Health Professions Council of South Africa (HPCSA). The Health Professions Act 56 of 1974, in considering the ethical rules of conduct for practitioners registered under the HPCSA, provides clear requirements as to how psychologists should engage with clients. Throughout the Act, the themes of beneficence, fidelity, responsibility, justice and respect for people’s dignity are as clearly prescribed as they are by the APA. A discussion of the entire Act is outside the scope of this paper; however, there are salient statutory guidelines that are relevant to the research conducted. These include the necessity to uphold and respect the dignity and human worth of a client; to respect the client’s right to hold values and beliefs which differ from the health professional’s own; to recognise the client’s right to psychological integrity; to refrain from imposing stereotypes of behaviour or beliefs on a client; to refrain from discrimination on the basis of any factors, including religion, values or beliefs, and to avoid harming a client in any manner (HPCSA 2008, 2). Furthermore, all South Africans are required to adhere to the South African Constitution. In section 15 of Chapter 2 of the

Constitution (the Bill of Rights), it is stated that every person has the right to freedom of conscience, religion, thought, belief and opinion; this, therefore, requires that all practitioners and citizens respect everyone's right to religious freedom to the extent that this right does not infringe on any other constitutional rights.

In addition to the protection of religious freedom afforded by the Health Professions Act, the South African Constitution, the HPCSA and the Professional Board for Psychology, the South African Society of Psychiatrists (SASOP) has published the "SASOP Position Statement 9 on Culture, Mental Health and Psychiatry". This position statement stipulates guidelines for the inclusion and consideration of spirituality in specialist psychiatry practice (Janse van Rensburg 2014, 134). These guidelines not only consider spirituality in clinical practice, but are extended to the necessity of providing training on cultural, religious and spiritual factors to medical practitioners who are completing their training as psychiatrists, especially within the South African context (Janse van Rensburg 2014, 136).

These practice guidelines include the incorporation of patients' religious and spiritual histories during clinical assessments; the identification of the role that spirituality and religion may play in psychiatric disorders; the inclusion of spirituality in training psychiatrists to take a biopsychosocial-spiritual approach to patient care; continued training in the role of spirituality and religion in psychiatry; and the development of appropriate referral systems across the borders of psychiatry and spiritual/religious fields (Janse van Rensburg 2014, 138). The Diagnostic and Statistical Manual of Mental Disorders, Fifth Edition (DSM-5) amplifies the necessity of integrating a cultural perspective in the diagnosis and treatment of psychiatric and psychological disorders in that provision is made for the consideration of cultural factors that may influence a patient, as well as guidelines for culturally sensitive formulation of a diagnosis. The DSM-5, therefore, allows for the diagnosis of a V-code. A V-code in the DSM-5 is used to indicate factors other than disease, medical conditions that are significant to the treatment or diagnosis of a patient. When the the focus of the patient's presentation and clinical diagnosis is on cultural factors such as religion and spirituality, a V-code can be used to indicate this (Janse van Rensburg 2014, 135).

A discussion about religion cannot be separated from a discussion about culture. Loewenthal (2013, 239) states that, in order to understand the nature of human behaviour, one must understand the interplay between culture and religion and spirituality. Therefore, if we are to respect cultural differences, then we must also respect religious preference. However, the

“how-to” of respecting a client’s religious freedom is not well defined, and requires more research and investigation. Nevertheless, the implication of these statutes, laws and principles of professional practice would clearly encompass a professional’s sensitivity to, respect for, and acceptance of the client’s religious perspectives as a requirement.

Therefore, in order to gain greater insight into the integration of religion, spirituality and psychology as a means to inform knowledge and client care, the initial results of the interviews are summarised.

### **Nature of the Study**

The study is a qualitative one and uses grounded theory as its main methodology. The main research question is “How do Christian church leaders and psychologists perceive the role of Christianity in mental health interventions for Christian clients?” Semi-structured interviews were conducted with two groups of participants, the first consisting of church leaders leading large protestant, evangelical church groups, and the second consisting of registered clinical and counselling psychologists. I asked a number of questions about the perceptions of these two groups relating to certain topics, such as “What have your experiences been concerning the integration of psychology and Christianity?”

### **Analysis of Interviews and Discussions**

Some dominant views emerged in the data from the formal pilot study results, as well as the informal discussions with the pastors and church leaders concerning their perceptions relating to the integration of religion, spirituality, and psychology. In order to define these views more concisely, I will place them in categories and then give a brief explanation of each one. When discussing the perceptions of the church leaders, the term “secular” has been placed in inverted commas because some of the church leaders themselves differentiated between psychology and psychiatry, viewing the former as representing a secular worldview that does not incorporate or give adequate emphasis to a Christian or biblical worldview.

## **Interviews with Church Leaders: Categories**

### ***Ignorance***

Some of the church leaders stated that they were ignorant about many facets of the field of mental health. This included the training that professionals undergo, their scope of practice, their skills, and exactly what it is that each professional “does”. Although some of the church leaders had a general idea of the professional’s role in treating mental health problems and illnesses, there were also a number of misconceptions. For example, one of the participants in the pilot study had reservations about the field of psychology, perceiving it to be focused primarily on self-enhancement, self-improvement, and self-centredness. This was seen by the participant as being antithetical to certain fundamental biblical principles, such as altruism. Therefore, the perception that psychology favours the self over the other person caused this particular participant to feel nervous about and resistant to the treatment that congregants would receive should they consult a “secular” psychologist. The participant wondered whether or not this was an accurate perception, or one stemming from ignorance.

Another participant mentioned that on some occasions people appear to be “over-medicated”, or seem to be diagnosed and medicated hastily without due consideration for the possibility that their symptoms may be rooted in a spiritual dilemma or crisis. This was seen by the participant as ignorance on the part of mental health professionals because it does not allow for the spiritual life of a person to be the focus of investigation, diagnosis, or treatment – in other words, that person is not treated holistically.

The self-perceived ignorance that these leaders expressed also extended to the nature of mental illness itself, that is, symptomology, aetiology, diagnosis, treatment, biopsychosocial factors, as well as prognosis.

Some church leaders, however, had gone to great lengths to form counselling centres for their congregations with the assistance and participation of mental health professionals. These church leaders felt less ignorant about the field of mental health and mental health professionals, but still felt their knowledge to be limited. One of the participants stated that his congregation had an effective collaborative relationship with psychologists and psychiatrists in their area, but that these were Christian professionals with whom the church leaders had had extensive interaction. This will be discussed in more detail under Trustworthiness.

### *Arrogance*

The second category relates to perceived arrogance on the part of both church leaders and mental health professionals. The church leaders interviewed stated that the resistance against mental health professionals can also stem from arrogance. There is a long history within church communities of a “faith heals” mentality, and in some communities this may be used to discourage the use of medication or consultations with mental health professionals, with these forms of treatment being seen as inferior in efficacy to more faith-based interventions such as prayer and fasting. The danger in this perception, in their view, was the possible growth of arrogance, leading to reduced open-mindedness to the value of mental health interventions.

Another form of self-perceived arrogance that the participants mentioned was the assumption by some that psychology and psychiatry are not “real” sciences, and that the validity of mental health disorders such as depression is debatable at best. Linked to that is the perception that some of the professionals who enter the field of mental health are unreliable, as revealed in the quote below:

It often seems as if the type of people who pursue the field (mental health) do so in order to better understand themselves, or in a quest to find some kind of closure from their own pain, it just seems as if so many of them have some serious baggage....

The participant was aware of the generalisation and fallibility of this statement, and clarified it as such; nevertheless, it is an example of the type of perception that the participant felt gives rise to arrogance on the part of some church leaders, an arrogance that assumes that the field of mental health, or the professional within that field, cannot be trusted with the treatment of their congregants. This can at times be explicitly communicated to congregants, but this is also done implicitly.

Of note within the context of the interviews is the fact that all the participants mentioned what a contentious issue mental health can be in terms of agreement among church leaders within and between church congregations. Church leaders held divergent perceptions and opinions, with variability in agreement about the extent to which religion, spirituality and mental health can be integrated. However, the church leaders were quick to clarify that the vast majority of church communities with whom they have contact are transitioning towards an integrative form of thinking about mental health. Some church leaders in the pilot study

sample in fact supported mental health interventions for their congregations, which will be considered in more detail under the next two categories.

### ***Trustworthiness***

One of the questions posed in the interview was what the church leaders' own personal experiences had been within their congregations in relation to the field of mental health and mental health professionals, and the extent to which they, therefore, had integrated the disciplines. All the participants interviewed recounted an instance in which their congregants had been adversely affected by treatment by a psychologist/psychiatrist. However, all participants were also able to recount instances in which there had been successful collaboration. The instances in which there was successful collaboration and communication between the two disciplines inspired the church leaders to form ongoing relationships with professionals. The prerequisite for the sustainability of these relationships, however, was a sense of trustworthiness. As mentioned, perceptions vary within and between congregations and denominations. However, the church leaders interviewed were unanimous with regard to one central principle: The field of mental health was only as reliable as the professional with whom the client had a close relationship. This relationship needed to be based on knowledge of the professional in terms of their values and their worldview. The church leaders considered it essential that the professional be aligned with and respectful of the church's basic values, principles and worldview to the extent that they could be like-minded about the approach to multidisciplinary and holistic treatment. If the church leaders felt "safe" with the professional, and felt that the professional could be trusted to treat congregants in a manner that did not undermine their spiritual well-being, then trustworthiness could be fostered so that collaboration could ensue. When this was possible, then the church leaders felt that there would be a decrease in both arrogance towards and ignorance about the field of mental health.

### **Interviews with Psychologists: Categories**

Similarly, it was possible to identify common themes from both formal and informal discussions with the psychologists interviewed.

### ***Ignorance***

The psychologists interviewed all referred to the concept of ignorance, and were concerned that ignorance exists within church communities about the field of mental health as well as the construct “mental health”. There was a perception among these participants that not all diagnoses are seen as being valid, or “real” within the church context and that some disorders, such as depression, are seen as being spiritual in origin to the exclusion of other factors. It was therefore the perception of the psychologists that there is a danger of churches at times oversimplifying the nature of a person’s symptomology as being spiritual without a full consideration of the complexities at hand as well as the interplay between these complexities, and that this could be harmful.

Another concern that psychologists raised both within the formal pilot interviews and during informal discussions related to the perceived ignorance of some lay counsellors or counselling services within church organisations. Some participants gave accounts of situations in which their clients had received counselling or psychotherapy from lay counsellors from a church organisation which had been contra-indicated for their symptoms, and these participants consequently felt that their clients had been adversely affected by these interventions. Therefore, the psychologists were left with the perception that some lay counselling services provided within a church context can be detrimental to clients because the lay counsellors are not adequately trained to deliver certain forms of treatment. Other psychologists in this sample did, however, state that they recognised the significant value and usefulness of lay counselling services, provided that the counsellors had received the necessary training and ongoing supervision by qualified professionals.

### ***Open-Mindedness***

One of the words that was used frequently within the interviews with the psychologist participants was the word “open”. These participants perceived church organisations to be more closed or narrow-minded in their understanding of and approach to the field of mental health. The perception, therefore, is that much greater collaboration would be possible if church leaders were more open-minded. This open-mindedness would be expressed in a willingness to gain knowledge about the biopsychosocial approach to mental health conditions and diagnoses. There would also need to be open-mindedness towards “secular” forms of treatment, for example the use of medication and psychotherapy, its scientific

undergirding as well as its effectiveness. Open-mindedness, as perceived by the psychologist participants, would include openness to mental health professionals and the information that they could impart within church contexts.

### *Prejudice*

The third category that will be mentioned as a preliminary finding is prejudice. The psychologist participants perceived there to be prejudice against the mental health profession in church contexts, but they also perceived their own prejudice against church contexts. This was assumed to be due to a relatively long history in which the two disciplines have not always been in agreement on this subject, and at times seem to be in opposition to each other. Therefore, at times, their perceptions of religion and spirituality have been tainted, and the usefulness of religion and spirituality questioned.

As the data was being analysed, it became apparent that there was a sub-group of psychologist participants who frequently referred to prejudice during the interviews and discussions. The selection of the psychologist participants was not based on their religious views; in fact, their religious views were not known before the interviews and discussions commenced. During the course of the interviews, however, this sub-group of participants mentioned that, as psychologists who were also Christian, they often experienced the prejudice of other psychologists who did not share similar religious views. This is evident from the quote below from a psychologist participant:

The admission of being a Christian and a Psychologist seems to create the impression with colleagues that you are, by virtue of being a Christian, no longer a fully-fledged Psychologist, and that you are a lesser Psychologist because you happen to be a Christian. There is the assumption that being a Christian somehow interferes with your ability to be a professionally acceptable Psychologist.

The participants who echoed this above perception responded by remaining silent about their beliefs, or by being hesitant to discuss their beliefs with colleagues, unless they knew that those colleagues shared similar religious views. This sub-group of participants was particularly concerned about Christian clients whom they had treated, because many of these presented with obvious spiritual difficulties that clearly operated alongside emotional and cognitive factors present in the client's symptomology. However, because these participants had received little to

no training about the interaction between religion, spirituality, and psychology, they often felt ill-equipped to treat these clients as holistically as they needed to be treated.

## Discussion

When reviewing the categories and themes present within this initial data analysis, the concern of both the church leaders and the psychologists about the concept of valence becomes abundantly clear. The questions relating to what is harmful about what the church context does, and what is harmful about the field of mental health, are all queries concerning the valence of each discipline's conceptualisations as well as the interventions it promotes. Of interest, however, was the fact that the participants made more generalisations and categorisations concerning the valence of the other discipline than they did in context-specific statements. As mentioned, a consideration of the multivalence of religion, spirituality and psychology through asking questions of when, how, and why they take on either constructive or destructive forms would be more useful.

Through the categories of ignorance, arrogance, and prejudice one becomes aware of the disunity that arises from perceptions. As can be seen from the data, both church leaders and psychologists shared some similar experiences. Both groups feel that ignorance prevents the disciplines from understanding each other. Both groups feel that this ignorance can give rise to arrogance, and that significant harm can be caused as a result. Both groups alluded to ignorance and arrogance as giving rise to a sense of territorialism in which either side can lay claim to possessing the definitive answer. This can breed prejudice within and across disciplines, further reducing the possibility of recognising the salience of holistic care, which can perhaps best be described as biopsychosocial-spiritual (Janse van Rensburg 2014, 138).

What must be noted at this stage of the study is that although common themes were found in the interviews conducted, it was also clear that a wide divergence of opinions about this topic exists. These opinions and perceptions are influenced by a myriad of factors such as the beliefs of the participants' family of origin, the participants' personal experiences with religious or psychological institutions, their value systems, their undergraduate and graduate training, and theoretical frameworks. The fields of religion, spirituality, Christianity, and psychology are so vast that it is no wonder that unity or collaboration can seem elusive at times. However, amidst the perceived elusiveness, there exists a desire for some degree of accord. Although all the participants spoke about the perceived

fissures between the two disciplines, there was not a single participant in the formal pilot study or informal discussions who did not voice the desire for the forging of greater accord and partnership. The participants were also unanimous in the view that, ultimately, it is the congregant or the client whose best interests need to be promoted.

The participants were asked, therefore, what would be necessary in order for there to be higher levels of collaboration between the fields for the benefit of congregants and clients. For successful and beneficial integration of religion, spirituality and psychology to take place, the three scales that were drawn from their responses can be described as a continuum of three main factors, the left side of the continuum being most likely to lead to successful integration, and the right side of the continuum leading away from integration. Although a comprehensive discussion of those results is beyond the scope of this paper, the three factors were as follows:

1. Open-mindedness (within and across disciplines) versus closed-mindedness (within and across disciplines)
2. Knowledge astuteness (within and across disciplines) versus knowledge complacency (within and across disciplines)
3. Collaboration (within and across disciplines) versus fragmentation (within and across disciplines)

The qualification “within and across disciplines” refers to the fact that all of these factors need to be present within the same discipline: for instance, church leaders need to be open-minded in relation to other church leaders and other disciplines, and psychologists need to be open-minded in relation to other psychologists and to church leaders. Knowledge astuteness must be within one’s own discipline, particularly regarding the field of religion and spirituality and psychology, as well as across disciplines in order to reduce ignorance and arrogance. Professionals therefore need to collaborate within professional boundaries to avoid prejudice, and to collaborate across professional boundaries in order to further reduce prejudice and fragmentation.

## **Conclusion**

This preliminary study reveals areas of disunity and fragmentation within and between disciplines, but it also shows evidence of the perceived value of and need for greater levels of collaboration across disciplines. Diversity of opinion and existential meaning within the realm of religion and

spirituality is not in fact surprising. According to Paden, as cited by Pargament et al. (2013, 5), every person's religious world carries uniqueness to an extent: "within a single tradition like Christianity, there are thousands of religious worlds" (Paden 1994, 7 as cited in Pargament et al. 2013, 5). Within the tradition of psychology there are many worlds of opinion too (Hackney and Sanders 2003, 43). However, as Wulff (1996, 43) states, there is no other human preoccupation that is more challenging to psychologists than that of religion; therefore, in order to fully engage with the complexity of human functioning, and to assist people, psychologists must take religion into consideration.

The integration of these disciplines, therefore, would yield much valuable knowledge for the promotion of health and well-being, and answers to some critical questions relating to what an integrative approach to the psychology of religion and spirituality would entail (Pargament et al. 2013, 4). It is ethical practice for those concerned with the human condition to know as much about that condition as possible. In order to do so comprehensively and meritoriously, professionals within the areas of religion, spirituality and mental health can begin by seeking greater levels of open-mindedness and knowledge astuteness to achieve effective collaboration.

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# SUPERNATURAL HEALING: EMOTIONAL REACTIONS TO HEARING LOSS IN THE SOUTH AFRICAN CONTEXT

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AND SHARON MOONSAMY<sup>2</sup>

## **Abstract**

The roles of science and religion in healthcare are a topic of ongoing discussion. Healthcare has focused on the medical model of service delivery, but some researchers argue that the spiritual aspect of patient care is equally important. More integrated models of patient care are becoming popular as healthcare practitioners embrace the spiritual. The diagnosis of a hearing loss – the “hidden disability” – is accompanied by an array of emotions. The patient, the family members and significant others will go through different psychological processes when a hearing loss is initially identified. The emotions related to the diagnosis of a hearing loss include grief, devastation, isolation and depression. The opposite was evident when participants in this study experienced a supernatural healing; participants experienced joy and happiness. The emotions that emerge from the narratives in this study provide a deeper understanding of emotions related to a hearing loss. When sharing of the individual’s story is part of the consultation process, an integrated service delivery model is born.

## **Keywords**

Supernatural healing; hearing loss; emotional reactions

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## **Introduction and Background**

Healthcare is not restricted to the diagnosis and management of illnesses, diseases and disorders, but is evolving into an all-encompassing care system in which a person is viewed through a holistic lens. Wholeness in healthcare has grown to include alternative medicine, conventional medicine, integrative approaches and integral approaches (Ross 2009; Pan and Zhou 2013). A move away from a purely medical model of service delivery in healthcare to a biopsychosocial-spiritual model of patient care is becoming evident (Pan and Zhou 2013; Sulmacy 2002). Audiology in healthcare provides the context of this paper.

### **Shifting from the Medical to the Biopsychosocial-spiritual Model in Audiology**

Audiologists in South Africa and globally have traditionally worked within the medical model of patient care. The medical model of service delivery does not consider the person as whole (Pillay and Moonsamy 2016), as it does not take into account psychological and spiritual influences on the life of a patient. When evaluating and managing a patient, medical professionals should consider the patient's lifestyle, family, vocation, disease or illness, values and religious beliefs (Ferrans 1990, 1996) in order to provide the patient with a holistic and effective service. Figure 12.1 depicts the proposed shift from the purely medical to a more integrative model of care.

Bronfenbrenner (2009) classifies the environmental influences on behaviour as operating on the micro, meso, exo or macrosystem level. Microsystems relate to face-to-face encounters of influence, mesosystems are the various settings in which these interactions occur, exosystems refer to forces within the various settings that have an external influence on the individual, and macrosystems are the cultural beliefs and values of the individual (McLeroy et al. 1988). Cultural and religious beliefs and practices are two of the biggest influences on an individual's reactions to life events, including illness and disease, with spirituality being one of the key strengths in personal well-being (Koenig, King, and Carson 2012).

Like all medical practices, audiology is subject to all four environmental influences. However, the macrosystem of cultural beliefs, religious beliefs and values is rarely considered. Individual differences in terms of values and beliefs will determine how people react or respond to situations; impairment and its diagnosis may affect people differently, depending on individual preferences, values and beliefs (Wilson and

Cleary 1995). Hearing loss and its management does not affect the patient only, as there are a number of role-players in the patient's ecosystem. The emotional reactions of the patient, the family and the community to the diagnosis of a hearing loss will influence the outcomes of the decision-making process with regard to the management recommended and finally applied. This article examines the emotions related to the diagnosis, management and reported healing of hearing loss.

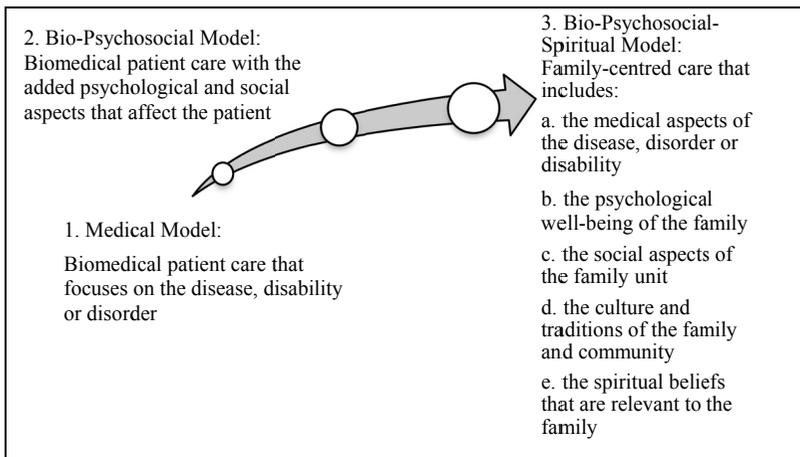


Figure 12:1 Medical model leading into the biopsychosocial model

## Hearing Loss

There are three major types of hearing loss, namely conductive hearing loss (a hearing loss which may result from pathologies of the outer and middle ear), sensorineural hearing loss (a hearing loss caused by damage to the sensitive structures of the inner ear) and mixed hearing loss (a hearing loss resulting from the combination of conductive and sensorineural pathologies) (Gelfand 1997). Permanent sensorineural hearing loss (SNHL) occurs at the cochlea and beyond.

Permanent cochlear damage resulting in a permanent SNHL may be associated with presbycusis, ototoxicity, injury, trauma, diseases and congenital factors (Møller 2006), with irreversible damage to the hair cells in the cochlear structure. Tanner (2007, 181) explains that irreversible loss of hearing sensitivity is termed a permanent threshold shift, and Eddy (2013, 43) states that there is no cure for sensorineural hearing loss. From a medical perspective, audiological rehabilitation is seen as the only option

for individuals with a permanent hearing loss. Assistive devices such as a cochlear implant are able to provide the hearing-impaired person with enhanced speech reception, but fall short of providing “normal” hearing. Despite these medical advances, people continue to seek alternative means of intervention, believing in supernatural healing to improve or cure a permanent hearing loss and its symptoms. Medically it seems impossible to re-grow damaged cochlea inner hairs, despite attempts in this regard by researchers (Vernikos 2004).

### **Emotional Reactions in Response to a Hearing Loss**

The diagnosis of a hearing loss tends to be met with a range of emotions. The patient and their family members and significant others will go through various psychological processes when a hearing loss is initially identified. The management process for the family is important if positive outcomes are to be achieved. The healing of the hearing loss and restoration of hearing may occur in different ways, as each individual will respond in a unique manner, and every person has a different perspective on what constitutes healing. Emotions are self-organised changing processes relating to the individual’s everyday life (Fogel, Nwokah, and Dedo, 1992).

The existence of an abnormality at birth may change joy into sadness, anxiety, grief and fear (Braam et al. 2014; Douglas 2014). Family-centred services and family quality of life are vital (Hong and Turnbull 2013) when a hearing loss is diagnosed. Human communication is affected by a hearing loss, and families may feel isolated when a hearing loss is diagnosed (Prakash et al. 2013). The quality of life of a family with a child with a disability is affected in the following domains, as depicted in Figure 12.2 (Schalock 2000):

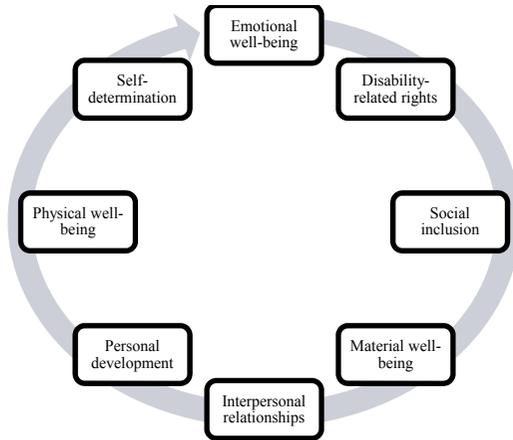


Figure 12.2 Domains affected by disability

### **Perspectives on Healing of a Hearing Loss**

Healing is not, as it is often characterized, a “making whole.” Rather, healing, in its most basic sense, means the restoration of right relationships. What genuinely holistic health care means then is a system of health care that attends to all of the disturbed relationships of the ill person as a whole, restoring those that can be restored, even if the person is not thereby completely restored to perfect wholeness. A holistic approach to healing means that the correction of the physiological disturbances and the restoration of the milieu interior is only the beginning of the task. Holistic healing requires attention to the psychological, social, and spiritual disturbances as well (Sulmacy 2002, 26).

Healing and restoration can take various forms during the management of a hearing-impaired individual. There are non-physical healings that occur when the individual accepts the diagnosis of the hearing loss; thus, an emotional restoration occurs on a psychological level. An individual may also experience a healing and restoration when hearing aids are fitted, as, if there was prior hearing; communication with the hearing world has been re-established. The physical restoration of hearing in the case of a permanent SNHL is possible only through supernatural means, however, as there is no medical cure available.

## **Paucity of Research Internationally and in South Africa**

There are reported claims of supernatural intervention, healing and cures that have produced a total recovery from health-related problems. Continuing scientific research in the area of hearing restoration has indicated that there is no “cure” in the case of a permanent SNHL. However, this contradicts the claims of individuals who state that a permanent SNHL has been cured through spiritual intervention. There is a paucity of published research into the links between supernatural healing and a permanent hearing loss. Research is required to contribute to the body of knowledge pertaining to the holistic treatment of audiological patients in which the medical and spiritual aspects are considered during the rehabilitation of hearing-impaired individuals. The outcomes of such studies may shed light on the unexplored area of supernatural healing in the treatment of such patients – hence the need for the current study.

## **Methodology**

### **Aims**

The main aim of the study was to document and explore the narratives of South African individuals who reported experiencing a supernatural healing of an SNHL. One of the sub-aims of the study described in this paper was to explore the emotional effects of the diagnosis, management and healing of a hearing loss.

### **Setting, Sample and Sampling**

Letters of information and request for participants were mailed to various religious leaders in South Africa. This elicited little response, however. Thereafter snowball sampling was employed in order to identify individuals whose experience was similar to that of the study participants (Babbie 2012). All ethical parameters were observed, and ethical clearance number H15/02/07 was assigned by the University of the Witwatersrand.

### **Description of the Sample**

Owing to the depth of information required and because of the uniqueness of the area being researched, the target number of participants was between 7 and 10. Jones, Brown, and Holloway (2012) state that narrative researchers should select a small number of participants so as to have

adequate information to answer the research question. The study aimed to obtain a varied distribution of participants from the major religious groups in South Africa. However, six of the participants belonged to the Christian faith and one participant belonged to the Hindu faith.

### **Design**

An exploratory design within a qualitative paradigm was selected for the study. A narrative inquiry was used to obtain the data. The study was exploratory, as there has been limited theoretical analysis of supernatural intervention, and this is an area of undocumented occurrences (Sim and Wright 2000), particularly within the context of audiology in South Africa.

### **Procedure**

A semi-structured interview guided the documentation of the narratives. Narrative data is “powerful and rich” and “transcends time and space” (Connelly and Clandinin 1990). The interview began with an open-ended question that allowed the participant to narrate his or her experiences of the reported healing process. Additional follow-up questions were asked if and when necessary to guide the research process.

### **Analysis**

Rather than applying the positivist manner of merely coding and categorising data into *content*-based information (Hennings 2013), we opted for a thicker way of analysing the data acquired into *content and manner of utterances*. All narratives were transcribed, and the words and sentences were coded. Thereafter the codes were grouped into familiar categories. Themes were then identified within these categories and the content and manner within these themes analysed (Kim 2015).

## **Results and Discussion**

### **Emotional Reactions to the Diagnosis and Healing of the Hearing Loss**

In this category the participants’ lives were found to be influenced by the actions and reactions of significant adults in the environment. Positive and less positive reactions of adults who belong to the circle of influence of the Hard of Hearing or Deaf (HoH/D) child have an impact on the future of

the child. This study found that the emotional reactions of the parents, grandparents, family members and teachers shaped the themes within this category. Furthermore, this combined perspective cements the need for an integrative perspective in the management of individuals diagnosed with a hearing loss.

## Results

### Parents' Reactions to the Diagnosis of the Hearing Loss

Human beings react to situations with emotions such as joy, anger, frustration and disappointment (Lewis, Haviland-Jones, and Barrett 2010). The parents of the participants in this study displayed distinct emotional reactions that included devastation, sadness, concern and fear; these are further revealed in the quotes presented.

P1 described her mother's reaction as being more pronounced than her father's reaction:

They took me for tests and they found out that I was Deaf and my mom was devastated. Um my dad not so much.

Parental grief was evident in the response of P3, who said:

So my parents were like heartbroken. Didn't understand why I am Deaf.

Maternal reactions were stated more often than paternal reactions. In the words of P4,

My parents are full of hearing. I'm the only Deaf [person] in my family. Mum was feeling it difficult. She is coping because God loves us.

The narrative of P7 and her mother contained multiple emotions. P7 was born prematurely; her mother had been unaware that she was pregnant, and took chronic medication during the pregnancy. P7's mother reported:

I had a thyroid problem and I was on you know, Thyroid medication. So he [The Dr] said you know this is a very risky pregnancy and would I like to terminate and at that time I was in hospital and I didn't have my husband around and whatever it was and it was a very tough decision to make. Because a baby that far you know and to just go and abort it, for me it was the biggest thing you know, so anyway I spoke to my husband and whatever and he said "no we'll take the chance" because he said "if she was born, she wouldn't be a normal child". So anyway I said doesn't

matter I will take the risk and whatever it is, I'll leave it in God's hands you know.

### **Reactions of Significant Others to the Diagnosis of the Hearing Loss**

Extended family and community involvement in the raising of a child (Falola and Jean-Jacques 2015) is common in South Africa, and extended family and community members have a significant influence on the future of the child. Having grandparents act as caregivers or daytime guardians is a familiar practice in South Africa (Singh and Devine 2013). Communities tend either to be supportive and caring, or to stigmatise the family who has disabled children.

P1 and P6 had receptive and observant grandmothers who in simple ways tested their observations of possible hearing loss in their grandchildren. P6 said:

it was very real for her [Grandmother]... you know what I mean like she knew that something was very wrong.

Respect was revealed in P2's utterance, as she explained that people in the community were fully aware of her hearing loss, but out of respect for the family they did not mention it. P2 reported:

And it's amazing how people when they know that you basically um have ... they know that there's sort of like, how can you say it, like an issue in the family. People especially when you like in a small community, they tend to not speak out about it, they sort of feel like, they need to respect [us].

In speaking about the role of the community and extended family, P3 and P6 provided narratives characterised by positive, caring and loving emotions. P3 stated:

People in church did not have a problem. They showed love and try and communicate with me.

P6's mother stated:

Family everybody was very concerned, they were all very concerned about her hearing.

### **Participants' Reaction to the Hearing Loss**

Emotional reactions may differ among individuals who are diagnosed with a hearing loss based on the age of onset (Kail and Cavanaugh 2015). However, there are certain common emotions experienced by all HoH/D individuals, and these include personal questioning, a feeling of isolation, and sadness (Cambra 2005). The hearing and Deaf worlds use different modes to communicate (Caselli 1983). There may be instances where an individual from either world feels socially excluded from the dominant group. Children who are educated in a mainstream setting despite the diagnosis of a hearing loss may be at a disadvantage (Mogford-Bevan and Sadler 1992) and may feel isolated, as the difference is noticeable when there is a comparison with other children.

P1 and P4 indicated that they both hold an ongoing internal personal conversation about the reason for the hearing loss. In the words of P1:

Sometimes I ask why me? And I do have days when I feel, why or why I am Deaf, why you know.

P4 stated that he is alive only because he stayed with God after the questioning:

Because I stayed with God and without God I don't know where I would be.

P1 said:

I feel left out. Especially with family, they all forget that I'm Deaf, you know, and they carry on talking and I get left out.

P7's mother articulated the isolation and sadness that her child experienced at school:

From day 1 at school she was treated badly by the kids and kids are like you know ... they don't understand what's going on until I approached the teacher and I told her this is what's going on, this is the story. So she called her P7 to the front, she showed the kids her hearing aids and she explained to the kids, this is what you'll were lucky enough that God gave you'll, you know with your ears you'll can hear everything. This is why she needs this equipment; this is why she needs this to hear. You'll are fortunate enough you know that you'll can hear properly, you'll can speak properly so if she can't speak properly it's because of her hearing problem. She has a speech problem.

## **Reactions to the Healing of a Hearing Loss**

### ***The Reaction of Participants' Significant Others to the Healing of the Hearing Loss***

P3 and P5 described their parents' reaction as positive, stating respectively, *"Yes, so now they told me they very happy, they told me they are proud and very happy to have me, they say God is good all the time"* and *"Ya they were happy for me. They were shocked"*.

P6's mother stated that family reacted encouragingly to the healing event:

Everybody in the family were concerned and after this [the healing] they saw the big difference you know and, I must say it's a very big testimony and I can still very clearly the person that spoke to me Michael you know [laughter with joy]. And just to say that your daughter has been totally totally healed and got a new set of ears [laughter with joy] ... after that [after the healing] when we take her into the service she would, when there was music she would react and you know cry or she would react and you know family could see the difference you know. Absolute, absolutely a big big difference. In fact we also tested after that, when we dropped something she reacted, and before that she wouldn't. We would test in various ways and you know her hearing was exceptional.

### ***Deaf Reaction to the Hearing Loss***

P1 witnessed the healing of friend, and reported as follows:

There was a big thing about it and um the Deaf went against her. They were like, how can you change like that, you know. And she said but no, it was God, was God, was God. It actually turned them away from God. Why God gives favouritism [participant gestured to indicate that these were the words of the people] why God chooses her to be healed and not us, you know. There was big talk about it [meaning that is was the topic of conversation at the time, by everyone].

P1 described witnessing the reactions of Deaf individuals in a school setting:

And when she [a student who was healed] came back there was a big upheaval because a lot people don't believe in God and it's very sad. And they were all like, no she is making it up, it's not true. This girl already has hearing, you know. So then, this youth pastor did not give up, he still comes to school, still interacts with us and um preachers, he

has close contact with us. So God doesn't only heal one child he heals us all indirectly, you know.

## **Discussion**

### **Grief and Devastation**

Theories of grief have evolved from recognition of the primary five stages of grief (Kübler-Ross 2003) to more complex meaning-making theories (Douglas 2014). Families with a baby newly diagnosed with hearing loss will go through the stages of denial, anger, bargaining, depression and acceptance (Kubler-Ross 2003). The constructivist perspective allows the individual to construct and maintain an understanding of life due to their experiences (Neimeyer et al. 2010). Parents who have a child with an abnormality will construct their understanding of the situation and go through stages of grief and questioning (Ramachandran and Stach 2013), with the ultimate concern being the future of their child (Hong and Turnbull 2013). Making sense of the hearing loss can be related to either the parents' spiritual belief, or a change of spiritual beliefs to respond to the loss (Neimeyer et al. 2010).

Parents of a baby who has been diagnosed with a hearing loss may respond in three stages, according to Stein and Jabaley (1981):

- An initial expression of anger. This is usually directed at the professionals who diagnosed the hearing impairment.
- Anger towards the child, as the existence of a hearing impairment cannot be denied.
- Acceptance of the hearing impairment; coping and adaptation behaviours start to develop.

The stages of reaction must be understood and supported by the medical multidisciplinary team that will be working with the family and with the patient as the focal point. Team members representing different perspectives, which are linked to the patient, may be more supportive during the three reaction stages than the traditional team of medical staff. Audiologists must initially establish and build a rapport with the family and the child in order to integrate them into an inclusive team of advisors. An integrative model of healthcare would allow for the family and the medical advisors to discuss the options available for the child, with expectations and guidelines being clearly facilitated.

## **Genetics Counsellors**

Support structures can play a vital role in the well-being of parents and children. The child's success is dependent on the parents' decisions and self-esteem (Prakash et al. 2013), and support for parents right from the beginning can ensure that well thought-out decisions are made for the benefit of the child and family.

An audiologist is responsible for the feedback session to the parents, when the diagnosis of the hearing assessments is discussed. Audiologists are not genetics counsellors, and they do not have the depth of training to answer questions that parents may have in this regard, but unfortunately genetics counsellors are sometimes overlooked when a multidisciplinary team is being put together. Parents are usually in a state of sadness and distress, even numbness, but they are forced to make life-changing decisions at that point. The diagnosis of a hearing loss is emotionally draining, and the inclusion of a genetics counsellor would be beneficial, as the parents would then receive support right from the start (Douglas 2014).

## **Psychologists**

Parents are usually in a synchronous state of grief in response to the diagnosis of a disability and a state of relief at the early diagnosis (Young and Tattersall 2007). Mothers who experience difficult pregnancies are at a higher risk for negative emotional reactions (Narayan 2015), as articulated by P7's mother. Mothers of children who have disabilities present with higher stress levels than mothers with children without disabilities (Prakash et al. 2013). Pre- and post-natal depression is possible due to the stress of having a baby (Bergh et al. 2005); the added diagnosis of a hearing loss can increase the severity of depression, and the unsupported mother is left in a vulnerable state (Prakash et al. 2013). Difficult emotions cannot be dealt with by the audiologist alone, and appropriate referral to a psychologist is necessary.

## **Spiritual Support**

Parents are the decision-makers and major role-players in the life of a newborn, and if they are well supported during the stages of grief and devastation, the outcomes are positive. Neimeyer and Sands (2011) report that parents tend to either:

- fit the implications of the loss into their previous understanding of the world and of themselves, essentially maintaining consistency in their identity and the way they see life;
- create a new narrative and understanding, or
- lean on spiritual leaders and support structures.

Emotional and spiritual support for an expectant mother is as warranted as physical and medical support (Kavanaugh, Moro, and Savage 2010). A study by Prakash et al. (2013) found that mothers who acquired coping strategies and received assistance had children with better developed emotional sensitivity, reading competence and problem-solving behaviour. The support of the community and religious leaders in difficult situations (Sixsmith, Boneham, and Goldring 2003) is not always given the credit that it deserves. The inclusion of religious leaders in the decision-making processes can provide additional emotional comfort to the parents on a personal level (Barnes et al. 2000). These individuals are able to exert an influence on the parents more frequently than a doctor or therapist would. The support that religious leaders can extend to parents can ease the burden of raising the child alone (Barnes et al. 2000), as doctors and therapists cannot provide that level of support.

The cost of counselling and ongoing support from medical professionals is too high for the majority of people in South Africa to afford. Social and spiritual support from religious leaders included in the multidisciplinary team, however, is available and this should bridge the gap and lighten the load on medical professionals (Barnes et al. 2000). Furthermore, social and spiritual support will also be long term and advantageous for the parent and the child, as the religious leaders can have a lasting influence over a period time.

Having a child who is differently abled can place a financial burden on parents (Hong and Turnbull 2013), and so the inclusion of a social worker on the team is recommended. Parents are faced with costs associated with purchasing hearing aids, special education and medical services. The multidisciplinary team can support the family from a medical, psychological, social and spiritual standpoint. Families do, however, often face negative reactions from their community.

### **Stigma, Isolation and Depression**

The family members of participants in this study displayed concern and worry. Worry is associated with the negative effects of the diagnosis of a hearing loss, as families predict what the future of the child will be. The

stigma associated with differently abled children still exists. A study conducted in Canada found that families with an HoH/D child experienced social isolation and stigmatisation (Hong and Turnbull 2013).

South African children in the rural areas are still stigmatised and excluded from society if they are diagnosed with a neurological or physical disability (Cluver and Orkin 2009). Children with disabilities are kept in isolation, and the lack of socialisation gives rise to inappropriate behaviours and interaction with society. However, children with disabilities may or may not benefit from inclusion in mainstream environments (Palmer et al. 2001). Educating the community (Yong et al. 1992) about communication and disabilities should help to integrate and include all children within the community. The notion of educating the community and raising community awareness may be idealistic, however, as the mechanisms for conveying the necessary information are not always clear.

The HoH/D individuals in the current study experienced exclusion from family conversations, which is a common phenomenon (Cambra 2005). Families tend to ignore or forget about the need to speak louder or face to face with a HoH/D individual, which constitutes a barrier to the interaction. The HoH/D individual may become depressed due to the fear of God (Braam et al. 2014), as the hearing loss may be seen as a punishment. Self-reflection and blame can be either beneficial or detrimental to the individual, and support from a psychologist or social worker can assist in this process of internalisation.

Holistic care that integrates all facets of family life will have long-term positive implications for the family and society as a whole. The HoH/D person tends to battle with the reasons for the lack of hearing, and the cause of the hearing loss is sought. In this study, a range of reasons was identified.

### **Joy and Happiness arising from the Healing of a Hearing Loss**

The stages of grief (Kübler-Ross 2003) are discussed in psychology, yet the stages of joy are not described. It is understood that joyfulness is the ideal state of being, and people undergo therapy to restore them to that ideal. When participants reported the healing of hearing loss to their loved ones or when their loved ones noticed that healing had occurred, there was joy. Parents, spouses and family members reacted in a joyous and positive manner when the healing occurred, as the healing meant that the participants' lives had been altered supernaturally in a positive manner.

The belief in God and the strength of faith grew within these families, with the supernatural event being seen as a testimony of the goodness and love of God. There was an interest in seeing the life of the HoH/D individual becoming more “normal”.

The patients who reported a supernatural healing felt a personal change in their emotional and physical state. Audiologists who hear testimonies of this kind need to be equipped to relate to the patient without judgement and disagreement. The aim of any medical intervention is to support and facilitate a healthy and positive state of being for the patients. Other HoH/D individuals, however, tended to respond in a very different way from the family members.

### **Conclusion**

The emotional reactions of parents to the diagnosis of hearing loss in a child, its management and healing are to be expected. Audiologists and all related professionals should therefore be cognisant of these psycho-social states when providing a service to the HoH/D community. Healthcare professionals need to be aware that in South African communities children are raised by extended families and neighbours, and so the diagnosis affects all involved. Decisions are collectively made by all leading role-players in the family structure. Community and religious leaders therefore need to have access to information to provide the necessary support to the parents who receive a new diagnosis of any illness or disorder. Workshops and information-sharing sessions usually focus on caregivers, religious leaders and community leaders, as they are seen in the hospitals, but community halls and elders’ meetings are also sites that can be explored for empowerment of the community.

Grandmothers and women in South African communities take on leadership roles, and they are a resource readily available to the communities. In South Africa, because women frequently and regularly gather at shopping centres and pension payout points, information pamphlets could be distributed and educational workshops could be held at these sites as a means to disseminate information to them. Caregivers can gain valuable strategies to implement at home, and they can be the change that is needed to destigmatise the disabilities seen in the community. Grandmothers specifically have authority within South African communities, and their informed positive influence could bring about significant change.

Audiologists should not aim to prove medically that a healing of hearing loss has occurred, but they need to consider the most positive way

to accommodate the patient's belief into sessions. Healthcare professionals should thus strive to develop cultural competence so that their integrated service is appropriate and relevant, responding to their context. The emotional reactions of parents to the possibility of a hearing loss (Alpiner and McCarthy 2000) will dictate whether early intervention would be possible. Thus, there is a need for an integrated audiological service delivery model that educates and supports potential parents, caregivers and educators. Early intervention provides the family with more time to come to terms with the diagnosis (Young and Tattersall 2007) and to support the child from the early stages of development.

The emotions that emerge from these narratives provide a deeper understanding of the individuals with hearing loss and their families. When sharing of the individual's story is part of the consultation process, an integrated service delivery model is born.

## Limitations and Future Research

The study was limited to the field of audiology, and despite the value that is added to the profession, it is recommended that similar studies be undertaken in all healthcare professions. Studies that focus on the health, religion, spirituality and wholeness of a family are vital for the transformation of healthcare service delivery.

## Acknowledgements

The authors are grateful to all the participants who shared their experiences so generously and frankly.

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# THE ROLE OF CHRISTIAN CHURCHES IN RENDERING SPIRITUAL SUPPORT TO CHILDREN IN HEALTHCARE

ANNEMARIE E. OBERHOLZER<sup>1</sup>

## **Abstract**

Children can find a hospital stay traumatic, and they need all kinds of support to cope with the experience, including spiritual support. Children themselves value their own spiritual support highly, but research in this area is limited. The purpose of this study therefore was to gain insight into the topic, exploring and describing current practices of spiritual support rendered to children in hospital by churches of the Christian faith. A core element of spirituality is the search for meaning and making sense of illness, pain and suffering; the viewpoints of the different churches in this regard were therefore also explored to gain an understanding of how churches would explain illness, pain and suffering to children. An explorative-descriptive qualitative research design was used during this study and semi-structured interviews, consisting of a set of open-ended questions, were conducted with representatives of the major church groups of the Christian faith in South Africa. In general, all churches consider it important to visit the child in hospital, but different themes emerged with regard to what constitutes spiritual support, and different views were expressed with regard to illness, pain and suffering.

## **Keywords**

Spiritual support; Christian churches; children; healthcare; meaning of illness

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## Introduction and Background

Hospitalisation and other healthcare encounters can be very traumatic for children, and they need various forms of support to cope with the experience, including spiritual support. According to Nash, Darby, and Nash (2015, 17–18), children in hospital may experience spiritual pain or distress due to painful treatments, a loss of trust in the adults causing the pain, the experience of separation and loss as well as fear when witnessing other children experiencing trauma. Spiritual support is therefore important when a child is hospitalised. After interviewing children diagnosed with cancer, Spilka, Zwartjes and Zwartjes (1991, 298) came to the conclusion that “as the importance of religion declined, anger, fear and denial became the dominant expressions of the children”. Barnes et al. (2000, 900) found that a child’s sense of spirituality and religious engagement resulted in better coping with difficult circumstances such as illness. Children themselves place a high value on spiritual support when in hospital. When children in a haematology-oncology unit were asked to prioritise the resources they would need when coping with hospitalisation, spiritual support was rated as fourth most important out of 19 resources (Oberholzer et al. 2011). Not only is spiritual support important to children, but, as Nye (2004, 93) explains, they “have an intriguingly rich capacity for spirituality ... which is neither contingent on their religious knowledge nor moral accountability.”

Spirituality can be interpreted in different ways, and for the purposes of this article, we will adopt the definition given by Puchalski, Vitillo, Hull, and Reller (2014, 646):

Spirituality is a dynamic and intrinsic aspect of humanity through which persons seek ultimate meaning, purpose and transcendence, and experience relationship to self, family, others, community, society, nature and the significant or sacred. Spirituality is expressed through beliefs, values, traditions and practices.

According to this definition, spirituality is expressed through religion. In the literature, there is a further distinction between spirituality and religion. As Barnum (2011, 19) explains, some people follow a religion for reasons other than spiritual expression, while others are highly spiritual without giving expression to this through a religion. This author further explains that while spirituality is highly individual, religion is characterised by shared beliefs. Over the past 25 years, there has been a movement in the medical profession to “reclaim medicine’s spiritual roots, helping to define spirituality broadly and to build acceptance for its

relevance to patient care” (Puchalski, Blatt, Kogan, and Butler 2014, 10). However, when spiritual care is rendered within the healthcare system (as opposed to being rendered by religious organisations), the separation of religion and spirituality ensues. Nash et al. (2015, 16) caution that this tendency to separate religion and spirituality has resulted in “a broad, generic approach to spiritual care which makes it hard to explain and difficult to put into practice”. For this reason, a Christian perspective was adopted in exploring and describing the spiritual support given to children in healthcare.

### **Description of the Research Problem**

It is apparent that children in hospital value spiritual support highly. Clutter (2005, 375) emphasises the importance of supporting a child’s existing faith when rendering spiritual support to children in hospital. It can therefore be beneficial to involve churches and religious communities in the care of the child in hospital. However, the way in which children are receiving spiritual support from the different denominational churches while receiving treatment in healthcare facilities in South Africa is unclear, and has not been adequately researched. This brings us to the first topic to be explored:

*What kind of spiritual support are churches rendering to children in hospital?*

Feudtner, Haney, and Dimmers (2003, 68) proposed a model relating to the spiritual care needs of children that includes a number of human concerns, such as the meaning of suffering, hopes, fears, challenging relationships and the stigmatisation of cultural beliefs. Children often harbour misconceptions with regard to their own illness, and they frequently see hospitalisation and healthcare encounters as a punishment for some imagined wrongdoing. Clutter (2005, 359) explains that children’s spiritual perception with regard to illness, pain and suffering are learnt within the family, and can significantly influence the experience in hospital. It is important to explore this topic as well, and therefore the final question was:

*How do the abovementioned churches see illness, pain and suffering?*

## **Research Objectives**

The objectives of the study were:

- To explore and describe the manner in which churches render spiritual support to children in hospital
- To explore and describe the viewpoints of the different churches with regard to illness, pain and suffering

## **Research Design and Method**

### **Research Design**

Not much is known about the spiritual care of children in hospitals in South Africa, and therefore an exploratory-descriptive qualitative research design was used during the study with the intention of gaining insight into the topic. This kind of research design is described by Grove, Burns, and Gray (2013, 66) as “being qualitative without indicating a specific approach like phenomenology or grounded theory”. They further explain that an exploratory-descriptive qualitative research design is useful for understanding a specific topic with the purpose of finding a practical solution for a problem, such as developing future programmes or interventions. The information gained from this study could be used in future to develop a model or to describe best practices for churches for the spiritual support of children in hospital.

### **Research Method**

During the study, the spiritual care of children in hospital was explored and described through semi-structured interviews. The interviews consisted of a structured set of open-ended questions that required “no fixed responses”, and were compatible with an exploratory-descriptive qualitative study (Grove, Gray, and Burns 2015, 83).

### ***Population and Sampling***

Interviews were held with representatives of eighteen Christian churches in South Africa. Selection was done according to the classification of denominations used during the last population census to include religion, which was held in 2001 (Statistics South Africa 2004, 28). Census 2011 did not include a question about religion, as during consultations held with

users in 2008, Statistics South Africa found it to be a low priority (Statistics South Africa 2011).

<b>Church (n = 18)</b>	<b>Denomination</b>
African Methodist Episcopal Church	African Independent Churches
Afrikaanse Protestante Kerk	Other Reformed Churches
Apostolic Faith Mission	Apostolic Faith Mission
Christian Revival Church	Pentecostal/Charismatic
Dutch Reformed Church	Dutch Reformed Churches
Ethiopian Episcopal Church	Ethiopian-type Churches
Greek Orthodox Church	Orthodox Churches
Lutheran Church	Lutheran Churches
Methodist Church	Methodist Churches
New Apostolic Church	Other Apostolic Churches
Old Apostolic Church	Other Apostolic Churches
Pinkster Protestante Kerk	Pentecostal/Charismatic
Presbyterian Church of Africa	Presbyterian Churches
Reformed Evangelical Anglican Church	Anglican Churches
Rhema Bible Church	Pentecostal/Charismatic
Roman Catholic Church	Catholic Churches
Salvation Army	Other Christian Churches
United Congregational Church	Congregational Churches

**Table 13.1 List of churches**

### *Data Collection*

The leadership of each church was contacted and invited to participate in an interview or delegate a spokesperson to participate in the interview. Telephonic interviews were then held with the participants and recorded. Specific open-ended questions were formulated, with the same wording and same order of questions being followed for each participant.

In pursuit of the first objective, *To explore and describe the manner in which churches render spiritual support to children in hospital*, the following open-ended questions were asked:

- If a child is admitted to hospital, how would you describe the spiritual support that is currently rendered to that child by your church?
- If a child is admitted to hospital, how would you describe the spiritual support that should be rendered to the child?

In pursuit of the second objective, *To explore and describe the viewpoints of the different churches with regard to illness, pain and suffering*, the following open-ended questions were asked:

- How does your church view illness, pain and suffering?
- Why are people subjected to illness, pain and suffering?
- How would you guide your hospital visitors/pastors/chaplains on what to say and what not to say to children in hospital?

### ***Data Analysis***

According to Halcomb and Davidson (2006, 40), the process of verbatim transcription is not only time consuming (up to 7 hours is required to transcribe an hour of a recorded interview), but it can also give rise to technical problems and lead to a number of human errors and misinterpretations. They propose the following six steps as an alternative (Halcomb and Davidson 2006, 41), and these were applied during the study under discussion:

*Step 1. Audio taping of interview and concurrent note taking:* For the study under discussion, the telephone was set on speakerphone to record the interviews. Field notes were taken during the interview where applicable to record the interviewer's impressions.

*Step 2. Reflective journaling immediately post-interview:* Immediately after each interview, the interviewer elaborated on the field notes and documented the ideas and concepts mentioned during the interview.

*Step 3. Listening to the audiotape and amending/revision of field notes and observations:* The interviewer listened to the recording and compared it with the field notes to ensure that all ideas and concepts raised had been documented.

*Step 4. Preliminary content analysis:* All ideas mentioned during the interviews were recorded and repeating themes noted.

*Step 5. Secondary content analysis:* Halcomb and Davidson (2006, 41) proposed a second researcher to review all the interviews and field notes. However, for the purposes of this study, a second researcher

was not used to review all the interviews and field notes. Instead, the analysis of each interview (including the themes that were established) was e-mailed to the participants with the request that they comment on, change or add to the analysis if they felt this to be necessary.

*Step 6. Thematic review:* A summary was compiled of all the responses and recurring themes obtained from the interviews.

### **Ethical Considerations**

During the study, the rights of the participants with regard to beneficence, non-maleficence, autonomy and justice were recognised and protected (Gray 2017, 162). It was explained to the participants that confidentiality could not be guaranteed, as each participant represented a church, and for the purposes of the study it was important to report on the views of the various churches. The purpose and objectives of the study were explained, and permission was obtained to use the information for the purpose of this study. The participants were informed that they were free to withdraw from the study at any time. They were also informed that the session would be recorded and that feedback on the study would be given according to the views of the different denominations, but with the utmost sensitivity. Feedback on the study and information about any further developments or information gained in this field will be sent to the various churches so as to allow them to benefit from the research that has been done. Moreover, I will be available as a consultant to the churches with regard to the spiritual support of sick and hospitalised children.

### **Trustworthiness**

The trustworthiness of this qualitative study was ensured by adhering to the principles of truth value, applicability, consistency and neutrality of the study, as described by Lincoln and Guba (1985, 294–301). Strategies such as prolonged engagement in the research setting, assessing possible perceptions that could influence the research process, taking extensive field notes and correlating findings with research participants, purposive sampling and description of the population as well as a dense description of the methodology of the study all contributed to increasing the trustworthiness of the study.

## **Results and Discussions**

The results from the interviews that were held with the eighteen churches were divided into three categories according to the questions that were put to the participants. The answers to the first two questions gathered information on the *spiritual support* that is or should be rendered to children in hospital; the next two questions dealt with the view of the churches with regard to *illness, pain and suffering*; and the last question related to how to direct *communication* with children. The themes that emerged from the interviews will be discussed according to these three categories and compared with findings in the literature.

### **Category 1: Spiritual Support**

#### ***Activities***

Playing with the child, painting and drawing were some of the activities that were mentioned. Only one church stated that they would give the child a Bible story picture to colour in. Nash et al. (2015, 24) confirm that it is important to allow children in hospital to do normal things, referring to these as “windows of normalisation”, but they also mention including activities with a religious meaning to the child (Nash et al. 2015, 22). Bailey (1997, 243) concludes that “the arts and creativity can stimulate our imagination to help us confront life situations such as a life-threatening illness”.

#### ***Counselling***

One church mentioned working in a team with a psychologist and social worker, and another interview was conducted with a pastoral counsellor working with children. Hospitalisation and medical procedures can traumatise a child; according to Levine and Kline (2007, 183), these are a “frequently overlooked source of trauma in children”. Churches should have access and refer to qualified child counsellors if needed; Nash et al. (2015, 159) caution that spiritual care workers must be aware of their own limitations and know when to refer.

#### ***Gifts***

Six churches said that they would take the children a gift such as sweets, “goodies”, cards or an activity book and crayons. According to Chapman

and Campbell (2005, 75), giving a gift is one way of communicating to children that they are loved. If the gift has a spiritual meaning for the child, it can be so much more significant: Nash et al. (2015, 26) describe a gift of this kind as “concrete and visible expressions and reminders of spiritual care”.

### ***Healing***

Six churches referred to “praying for healing”, “healing through anointing”, reassuring children that “God is our Healer”, and encouraging them to “trust Him for healing”. Clutter (2005, 402) makes the observation that it can be beneficial for a child to believe in faith healing, and that their “beliefs and hopes are qualities of strength” (Clutter 2005, 404). However, it is important to have open discussions and to find out what the expectations of the child is so as to ensure that the child will not blame himself or herself for not receiving a miracle.

### ***Parents***

“Counselling of parents”, “prayer for parents” and “visiting the child together with the parent” were some of the suggestions made by a number of churches. A church that works with street children and children in shelters mentioned taking over the role of the parent if the parent is absent. O’Brien (2014, 221) and Nash et al. (2015, 21) identify parents as an important resource that should be taken into account when rendering spiritual care.

### ***Physical Care***

Five churches mentioned physical needs such as food and clothing as part of the support rendered by the church, and two of these churches also mentioned other practical help such as relieving the parents at the bedside or taking care of other children at home. Beyers (2014, 5) makes the observation that giving to the poor is not only a biblical principle, but that a number of other religions also see it as their responsibility to render physical help to those in need.

### ***Prayer***

Praying with the child and family was mentioned as a priority by the majority of churches. Two churches stated that they would encourage

children to pray, one said they would pray for the doctors and one mentioned praying in a simple way so that the child would be able to understand. Anderson and Steen (1995, 16) view prayer as a “quieting, peaceful time focussed on God as a source of strength and hope” and as building a bridge between God and the child; similarly, Grossoehme (1999, 68) describes prayer as “wasting time with God” and states that, through prayer, children can experience peace and wholeness.

### ***Sacraments or Other Rituals***

Five churches spoke about performing sacraments or other rituals when visiting the child, such as “anointing the child”, “serving Holy communion”, “giving absolution” and the “laying on of hands”. One church commented that the child should be reminded about his or her baptism as an indication that God will never leave him or her. Children can find meaning and purpose in sacraments and religious rituals and, according to O’Brien (2014, 212), children should be able to participate in religious practices that they are familiar with.

### ***Upliftment***

Five churches mentioned that the visit to the child should be inspiring and uplifting: terms used in this regard included “positive attitude”, “using humour”, “cheer up the child with a joyful spirit” and “lift the mood”. One church commented that they would take the mascot from the child’s church to visit the child in hospital. Bailey (1997, 245) explains that “joy is one of the spiritual strengths that enable people to survive – including the capacity to see the funny side of life”, and Clutter (2005, 390) concurs that joyfulness is an important aspect of spiritual care.

### ***Visitors***

All churches stated that they would visit the child immediately. The majority of these visits would be paid by the pastoral leadership of the church. Four churches said that the child would be visited by someone that they were familiar with, but this is not always possible in the mega churches. A number of churches mentioned visiting the child in order to “be there for the child”, and this is echoed in the literature in the form of concepts such as “the ministry of presence” (Clutter 2005, 376), “the gift of time” (Nash et al. 2015, 30) and a “caring presence” (Monareng 2012, 4).

Three churches commented on the restrictions placed mainly by public hospitals preventing visits from the church outside of visiting hours, but another church explained that they had built relationships with the local hospitals, and so were able to visit patients any time. Working with HospiVision, a non-profit organisation rendering spiritual support in a number of hospitals in Gauteng and Western Cape, can also be beneficial, as HospiVision reported that in the hospitals where they were active, “caregivers from congregations are welcomed with open arms” (De la Porte 2016, 2).

### **Category 2: Illness, Pain and Suffering**

The feedback received from the churches concerning their view on illness, pain and suffering presented diverse opinions. The themes that emerged will be mentioned only briefly for the purposes of this paper, as this category warrants a more detailed discussion in a separate article.

Some churches identified the devil as being responsible for all illness, pain and suffering, while others were emphatic that the devil is not the cause. A few churches would say that these experiences are part of God’s sovereign will for us, while others indicated that they are not God’s will or part of His plan for our lives. Some churches explained that illness, pain and suffering are the result of sin or the “sinful nature of mankind”, while others did not view them as a punishment from God. A number of churches mentioned that illness is caused by our lifestyles and results from factors such as the food we eat, bad habits and stress. The majority of churches saw a positive side to illness, pain and suffering, with statements such as “a blessing from God”, “to show His grace”, “to raise our faith up” and “so that we don’t become proud”. One church mentioned that illness happens so that God would get the glory if the person was healed. A few of the churches would also encourage people by referring to Jesus as an example in suffering, explaining that we are “tested as Jesus was tested” or “suffering as Jesus suffered”. One church also mentioned that “Jesus was forsaken so that we will never be forsaken”.

It is clear that even in the Christian faith there are a vast number of different opinions that can influence children’s beliefs, and it is therefore important to do a spiritual assessment of all children who are admitted to hospital. Children may harbour a distorted image of God, such as an “angry, demanding, ‘scowl on his face’ God” (Clutter, 2005), and according to Anderson and Steen (1995, 15), the spiritual assessment of children should include the child’s concept of God, sources of strength and hope as well as faith practices.

### **Category 3: Communication**

#### ***Honesty***

Seven of the churches mentioned being honest with a child, for instance not lying to a child, not giving false hope, and not pretending to have all the answers. Eade (2009, 190) explains that adults want to protect children and want to give them comforting answers to the difficult questions in life, but in doing so, we are often only protecting ourselves. He concludes that “in failing to help children recognise that some questions do not have easy or definite answers, we may discourage them from continuing to ask such questions”.

#### ***Information***

Seven churches suggested giving the child information about his or her illness, procedures and hospitalisation. Helping children to understand what is happening to them in hospital could reduce the trauma and lead to more successful coping (Boles 2016, 147). According to Mahan (2005, 55), “an entire profession, the field of Child Life, has grown up around our increasing understanding of the psychosocial needs of children and families in health-care settings, including the need for preparation”. The Child Life services referred to here are a growing profession across the world, but are unfortunately not yet available in South Africa. It could therefore be beneficial for churches to take over this role, but a thorough understanding of the needs of these children is paramount in order for this endeavour be successful. One church did mention not scaring children by telling them that they are very ill, but if sensitive, age-appropriate information is given in the right way, it will alleviate fears, not increase them.

#### ***Listen***

The importance of listening to children was mentioned by two churches. Nash et al. (2015, 173) state that “what children need from us is the sense that we notice, listen and take seriously their many ways of knowing about life, and any meaning they draw from that”. When Nye (2004) came to the end of the regular interviews she conducted with children for her research on children and spirituality, she suggested that they would find another adult with whom they could continue similar discussions. However, the children laughed at her, stating that none of the adults they knew had the time for or any interest in discussing spiritual issues with them. Kamper,

Van Cleve, and Savedra (2010, 305) make the observation that children are more than willing to talk about spiritual concerns if given the opportunity, and that listening to children can be “a window into the lives of the children revealing their humanness”.

### ***Not the Child’s Fault***

Explaining to children that their illness and hospitalisation were not their fault was brought up by six churches. Children often see pain and suffering as punishment, and Kamper et al. (2010, 302) explain that during stressful times, the “spiritual realm may be a source of comfort and hope, or may be viewed as punishment”.

### ***On the Child’s Level***

Seven churches noted that all communication, including prayers, should be tailored to the child’s level of understanding. Some of the guidelines given on communicating with children in hospital are: to use as few words in a sentence as possible, to utilise play in order to get to know the child, to avoid phrases that can be misinterpreted or have dual meanings, to avoid threatening words and to state directions in a positive way (Mahan 2005, 56–57).

### ***Reassurance***

Fourteen churches referred to the importance of dealing with children’s fears and reassuring them by giving them comfort and hope. They would also encourage children by saying things like “God shields us” and “God will take charge”. Illness can cause spiritual distress, and Barnes et al. (2000, 900) note that a child’s religious engagement results in better coping with difficult circumstances such as illness. After interviewing children diagnosed with cancer, Spilka et al. (1991, 299) came to the conclusion that the more important religion was for the children, the less anger, fear and denial they expressed, and during a study on religious coping styles, it was concluded that “children are more likely to rely on God during times of stress than avoid God’s help” (Pendleton et al. 2004, 370)

### ***Relationship with God***

Seven churches commented on encouraging a relationship with God and reminding the child that “God will always be with him or her”, “God is alive” and “God loves the child”. Nye (2004, 94) identifies the concept of relational consciousness as a core category of children’s spirituality, and explains that children have the innate ability to discover and engage in a personal experience with God. Wangerin (1986, 20) describes this relationship in more poetic terms:

Who can say when, in a child, the dance with God begins? No one. Not even the child can later look back and remember the beginning of it, because it is as natural an experience (as early and as universally received) as the child’s relationship with the sun or with his bedroom. And the beginning, specifically, cannot be remembered because in the beginning there are no words for it. The language to name, contain, and to explain the experience comes afterward. The dance, then, the relationship with God, faithing, begins in a mist.

### ***Share the Gospel***

Sharing the Gospel with children was mentioned by seven churches through suggestions such as “telling them a Bible story”, “give a short sermon” or “explain to them the heart of God”. Children develop the language of faith through listening to “stories of faith and faith traditions” (Mueller 2010, 199) – in related vein, Farrel et al. (2008, 270) concluded that when hospitalised children were given the opportunity to participate in Godly Play (where Bible stories are told with the help of props), the children experienced lower levels of anxiety and depression.

## **Other Suggestions in the Literature**

A search of the literature revealed the following themes that were not mentioned by the churches and that can contribute to the spiritual support of children in healthcare.

### ***Compassion for Others***

Kathryn Darby gives an account of a child in hospital who asked to pray for the other children there, and states that she often encounters compassion such as this on the part of hospitalised children for other children who are suffering (cited in Nash et al. 2015, 130). Clutter (2005,

388) explains that children who have experienced illness can have a meaningful message for both adults and children, and that “we foster spiritual growth when we foster giving in children”.

### ***Forgiveness***

The spiritual care of children in hospital could also include a discussion on forgiving oneself and others. According to Enright (2014, 312), there is scientific evidence that children are capable of understanding the concept of forgiveness from the age of five years, and Clutter (2005, 389) observes that children are able to experience forgiveness in a powerful way. In a previously published article, I discuss the importance of ensuring that a child does not harbour feelings of resentment and anger towards the medical staff due to misconceptions about the reason for their treatment and medical procedures (Oberholzer 2016, 5).

### ***Music***

Clutter (2005, 391) suggests that when music is combined with spiritual care, it can have a powerful impact on children in healthcare. Nash et al. (2015, 138) explain that the playing of music and singing of songs with and for children in hospital can be “a way of expressing the integrated nature of spiritual care”. A study conducted by Robinson (1977, 98) into the religious experience of childhood revealed that many adults had fond memories of the way church music had touched their souls.

### ***Touch***

Anderson and Steen (1995, 15) explained that touching a child appropriately can assure him or her of your presence, assist in connecting with children in a concrete way, comfort them, and also soothe a child in pain. Chapman and Campbell (2005, 29) explain that physical touch is one way of communicating love to a child, and Clutter (2005, 383) states that “human touch can convey spiritual compassion in a way that words cannot”.

## **Conclusion**

Through this study, valuable information was gained concerning the kind of spiritual support that the different Christian churches are rendering to children in hospital, as well as the way in which these churches view

illness, pain and suffering. This information can in future be used to develop a model or to describe best practices for churches relating to the spiritual support of children in hospital. In South Africa, there are few, if any, chaplains available in the hospitals to render spiritual support to children there. Churches can therefore play an important part in rendering spiritual support to children in healthcare. One church mentioned that more training should be done in this regard, and it can be suggested that churches focus on training and developing skills in order to improve the spiritual support of children in healthcare.

### Acknowledgements

The author declares that she has no financial or personal relationships which may have inappropriately influenced her in writing this article.

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# FROM POSTTRAUMATIC EMBITTERMENT TO WHOLENESS IN HEALTHCARE

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## **Abstract**

Some of the most challenging aspects of ministry are the integrities of human suffering, illness, spirituality and wholeness in dealing with people who need pastoral mediation and healthcare. Trauma and posttraumatic embitterment can be demystified in a manner that can make a positive difference to the quality of people's lives. This unique perspective in dealing with victims, survivors and people who become more than conquerors cuts across the fields of crisis management, trauma relief facilitation and pastoral services, with reference to the role of people's spiritual context in bitterness. Forgiveness and restoration of health is explored to understand the effects of discourses in a wholeness context. To achieve this, a posttraumatic wellness coaching model is utilised. This model takes into consideration the meaning of illness and how people can grow from posttraumatic embitterment to gracious wellness. This model is multi-dimensional and based in a holistic systems thinking technique, and serves as an early intervention instrument to enhance healthcare, although it is focused outside the sphere of a biomedical context.

## **Keywords**

Trauma; embitterment; posttraumatic embitterment reaction; holistic wellness; wellness; healthcare

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## Introduction

Some of the most challenging aspects of ministry are the integrities of human suffering, illness, spirituality and wholeness in dealing with people who need pastoral mediation and healthcare. In this context, there is a growing need to demystify trauma and posttraumatic embitterment in a manner that can make a positive difference to the quality of people's lives.

Many people become embittered after traumatic, but non-life-threatening events, which causes them to become unwell. The unwellness filters into every aspect of the person's being and has a negative influence on physical health, relationships, cognitive functioning, and emotional, spiritual and financial wellness.

Collins (1988, 122) defines bitterness as anger and resentment in response to what appears to be a justified grievance. The bitter person often is intent on attaining revenge, develops ulcers, is hypercritical, and is rejected by people who dislike being around bitter people.

Bitterness sets in when a person is suspended in a place of anger owing to the emotional grievances they have suffered. The bitter person's unique experience of harm and the extent of their angry reaction to the original offence may appear out of proportion to the actuality of the circumstances, which argues for an authentic element to the development of bitterness. Embitterment can easily become all-consuming as soon as bitterness settles in. Embitterment is a most resolute frame of mind and heart that pollutes all perspectives and influences actions, destroying people from the inside out. Bitterness becomes the motivator that forces people to engage in irrational and self-defeating internal dialogue.

Ordinarily bitterness has a limited life span, since other, more progressive emotions will cause personal transformation and enlightened growth. By contrast, embitterment is the immersion of multiple emotions over a perceptible period of time. Embitterment should not be classified as a pathological disorder in all cases, however, since it is a complex reaction to adverse life events.

From a spiritual perspective, bitterness can easily take root when the human spirit becomes feeble and worn out. Unbroken fatigue can lead to spiritual weakness and discouragement. The effects of trauma and the ongoing burdens of life can overwhelm the body, mind and spirit. Proverbs 17:11 states that "the beginning of strife is as when water first trickles from a crack in a dam, therefore stop contention before it becomes worse and quarrelling breaks out" (The Amplified Bible 1987).

In Hebrews 12:15 there is a warning not to allow any root of resentment, rancour, bitterness, or hatred to shoot forth, because that root

will cause trouble and bitter torment, and the many become contaminated and defiled by it. Once bitterness breeds rebellion, the rebellion aggravates the feelings of helplessness and hopelessness that have crept in as a result of the trauma. The desire to give up can have life-threatening consequences (The Amplified Bible 1987).

## **Embitterment as a Complex Emotion**

Embitterment is a multifaceted emotion, usually arising from a sense of having been insulted or let down, and entailing a sense of being a failure combined with a yearning to fight back and, simultaneously, a feeling of anxiety and destitution, which causes an individual to have fantasies of retaliation and aggression towards himself or herself and the environment (Linden and Maercker 2011, 49).

From his perspective as a psychiatrist, Linden (Linden and Maercker 2011, 1) describes posttraumatic embitterment disorder (PTED) as a response to an adverse, but not necessarily traumatic occurrence that a person identifies as unjust and demeaning. This affective response involves feelings of rage, powerlessness, negative disposition, tetchiness, restlessness, resignation, and in some cases, self-blame. Linden describes bitterness as a state-like emotion that people feel now, while embitterment is a continuing “state of being”.

Linden et al. (2007, 16) explain that the activating occurrence in PTED is a remarkable, negative life-changing incident such as conflict in the workplace, unemployment, death of a relative, divorce, serious illness, or an experience of loss or separation. The unwellness progresses in the direct context of the incident. The main characteristic is a protracted sensation of embitterment. Invasive thoughts, avoidance of situations or objects which are connected to the incident, anger, self-blame, depression, phobia, hopelessness, somatic symptoms, or suicidal inclinations are further symptoms.

PTED is defined as an adjustment disorder in which the activating occurrence is not necessarily an anxiety-aggravating or directly life-threatening provocation, but an extraordinary, yet normal adverse life event. Affected individuals see themselves as victims and perceive themselves as unable to cope with the traumatic occurrence and the aftermath of the incident. Although they realise that the adverse life event brought about the unwellness, and perceive their present undesirable state as a direct and lasting consequence of the event, they are despondent. They express hopelessness and they are uncertain of whether they want the emotional wound to heal. There is a diversity of unspecified somatic

objections such as sleep disturbance, loss of appetite, pain and phobic symptoms relating to the place or people connected to the incident (Linden et al. 2007, 17).

Embitterment demonstrates a relationship with aggression, fatalistic attitudes, helplessness and hopelessness and feelings of being “attacked” and victimised. This can give rise to remonstrance and open hostility, but also passiveness, seclusion, and retreat. In comparison to depression, emotional modulation is unhindered. Although these incidents happen in the everyday setting, the shared feature is that they are perceived as unjust, a personal insult and psychologically as an abuse of basic beliefs and values (Louw 2016, 194).

Embitterment demonstrates itself through various other emotions, for example revenge. Revenge is an adverse and destructive emotion, leading to deteriorating mental well-being. The negative effects on health include depression, an increased risk of developing psychiatric indisposition, reduced life satisfaction, moderated sleep quality and higher levels of emotional distress (Louw 2016, 178).

Revenge also damages physical well-being through amplified cardiovascular activity and subsequent increased risk of cardiovascular diseases. Physiological parameters, such as hormonal cycles and activity of the sympathetic nervous system, accompanying unforgiveness and grudge-holding are akin to the physiological patterns succeeding stress (Linden and Maercker 2011, 49).

## **The PTED versus PTSD Debate**

From a biomedical perspective, there is significant debate among professional bodies regarding whether to classify PTED as an adjustment disorder or as part of posttraumatic stress disorder (PTSD).<sup>2</sup> Although PTED and PTSD are not new disorders, these terms seem to reflect modern-day diagnoses for susceptibilities that are as old as humankind.

Linden et al. (2007, 13) differentiate between PTED and PTSD by noting the significant difference in the type of critical incident experienced and the type of emotional reaction. In PTSD there must be an extraordinary, life-threatening incident which provokes panic and anxiety, whereas in PTED there is an ordinary life event that can happen to many

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<sup>2</sup> Posttraumatic stress disorder (PTSD) is a psychiatric disorder that can occur in people who have experienced or witnessed a traumatic event such as a natural disaster, a serious accident, a terrorist act, war or combat, rape or other violent personal assault.

people in the course of life, such as separation, dismissal and unemployment. Although this is an ordinary life event, it remains exceptional, since it is not an everyday event for the individual. In PTSD anxiety is the principal emotion, and in PTED it is embitterment.

In the next section posttraumatic embitterment will be delineated further in terms of its identity as either a reaction or a disorder.

### **Posttraumatic Embitterment: Reaction Rather Than Disorder**

People are complex in nature, and research has shown that people do not function in a linear manner. In a sense, people are more multi-faceted than a polished diamond. From every angle that a diamond is examined, deeper facets are visible and shine through. This is an important analogy to keep in mind when counselling an individual (Louw 2016, 67).

As indicated earlier, one of the characteristics of events occasioning embitterment is the abuse of a person's basic beliefs and values. Sartorius tells us that basic beliefs refer to personal constructs, personal theories of reality, internal world models, structures of meaning, assumptive worlds, or general value structures. He states that the remarkable reaction in PTED constitutes a disconfirmation of basic beliefs and values caused by the adverse life incident. The violation of basic beliefs and values leads to the interrogation of beliefs and values as a result of the contradictions between core belief and the adverse life incident (Linden and Maercker 2011, 248).

### **Is the Term “Trauma” Appropriate?**

Trauma, including pain and suffering, is an inevitable part of human life. However, the effect it has on the lives of individuals varies, and certain individuals become embittered after these normal life events. As a result, people become unwell, and this unwellness affects every aspect of their being. This negative influence can be seen in their relationships with others, their physical health, financial wellness and cognitive functioning.

Abrams and Tutu (2014, 16) cite the view of Desmond Tutu that the traumas people have observed or experienced live on in their memories, and can cause them fresh pain every time that they come to mind, even years later. Tutu notes that “until people can forgive, they remain locked in their pain and locked out of the possibility of experiencing healing and freedom, locked out of the possibility of being at peace.” If they are unable to forgive, people remain tethered to the person who has harmed them.

Tutu's observation could apply equally to bitterness as a reaction to trauma and pain that limits the individual's quality of life.

Linden et al. (2007, 29, 62) believe that the term "trauma" is fitting in the context of PTED because the supposition is that the individual experiences and perceives the violation of their basic beliefs as traumatic. There is a disparity between the individual's beliefs and the violation of these by the incident. The individual does not define the significance and meaning of the incident impartially. This threat to the individual's deep-seated beliefs displays as a prevailing psychological shock to them.

### **Health and Wellness in the Healthcare Paradigm**

Health is not an easy word to define, because it means different things to different people. For some it includes mental health, while for others physical and mental health are separate concepts. An observation of health includes the medical context as well as the individual within their sociocultural context, which extends to the family and social network as well as a wide selection of potential providers. Furthermore, different cultures may define health, healing and well-being differently.

Health and being healthy is a significant feature of a modern identity. The active involvement of the individual has been present in healthcare maintenance and illness prevention. There is increased emphasis on being a "healthy", "creative" or "spiritual" person.

In traditional cultures, healing is the restoration of balance within an individual's body; it includes restoring the balance between the community and the individual, and between the community and the universe at large (Louw 2016, 24).

Healing in the context of dealing with trauma does not involve reversing the incident or ensuring that what happened will never cause pain again. Tutu explains that healing involves the restoration of people's dignity and enables them to move on with their lives (Abrams and Tutu 2014, 23).

In healthcare a distinction is made between healing and curing. Dossey and Keegan (2009, 21, 91) define healing as "the emergent process of the whole system bringing together aspects of one's self and the components of body–mind–spirit–culture–environment at deeper levels of inner knowing." This leads to incorporation and balance, and each aspect has equivalent importance and value.

With this in mind, curing can be explained as the external medical process of effecting a conclusion in which the ailment disappears.

From this perspective, healing can be explained as the internal process through which an individual becomes whole. Healing takes place on various levels. It can take place at a physical level when, for example, a wound or broken bones heal. Healing also occurs on an emotional level when an individual recovers from the death of a loved one or appalling childhood trauma. Healing takes place on a mental level when people learn to reframe and restructure critical and unhelpful ideas about the world around them and about themselves which they held in the past. Spiritual healing manifests when an individual grows toward God, toward a deeper connection with nature, or toward inner harmony and a sense of connection (Louw 2016, 25).

The Zur Institute (n.d.) explains that health entails a cultivation of that which is preeminent in us in order for us to live life jubilantly, intentionally, ethically, and well. A healthy life involves associations with other people, finding personal meaning, and paying thoughtful attention to one's body, mind, and spirit, as well as to one's community and the world. This requires that the individual make choices that support their optimal well-being throughout every phase of life and through their attitude towards death and dying.

## **Healing after Trauma**

Following trauma, a holistic approach for an early intervention model is appropriate to mitigate the unwellness stemming from posttraumatic reactions before any disorder settles in. In my practice, as well as through the work of Inter Trauma Nexus, I have observed that only 2% of traumatised people develop long-term psychological dysfunctions. By contrast, 98% of people recover from posttraumatic reactions, either spontaneously (75%) or with short-term interventions (23%). Effective holistic crisis intervention and trauma handling clearly reduces the development of long-term psychological dysfunctions (Louw 2016, 2).

In a community where trauma, health issues, crime and poverty are endemic, these statistics give hope. Unfortunately, modern society as a whole places too much emphasis on finding out what is wrong with the victim and treating victims as the architects of their own problems. We should urge counsellors to find a way of breaking the cycle of victim-blaming questions and to understand that trauma and stress form part of everyday life. Asking victim-blaming questions will provide the counsellor with erroneous answers. A healthier point of departure would be to ask, "What happened to you?" (Louw 2016, 7).

From this perspective, healing is an indistinct term that means something different to every person, despite attempts in the literature to delineate the concept. Healing may be an inappropriate word in the context of dealing with trauma and embitterment. A more appropriate term in this context might be “normalising”. When a person seeks help, the first step is to normalise the situation in which the individual finds themselves and present practical occurrences and risks. There is no sure-fire method for normalisation, since each individual is affected by trauma in a different way. The coping skills and resilience of each individual differ across their personal wellness–unwellness continuum.

I suggest that healing is an allegory that advocates that a wounded or traumatised person can develop toward wellness. In this context, healing as a metaphor is not a technical term, and therefore technical criticism is not appropriate in the holistic context in which wellness implies multiple levels of wholeness (Louw 2016, 59).

If wellness signifies overall well-being, it incorporates the emotional, physical, social, spiritual and intellectual aspects of an individual’s life. Each of these aspects of wellness directly influences the overall length and quality of a person’s life. Emotional well-being relates to a person’s capacity to cope with life effectively and to regulate emotions, and in that way to create fulfilling relationships. Physical well-being indicates fulfilment through physical activity, consuming nutritious food and clean drinking water and getting adequate sleep. Social well-being indicates a sense of connection and belonging in an effective support system. In a spiritual context, wellness entails a person’s awareness to express and experience a sound sense of purpose. Intellectual well-being relates to an individual’s aptitude for finding different ways to expand their knowledge and skills creatively, while occupational wellness denotes the experience of personal satisfaction within their workplace.

These different elements all contribute to wholeness, and most individuals cultivate these components throughout their lives, since life entails a continual process of growth and change (Louw 2016, 42).

Puchalski et al. (2014) define spirituality as a dynamic and intrinsic aspect of humanity through which people seek ultimate meaning, purpose, and transcendence, and experience relationship to self, family, others, community, society, nature and the significant or sacred. Spirituality manifests through beliefs, values, traditions, and practices.

The holistic wellness options allow opportunities for every individual, taking the individual’s background, culture and personality into account. Each individual is a vital, dynamic, multi-dimensional being, and a cookie-cutter approach is not in anyone’s best interest, as it will omit

vital aspects of the person's unique story and disable long-term posttraumatic growth. If a counsellor does not engage in accurate problem and need identification, their clients may demonstrate open aggression, prolonged protest, isolation, passiveness and retreat.

### **Unwellness, Illness and Disease**

There are various terms and definitions that convey the idea of human unwellness. These terms are discussed in the section below.

“Illness” denotes the sociocultural milieu within which an ailment is present; people describe the “dis-ease” or illness episode in a manner that is personally and socially significant. Spirituality and religion play an important role in describing, understanding, and responding to disease within “illness”, where a person's illness can be a sign of community imbalance or sin.

“Sickness” is a notion that combines the biomedical model (disease) with the sociocultural milieu of the patient (illness). The clinical perception of disease refers to biological and physiological failing. The biomedical model focuses on diagnosing and treating disease.

“Disorder” denotes unwellness in terms of mental well-being. There is an inaccurate supposition that everybody who experiences trauma will develop a disorder. This misconception is promoted by the popular media, leading to a situation where people avoid seeking help out of fear of social stigmatisation.

Berkefeld and Braus state in chapter 2 of Linden and Maercker (2011, 105) that social pain and social exclusion make use of neural networks that overlap with those of physical pain. The brain may react to extreme social pain in a similar way to what it would to chronic physical pain. This principle is illustrated in the poetic example of the pain of a broken heart. This non-physical experience of pain needs to heal in a way similar to physically experienced wounds.

Warren, Amen, and Hyman (2013, 187) explain that there are no shortcuts that will make an individual healthy overnight. Health denotes wise choices made daily, despite the setbacks of life. Committing to healthy living will make all the difference in the striving towards wellness. Many fitness plans and diets use guilt as a motivator, but this will fail in the long run.

From a Christian perspective, taking care of the body entails spiritual stewardship, since the body is the dwelling place of the Holy Spirit (1 Corinthians 6:19). When God puts his Spirit inside a person, that person's body becomes a temple of God and a residence of His love; this

would imply that people are not the owners, but caretakers of their bodies. Unwellness usually follows from neglecting to make consistently good choices in taking care of the whole person; the subsequent unwellness manifests through illness, disease and other maladies (Louw 2016, 56).

People cannot create life, but their will is a key component in change. Change encompasses new thinking and learning to do things in unusual ways. In this context, unusual denotes a way that is different from what is customary in a person's life, family or even community. The change is vital, since the existing ways of thinking and doing are what contributed to the unwellness in the first place (Louw 2016, 57).

## **The Hope Factor**

An individual's instinctive will to survive and thrive is what makes them resilient. One example of resilience is the manner in which an individual's body and brain is their unique biological apothecary. Their body can simulate the drugs they take. Resilience is the part of the hope factor that is an essential attitude for survival.

Resilience can be described as the ability to work with hardship in such a way that one comes through it unscathed or even better for the experience. This pliability involves facing life's snags with courage and endurance, refusing to give up. Resilience is the characteristic that allows a person or group of people to bounce back from misfortune, hardships and traumas. The emotional aptitude to rebound is entrenched in a tenacity of spirit; a willpower to embrace all that makes life worth living, even in the face of devastating odds. A clear sense of self and purpose enables an individual to be more resilient, because the vision of a better future is predominant (American Psychological Association n.d.).

Posttraumatic growth is a developing field of research, investigating why some individuals flourish after a traumatic experience. Such traumatic incidents inspire and motivate some individuals to engage in business, relationships and personal development more creatively. The work of Victor Frankl (1997) can be considered the origin of the posttraumatic growth school of thought. Frankl was a prisoner of war in a Nazi concentration camp, yet strove for meaning amidst war, hostility and victimhood. Frankl sought deeper meaning in his life as a result of, and not in spite of, past traumatic occurrences. His research illustrates the characteristics of an individual with an extraordinary sense that life has meaning in all circumstances. The example set by Victor Frankl teaches us that life has meaning in even the most humiliating and painful situations,

and suffering can be meaningful. Despair, however, entails suffering without meaning.

The despair displayed by embittered individuals suggests that they lack the concept of grace. The injustice and humiliation they have suffered leads to a sense of unfairness that overshadows their entire life. Since they received no mercy during their traumatic experience, they will not show grace to others. This absence of grace and mercy can be either subconscious or deliberate (Louw 2016, 163).

### **The Role of Forgiveness**

Supporting a client through the process of forgiveness entails investigating the present and future instead of focusing time and energy on past experiences and events. The events that led to the unforgiveness will, however, nevertheless affect the present. Forgiveness is a self-investigative process that frees the forgiver from the burden of resentment (Louw 2016, 23).

Tutu explains that forgiveness is rightly the grace by which a person enables another person to get up with dignity, to begin afresh. The absence of forgiveness leads to hatred, bitterness, self-contempt and self-hatred that will eat away at a person. Irrespective of whether an individual internalises hatred or projects it outward, it corrodes the human spirit (Abrams and Tutu 2014, 23). Forgiveness is a goal within the therapeutic process, since it entails a decrease in the negative consequences following an incident and replaces these with more positive experiences (Linden and Maercker 2011, 199).

From a Christian perspective, the concepts of mercy and grace should be highlighted, since they validate the need for forgiveness and entail freedom from shame and guilt. If forgiveness is viewed as a gift from God, then this gift makes it possible for an individual to forgive others and themselves. In Romans 3:23–24, the Apostle Paul says, “Yes, all have sinned; all fall short of God’s glorious ideal; yet now God declares us ‘not guilty’ of offending him if we trust in Jesus Christ, who in his kindness freely takes away our sins” (The Living Bible 1971).

The most disabling stance that prevents people from accepting forgiveness from God is their inability to forgive themselves. This lack of self-forgiveness chains people to their past experiences and encourages them to nurture grudges against the people they resent, tying them to the very people they wish to be free of. Forgiveness allows people to embrace hope for the future and let go of the pain, regret and bitterness of the past (Louw 2016, 55).

Forgiveness is a complex theme because people forgive others, and themselves, in various ways. Unfortunately, people experience resentment and hold grudges in equally diverse manners.

Without forgiveness there can be no wellness, and in this context, I identified the need for a holistic wellness approach, focusing on an accountable, all-inclusive carefulness to enrich wellness that will lead to wholeness (Louw 2016, 62). This identified need led to the development of a model, termed the posttraumatic wellness coaching model (PTWCM). This model was designed to act as an early intervention model. It does not function within the biomedical context, but rather deals with posttraumatic reactions such as embitterment in various contexts such as the workplace, counselling relationships, healthcare practices, pastoral intervention and educational environments. The practical nature of this model highlights its applicability to people of different cultures, ages and levels of education, and the model can be applied in conjunction with other educational and therapeutic interventions.

This model entails a holistic system. Holistic systems thinking is described as an investigation that focuses on the manner in which the parts of a system interrelate, and interrogates the manner in which the system works over time within the context of other systems (Jackson 2011, 281). The aim of holistic systems thinking is to reinforce effects and balance processes where one tends to maintain the equilibrium of a specific system (Louw 2016, 42).

Within this context, holistic medicine is based on the concept of the whole person and includes a balance between the person's body, mind, spirit, emotions and environment. In this context, emphasis is placed on personal responsibility for health, and a variety of health practices, therapies and self-care fundamentals are used.

Jackson (2011, 281) indicates that holism prioritises the study of wholes over the study of parts, and focuses on ensuring that the parts are operative and relate to one another in order to serve the purpose of the whole. The holistic approach will require counsellors and managers to apply a variety of perspectives in dealing with the diverse, complex and changing situation that they are faced with. Through this approach it is possible to improve goal determination and achievement, ensuring fairness and promoting diversity. Holistic systems thinking will give consideration to efficacy, efficiency, elegance, emancipation, empowerment and emotion.

When assisting individuals who are embittered, the preferred method is coaching, since procrastination delays healing, and people put off doing the things that they know they should do because they expect a

painful experience. This expectation of pain is also prevalent when dealing with bitterness, because the individual is afraid of failing or discovering that they are less skilled than they thought.

When dealing with embitterment, development and change is inevitable, and in fact desirable. Many people experience change as a negative occurrence, because there is safety and comfort in stability and sameness. A coach will help the individual to adjust their thinking and methods while continually encouraging and motivating the individual through the process of growth (Farmer 2010).

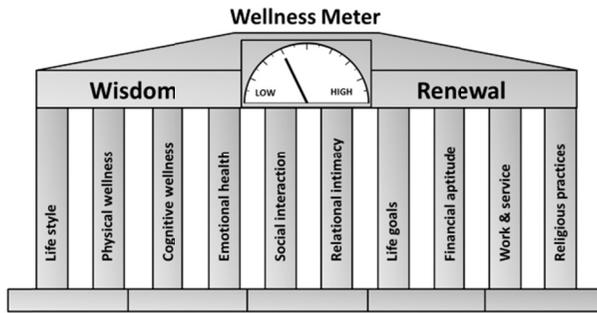


Figure 14.1 Wellness meter

In the model, the pillars are the areas that the solutions-focused coaching will focus on. They are: lifestyle; physical wellness; cognitive wellness; emotional health; social interaction; relational intimacy; life goals; financial aptitude; work and service, and finally, religious practices. The pillars are founded on various wisdom-based foundational concepts.

This model will enable the therapist to help the client to recover from embitterment, through a facilitation process. This facilitation approach contains five elements, namely empowerment, validation, connection, taking responsibility, and enhancing spiritual roots.

Empowerment is the first basic element. Since the individual will be in charge of their own healing process through managing the reactive effects of the trauma, bitterness and unwellness, the coach should empower them with the applicable skills and information that will ensure inclusive and participatory wellness activities.

The second element is validation. Traumatized individuals often lose focus and their support systems become overburdened with the accompanying bitterness and negativity. People who struggle with embitterment need validation of the importance of what happened to them

and the role that these events played in their lives. It is easier to deal with the fallout of embitterment when not travelling the road alone.

Connection is the third element. Trauma isolates its victims. The process of reconnecting with others tempers the embitterment and enhances the well-being and healing of these individuals. Disconnectedness and hostility form a vicious cycle that leads to alienation and more unwellness. Hope means looking forward to feeling better and is rooted in thoughtful gratitude and a reflective attitude.

Taking personal responsibility is the fourth element. This encompasses a sense of taking back control and refraining from blaming others. As soon as an individual is empowered to take back control over the various aspects of their life, they no longer need fear and bitterness, and they can embrace new experiences and new opportunities for wellness.

The final element that forms part of the PTWCM is spiritual roots. Religious practices include praying and reading the Bible, and these help people to feel more anchored. Serving the less fortunate involves doing something for someone else, and this opens the individual's eyes to look at others differently.

## Conclusion

The posttraumatic wellness coaching model adds value to the lives of individuals by serving as a benchmark for wellness and unwellness within the various systems in a holistic context. When working with clients within a counselling or coaching context, measurable outcomes can be achieved in every session, and this means that both the counsellor and the client know where the helping process originated, where the client is aiming to go, and when they have achieved set outcomes. This makes the PTWCM a valuable instrument for assisting embittered individuals.

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# SHIFTING LANDSCAPES: SPIRITUALITY IN THE LIFE OF THE AFRICAN HEALTHCARE VOLUNTEER

ANNALIE STEENKAMP-NEL<sup>1</sup>

## **Abstract**

Volunteers, as part of the healthcare worker corps, are an essential asset to the success of healthcare in South Africa. They are motivated by a cluster of factors, including spirituality. Little is known about the Christian spirituality of African healthcare volunteers however. This article does not focus on a particular methodology, but rather offers perspectives contributing to an understanding of African Christian spirituality in a healthcare context. In this paper I argue that despite societal changes, the service of African volunteers is not dependent on formal structures, but rather embedded in relationships. This is possible because they see the world as interconnected and en route to discovering a new interdependence. At a time when the healthcare sector in South Africa is being criticised for ineffectiveness, a shortage of investors and the lack of understanding of the broader contexts, this paper is a way of contributing towards the development of a new South African healthcare system.

## **Keywords**

Healthcare; spirituality; African spirituality; volunteers

## **Introduction**

An increasing body of scholarly work is paying attention to the shift in the South African health sector from political hegemony to active citizenry.

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Scholars have examined and speculated on the causes and manifestations of this shift and/or its implications for economics (Abrahams et al. 2012, 44–64), the health sciences (Hendricks et al. 2015, 59–72), ecclesiology (Koopman 2015), theology (Clarke and Linzey 2013, 140–145) and the relations between the government and society (Van Donk 2013, 10–18).

In South Africa, we are forced to a painful conclusion: all our conventional plans have not worked and cannot produce fundamental and long-lasting changes. Our expectation, along with the world's, was that, as Posel (2014) so eloquently puts it, transformation would:

link us to a rhetoric of – and aspirations to new beginnings, as though the post-authoritarian era ... would be a wholesale break rather than merely a gradual, uneven change.

Were we realistic? In my recent role as Community Mobiliser at CANSA (Cancer Association of South Africa) some of my responsibilities were to recruit, train and manage African volunteers and make contact with the local Department of Health and neighbouring NPOs (non-profit organisations) in the field. The lack of smooth collaborative action on all fronts in spite of a noble vision was conspicuous. While this is not an attempt to respond to the challenge of transformation specifically, personal spiritual transformation has (had to) become an integral part of my journey as a Christian and a theologian (Steenkamp 2010, 2011).

The foundation for spiritual transformation is already present in South Africa. Spirituality in African societies is a *plante à massif*. African Christian spirituality experiences God as a "rock, an anchor and the axis," and family members as a source of support and encouragement (Greeff and Loubser 2008). Spirituality generally gives sustenance, "support and guidance, acceptance, coming to terms with fate" and is a "resilience factor" (Greeff and Loubser 2008, 300; Dageid 2008, 191). Although a generalised description does not do it justice, African spirituality is characterised by its emphasis on a sense of belonging – to the soil, to one another, to oneself, to God, and to the ancestors, or "living dead", who are believed to be with God and benevolent towards their families, clans, communities, and society (Walligo et al. 2006, 236). Much has been done in association studies on the effect of African spirituality. It leads to personal and communal health (Manala 2006, 11) and can be a protective factor (Tuck and Anderson 2014). Spirituality cannot be ignored in the healthcare volunteer sector, because it is a core aspect of human life.

The health sector, however, is detached from its spiritual roots (I will show how later). What has been absent in development discussions is the role of spirituality in constructive health services and community

development.

Spirituality is in its essence transformational, and transformation is in its essence spiritual (Waaajman 2002, 455). Spiritual transformation goes one step further than transformation on its own: it rather is transformation by God. Spiritual transformation refers to the most significant transitions in the divine–human relational process (Waaajman 2007, 41), leading to unlimited possibilities (Rahner 1984, 61). In order to foster change a national study by the Peace Development Fund (1999, 21) confirmed that self-transformation is critical, asking "Can we truly transform society if we can't transform ourselves?".

The English word "transformation" originates from the Greek word *metamorphosis* for – "meta" means change, and "morphē" implies "form", and thus has to do with the special or characteristic form or feature of a person or thing (Merriam Webster 1984, 830) such as a caterpillar change to a pupa and a pupa to an adult butterfly. Considered in conjunction with "social development", it suggests that different spiritual transformations share characteristics in terms of form. It also suggests changes in one's own perception of change, or even that in certain changes, we ourselves are changed along with our shifting viewpoints. Transformation goes through different forms (or stages). Humans have an infinite horizon of experience of the Transcendent God (Rahner 1984, 61) that is continually unfolding. Waaajman (2007, 3) distinguished two horizons: an outer and inner horizon. The outer horizon is a person's context, comprising historical, socio-psychological, economic and cultural environments. The inner horizon is the configuration of one's spiritual transformational experience, being the practice of virtues such as prayer practices (Van den Hoogen 2011, 101).

The psychologist Coder (2011, 8) looked at social development from the perspectives of two poles; socially advanced and not so advanced social change agents, and described an inner and outer horizon as a combination of inner spiritual development and outer social change efforts functioning dialectically to engender constructive transformation.

Spiritual transformation is not a linear process. Waaajman (2002, 424) describes that spirituality is:

a human enterprise with moments of real growth and false growth, inwardness and self-transcendence, a search process and a divine enterprise with moments of revelation and eclipse, a phased and layered process.

The point is that what is needed in the health sector is that abstract reductionist "theories of change" community or mechanistic enrichment

models not just to accommodate specific social circumstances, but to incorporate spiritual transformation as well. Overly optimistic social, political and public health theories pursue empowerment via grassroots mobilisation, capacity building and partnership promotion (Kautzky and Tollman 2008, 17-30). Few interpret the spiritual dimension, "incarnated in life".

I distinguish between three types of spiritual transformation: deformation, reformation and transformation. Reformation proceeds from God and entails a renewal of the mind to distinguish what is good, recognisable by action. It brings light into a situation. Deformation is conformity to the world. One has no prospects or hope, and is limited by people or situations or oneself, self-oriented and/or self-absorbed (Waaijman 2007, 44, 460–461). Transformation is to be dissolved in God. His thoughts and strategy become yours. During this process, individuals can swing between ecstasy and confusion, a feeling of nothingness and a sense of triumph. The more you become transformed, the more you become transparent, so that God shines increasingly through you to the world or community. "Insofar as spirituality consists in the reflective study of the process of formation and transformation of human personal identity on account of spiritual experience" (Fortin 2016, 46), government policy as well as NPO actions can be considered a form of applied spirituality.

I will dare to enter the inner horizon, its "transformative power, and the way the divine–human relation takes shape" (Hausherr 1937). In order to do this, I will use a theory of spiritual transformation (Waaijman 2002, 426–481), lingering on the intersection of volunteers' outer and inner horizons. The two outer horizons will be African volunteers in the healthcare context and NPOs in South Africa. The inner horizon will focus on African healthcare volunteers' shifting spiritual landscape.

I will keep in mind that on these horizons volunteers encounter formation and deformation on their way to transformation. I will not focus on religion or intrinsic motivation per se. The volunteers' first outer horizon, the landscape of the South African healthcare context, will now be discussed.

## **Volunteers in the South African Healthcare Context**

In 2012 the South African government envisioned for all South Africans "a long and healthy life" by 2030 as part of its NDP (National Development Plan 2030) (Department of Health 2012, 3). The first difficulty was soon encountered. In 2012 the National Planning

Commission (2012, 25) admitted that the public health system could and "cannot meet demand or sustain quality". As a result of this disappointing outcome, the national developmental strategy changed direction in 2015 and is currently moving towards a more "active citizenry" that "champions their own development, supported by an effective government" (National Youth Development Agency 2015, 2) as a way of discouraging reliance on the welfare state (Jochum, Pratten, and Wilding 2005, 8). I will show later that to be and to act as an active citizen is slightly distinct from the mere collective, social or political.

A programme in the community-based primary healthcare sector was rolled out. Citizens could become more active and take control of their destiny as CHWs (community health workers) (National Planning Commission 2012, 346). A CHW is any health worker carrying out functions related to healthcare delivery for a population under 2 500 people who is trained in some way in the context of the intervention, and who has no formal professional or paraprofessional certificate or tertiary education (UNICEF 2014, 1). In South Africa, CHWs are sometimes called community home-based care workers (Kok 2015, 45). Tasks can be preventive, curative and/or developmental (Lehmann and Sanders 2007, v). CHWs in training are called volunteers.

This programme is not without its problems, however. Although it receives state funding it is time consuming, unsustainable and frustrating, although genuinely caring. In addition, the programme thrives in mobilised communities, but struggles where CHWs are made responsible for galvanising and mobilising communities (WHO 2007, 5).

Numerous studies (Tulenko et al. 2013; UNICEF 2014; Kok 2015) have examined problems such as these. The South African Development Plan suggested a solution in the form of partnerships with experienced NPOs (non-profit organisations) (National Planning Commission 2012, 349), probably in the wake of findings that successful programmes are often recruited and facilitated by non-governmental, community-based or faith-based organisations (WHO 2007, 5).

The government's own relationship with NPOs at which volunteers work is, however, problematic. There is a lack of collaboration, competency and information between NPOs and government entities. Many NPO staff took up upper management positions in the newly elected democratic government following apartheid, and regard NPOs as "white". This tension is not new. NPOs, with their difficult questions (Berger 2003, 36), play an important role in holding the government accountable for a range of responsibilities. This tension is in addition to 50 000 South African NPOs that deregistered at the end of 2012 amidst new regulations

and fresh fears of government control over civil society. Furthermore, a new Nonprofit Organisations Act is currently awaited (Pather 2016).

The South African government cannot, however, afford to be too dismissive of NPOs because their own recent history provides a glowing example of religiously inspired public and political action in the form of the role of the churches and "outside" NPOs in the abolition of apartheid in South Africa. The international tide is turning, though. Berger (2003, 16) makes the observation that: "There is increasing recognition of the limits of a purely secular approach to the solution of the world's economic, environmental, and social problems. "

In spite of and amidst the above shifting landscape, healthcare volunteers are being recruited, trained and facilitated daily by NPOs. I will now discuss another outer horizon of volunteers, namely the NPO landscape volunteers are working in.

### **Shifting Landscapes: NPOs in South Africa**

South Africa is the 24th most populated country in the world (DESA 2015b, 23), with 54.490 million people (DESA 2015a). Volunteering is well established in the social services in South Africa (Patel 2007, 15). In 2014, over a million South Africans volunteered – a figure 2.1% higher than in 2010 (Statistics SA 2014, iii). Of these volunteers, 60 000 provided healthcare or support (Statistics SA 2014, 40).

According to the National Nonprofit Organizations Registry Database (Department of Social Development 2012, 1), 11% of NPOs in South Africa provide healthcare – that is, 8 723 out of approximately 100 000 NPOs in South Africa. In 2014 the black African population recorded the second highest volunteering rate (Statistics SA 2014, 14). Statistics SA (2014, 14) reported that:

Volunteer work is important in the lives of people who benefit from volunteer work, given its economic importance to South Africa's growth and development.

NPOs enjoy the trust of the people they serve because they are able to mobilise people within a relatively short space of time and with limited resources, while governments cannot engage with people effectively for awareness building concerning various social issues (Kumaran 2012, 37). The South African NPO landscape is changing too. NPOs are accused of unwillingness or of lacking the capability or evidence to reach out, intervene or cooperate with individual NPOs or

NPOs from both developing and developed countries (Kumaran 2012, 41, 43). A self-imposed and government-imposed regulatory framework to promote NPO transparency and accountability is lacking (Kumaran 2012, 37). The reason NPOs are currently selective regarding time and resources is that after 1994 international funding was rerouted to government initiatives, as a result of which NPOs went into "survival mode". To ensure their continued existence, NPOs turned to the business world for sponsorships. Technocrats have their own funding preferences, however, which led to a "corporate paradigm" of care (in other words, a greater emphasis on quantifiability and target achievement) (Vale 2012, 21) and fiercer competition between NPOs as well as a "territorial" mentality (Kumaran (2012, 37). As a result, active citizenry began misfiring.

It is apparent that unless the present incongruences are resolved, there is little possibility of recasting the relationship between the state and the NPO sector. One can change the present. At the core of the health sector are the African healthcare volunteers and their legacy of spiritual understanding of interconnectedness and interdependence. The South African government recognised as early as 1995 that "religion, spirituality and belief play a central role in the lives of millions of women and men" and undertook to respect spirituality (Larson 1996, 257, 261; Department: Women, Republic of South Africa 2015, 6), which provides an excellent platform for the volunteers to consider their strengths.

It is argued that in order to return to the Christian tradition of transformation and to revisit the dynamic roots of African healthcare volunteers, the healthcare sector have to undergo a paradigm shift in theory formation from a fragmented to a transformational, processual approach. This leads us to the next landscape: the contribution of African spirituality, taking into consideration the global plea for spirituality in transformation. We will now explore the shifting spiritual landscape of healthcare volunteers and how they rise above their circumstances. I will suggest that African spirituality is undertaking a spiritual journey in which the experiences of healthcare volunteers foster profound transformations.

## **Healthcare Volunteers' Shifting Spiritual Landscape**

African spirituality is on a journey during which landscapes shift and viewpoints change. The inner landscape's inner horizon will now be discussed. During "transformation in re-creation" or re-formed existence new, horizons and fresh initiatives can emerge (Waaajman 2000, 658; Waaajman 2006, 44). Because they are so life changing, new experiences can be both exciting and frightening. A person can thus choose to go

forward (reformation) or turn back (deformation). A community or individual can consequently choose either to give their services, time and talent, or to use "power to change the behaviors of others to advance selfish interests" (Edwards and Sen 2000).

African healthcare volunteers have the potential to greatly enrich our understanding<sup>2</sup> of how deformation and reformation work. In this section I am limiting myself to only two components, "knowing full well that this delimitation is also a reduction" (Cilliers 2008, 3). The two components, interdependence and interconnectedness, are distinguished, but these cannot in fact be separated.

### **Shifting Interconnectedness**

Unlike individualistic Western cultures, traditional African cultures view the world, the self, and others in the world as extensions of one another (Beattie 1980). The sacred and secular worlds exert a mutual influence on each other (Mulago 1991, 119–120). This interconnectedness has fostered volunteerism. During the period in which modernity developed in Europe, indigenous volunteerism "involving African spirituality, was practiced in Africa south of the Sahara Desert, where it still thrives". Patel (2007, 9) argues that:

Service has deep historical and cultural roots in the African context. Pre-colonial African societies relied on mutual aid, kinship and community support to meet human needs. Traditional cultural beliefs and practices encouraged collective responsibility, solidarity and reciprocity.

The inner horizon of interconnectedness in South Africa is stretching, though. Quality and luxury, prosperity and the so-called "good life" is "hollowing out" Africa's caring core. Cilliers (2008, 12; Cilliers 2013, 3) explored urban African contexts and noted that African spirituality's sense of the integration of life is under threat. Sperry (2002, 30) notes that like people in any other Westernised country, Africans have adopted a self-fixation, giving rise to the danger that good living will be reduced to self-fulfilment and self-realisation, individualism and spiritual narcissism. This individualistic approach is juxtaposed with a systemic, networking and dynamic relational approach. Interconnectedness has

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<sup>2</sup> Being from a different culture from that of the African volunteer healthworkers, I admit that my cultural horizon has blind spots. However, it is the only means through which my interpretation is possible (Sheldrake 2006, 21).

become fragmented. There is a shift from "all is one" to "all is I".

Another seismic line is shifting; interconnectedness between citizens and the state is being redefined in the course of economic struggles over access to salaries and personal development. This fragmentation has penetrated volunteerism. Apart from the personal satisfaction that comes from helping people, some volunteers in an urban landscape, according to Statistics SA (2014, 8), expect to receive compensation in the form of cash, food, skills, transport, clothes or shelter. Although all unpaid work needs to be supported economically through some means, for example through emolument activities by other family members and the community, it seems that national citizenship is giving way to a new kind of altruistic citizenship.

Such individuals can be susceptible to deformation. Many Africans define themselves by finiteness bypassing spiritual transformation. Corin and Murphy (1979, 147–178) pointed out that separated from or rejected by their reference group and support structures within family, community, or tribal group Africans can experience confusion, helplessness, and even panic. Interconnectedness then becomes fragmented and redefined in the course of economic struggles over access to opportunities and finances. This deformation should not surprise or derail us. Hardship has a role to play. It can be transformative. As Chimhanda (2013, 4), an African Christian theologian, reminds us: "Humankind as spirit is said to be transcendent – to transcend human limitations in the quest for God."

Volunteers can journey through deformation to reformation. By coming to terms with shortcomings, inconsistencies, irregularities and contradictions volunteers can achieve an intimate knowledge of themselves and their inner resourcefulness. In fact, active citizens are already engaged in the development process (Van Donk 2013:120), and reduce barriers in different contexts. Goudge et al. (2009) report how a mother became a volunteer to give informational and emotional support to others, as it had been given to her.

In a shifting landscape people are shifting. In a shifting spiritual landscape people shift spiritually, or are internally transformed. African volunteers see the world as interconnected, and their service is not dependent on formal structures as it is in the West. Therefore, they can become embedded in interconnectedness in a new way en route to a new interdependence.

## Shifting Interdependence

Underpinning active citizenry in South Africa is the notion of ubuntu, a word in isiZulu meaning "humanity" or "interdependence" (Bangura, 2005). Ubuntu is at the core of volunteerism. The saying *umuntu ngumuntu ngabantu*, or "a person is a person through other people", is a mindset that celebrates community (Kevlihan 2005). Although "the concept of ubuntu is included in the South African constitution's postamble and in two Constitutional Court judgments" (Lenta 2003, 158), and has been incorporated in the business sector as a concept in management since the early 1990s (Karsten and Illa 2005), Knoetze (2014, 174) is of the opinion that *ubuntu* does not focus on nation building or national development yet since the focus of *ubuntu* is still on the inside of traditionally closely-knit communities such as the extended family or clan."

Another horizon is unfolding. Urbanisation and globalisation have brought about alienation from family systems and their concurrent value systems (Cilliers 2008, 3). The African value system is under threat, and has already given way to the breakdown of human relationships within the community, including those with the ancestors. Ubuntu in its original sense is, according to Van Binsbergen (2001, 73), just a sigh or the black elite's utopian sticking plaster on urban ills: the images of concrete social life featuring in statements of ubuntu do not correspond to any lived reality anywhere – they are allowed to refer to "no-place", and to merely depict, through social imagery, desired changes to be brought about by an application of the precepts contained in ubuntu.

Ubuntu can indeed be distorted into deformation of its value of interdependence. African Christian spirituality is "vibrant and pervasive", however (Galgalo 2012, 1). People nowadays experience, in spite of deformation, a new ubuntu or family in the form of congregations in cities and churches (Mouton 2014).

This landscape may change again because, as Delle Fave et al. (2011) state:

the aforementioned perspectives began to change, and it cannot be assumed that all individual African people or youth still adhere to these notions, because over time both the cultural context and the individual ceaselessly may undergo changes.

God speaks on an intuitive level, however, and African spirituality is intuitive and can per se be an impetus for rebuilding families and communities.

There are undoubtedly many ways to accomplish transformation, but the following suggestions regarding traditional and contemporary African spirituality are at least a start.

### **Some Perspectives on Spiritual Transformation of the Health Sector**

I propose a number of changes to the government and NPO policies while maintaining their attention on volunteer competence, along with improved primary healthcare outcomes.

The South African health sector does not yet have the required skills on all fronts and landscapes. While South Africa is waiting for a new dawn, another approach is needed. Active citizenry and transformation asks for a wider understanding than the earlier views. Some volunteers have already shown how one can break down the dichotomy between the sacred and the spiritual, push through difficulty and deformation and change one's mindset, and in that way become reformed and even transformed. Although social change and spiritual transformation are not neat, I humbly suggest considering inner transformation on all fronts as a way to move forward as the South African healthcare sector (the government, NPOs and volunteers) are seizing the opportunity to descend into and recognise their darkest self, making space for the living in their communities.

Future policy and regulation can and must address the themes, issues and challenges of future development, by addressing the spiritual transformation of civic engagement. Sekoa (1997, 9) states that "African spirituality is outward bound for inward nourishment of the community through shared experience". Bring traditional and contemporary African spirituality to expression in new and creative ways. Foster shared experiences during activities, for example, give volunteers the opportunity to work in teams or introduce the buddy system. However, it would be advisable for the Department of Health to test the impact of these changes before implementing major changes. This could be done on a small number of volunteer programmes.

South Africa is not destined to be infinitised by finite forms like unproven processes, procedures, programmes, arbitrary numbers or legislation. The focus can shift from improving the health system to the spiritual transformation of those in the health system.

## Conclusion

The anticipated dynamism in the South African healthcare landscape has given way to stagnation and hypoxia at the expense of volunteers' spirituality. However, healthcare in South Africa cannot be separated from the spiritual context in which it is performed.

This article is an attempt to articulate and contextualise the inseparability of the outer and inner horizon of volunteers' spiritual transformation. It sets out the aim of God's work in the world as the total transformation of the whole person in all its contexts. God can stretch our outlooks amidst our shifting landscape.

When spirituality is accommodated and unleashed, a new interdependence and interconnectedness in accordance with African spirituality can transform South Africa's healthcare system.

The quest for a South African healthcare system is fully under way as the contexts in South African healthcare continue to change. Despite the many challenges, the vitality of spiritual transformation is the contribution that African Christian spirituality makes to the discourse of healthcare. South African policy-makers must both go through and grow through their own policies to be able to make better plans, and not get entangled in them.

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# FROM DRY BONES TO RECONSTITUTED BODY: HEAD AND NECK MICROVASCULAR RECONSTRUCTION, BIBLICAL SPIRITUALITY, AND WHOLENESS IN HEALTHCARE

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## Abstract

Head and neck microvascular reconstruction, also known as free flap reconstruction, offers hope for bodily wholeness to patients facing cancers of the head and neck. In this paper, I seek to delineate how the healthcare worker can cull the spiritual resources necessary to treat not just the psychosocial-biological, but also the “existential disarray” of the patient’s life by drawing on the specific example of head and neck microvascular reconstruction understood from a theological perspective. I proceed by summarising the history and outcomes of one type of free flap reconstruction. I then turn attention to the remarkable vision and promise in the Book of Ezekiel (Ezekiel 37:1–14) of a reconstituted body in order to name microvascular reconstruction as a work of the Holy Spirit in actualising wholeness. Connecting free flap surgery with God’s desire for wholeness thus offers a depth to the hope that surgical oncologists and affiliated healthcare workers seek to express. Finally, by invoking the description of the Holy Spirit in the Christian scriptures as *Parakletos* or Comforter (John 14:16), I draw out the consequences of such a biblical spirituality for healthcare workers.

## Keywords

Microvascular reconstruction; head and neck; Ezekiel; Holy Spirit; pneumatology; spirituality; healthcare worker

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## Introduction

Head and neck cancers are among the most difficult malignancies to treat because they affect many vital organs that also influence a person's ability to function and relate to others. As we know, the mere word "cancer" can send a person into "existential disarray," but the destructiveness of this disease is especially evident when it affects the head and neck. Physician and theologian Daniel Sulmasy expressed this particularly well in a 2001 lecture to the American Academy of Otolaryngology-Head and Neck Surgery:

You must not underestimate the great human significance of your field. The region of the body on which your professional gaze is fixed is the primary venue in which human beings relate to each other as persons. The head and the neck are the primary means by which we identify others and are in turn identified by them... Four of the five senses belong exclusively to the head and neck (Sulmasy 2002).

Without the tongue, larynx, oesophagus, jaw, cheek, or cheekbone, a person can be left with significant deformities that affect in particular body image and the ability to interact with others. However, there are surgeons around the world who offer tremendous hope to such cancer patients by performing head and neck microvascular reconstruction.

I was blessed to work for a team of world-renowned surgeons who possess the capability to simultaneously excise a tumour and reconstruct the affected area by taking vascularised tissue from another part of the body. Over my four years of service in the Head and Neck Institute of Mount Sinai Beth Israel, I came to see that through free flap surgery, my attending physicians demonstrate remarkable sensitivity to bodily wholeness in healthcare, and that remarkable convergences exist between this and the broader Judeo-Christian theological tradition which I as a healthcare worker could tap into and draw on for inspiration and sustenance as I accompanied patients in facing their "existential disarray." Specifically, I believe that the focus on wholeness in microvascular reconstruction resonates deeply with biblical theology, and with pneumatology. Drawing attention to these connections can profoundly transform how healthcare workers and clinicians treat patients by helping healthcare workers remain attentive to the awe-inspiring fact that healthcare is a realm in which the Spirit of God is at work. When one feels the Spirit's nearness, everything changes: the mundane is charged with God's presence and promises, and crosses become bearable.

In this paper, I seek to describe how a healthcare worker can cull spiritual resources from head and neck microvascular reconstruction to become more deeply attuned to not only the psychosocial and biological exigencies of cancer care, but also the existential. A secondary objective is to connect such care, and healthcare in general, with the discipline of pneumatology, the study of the person and work of the Holy Spirit. There are many opportunities for theologians and healthcare professionals sensitive to the role of faith and spirituality to make important inroads in pneumatology. I believe that more attention can be given to sustained theological reflection in this field. Indeed, I am convinced that the Spirit is powerfully at work in the hands, minds, and hearts of the surgeons who strive to preserve as much quality of life as possible for patients with head and neck cancer. Recognising that this is a mixed audience of clinicians and theologians, I will therefore proceed first by summarising the history, technique, and possible outcomes of microvascular reconstruction. I then turn to the remarkable vision and promise in the Valley of the Dry Bones in the Book of the Prophet Ezekiel (Ezekiel 37:1–14) as a leitmotif for healthcare and wholeness and to name microvascular reconstruction as a concrete work of the Holy Spirit in the world in actualising wholeness. Finally, I draw on the description of the Holy Spirit in the Christian scriptures as *Parakletos* (advocate or comforter, John 14:16) to develop a spirituality for healthcare workers. I will likewise name best practices that can foster wholeness in healthcare.

### **Microvascular Reconstruction: Overview and Example**

According to the American Academy of Otolaryngology, 550 000 head and neck cancers are diagnosed worldwide each year.<sup>2</sup> In the United States, it is estimated that approximately 110 000 people will be diagnosed with head and neck cancer each year. Sixty-six per cent of oral cancer cases are already at an advanced stage (stage III or IV) by the time they are diagnosed. It is this subset that often undergoes the radical resection of a malignancy with advanced reconstruction. While head and neck cancer cases ultimately account for only 6% of all cancer cases in the United States, they nonetheless require a tremendous amount of expert multidisciplinary care to manage. Patients with oral cancer, for example, often require continuous follow up with a surgeon, radiation oncologist, medical oncologist, dentist, oral surgeon, speech pathologist, and

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<sup>2</sup> American Academy of Otolaryngology, “50 Facts about Oral, Head and Neck Cancer.” <http://www.entnet.org/content/50-facts-about-oral-head-and-neck-cancer>.

nutritionist. Some may seek the additional services of a social worker, psychologist, psychiatrist, or chaplain to help them cope with the emotional and psychological effects of the disease. All of this is to demonstrate the complexity of head and neck cancer care, and that it shakes a person to the core.

Although reconstructive surgery has a lengthy history, with some techniques dating back to antiquity (Erovic and Lercher 2014), our focus here is on the more recent developments in microsurgery that have made the reliable use of microvascular reconstruction of the head and neck possible. These advances offer tremendous hope to patients to avoid severe disfigurement and protect some quality of life and the ability to relate to others. The key factor is the capability to transfer well-vascularised tissue and reconnect minor blood vessels to ensure a viable reconstruction. In many settings, the reconstruction takes place during the same surgery, immediately after or simultaneously with the resection of a malignancy, thereby frequently obviating the need for subsequent surgery (unless the planned reconstruction is staged).

To demonstrate the attention to bodily wholeness, one can focus on the fibula free flap, which was first performed in the head and neck setting in 1989 (Steel and Cope 2015). This type of flap is considered the gold standard in reconstruction of the jaw (Okay et al. 2016). In the case of patients with benign or malignant neoplasms of the jaw or with necrosis of the jawbone due to the effects of radiation therapy, a team of surgeons can cut out the affected portion of jaw, and simultaneously harvest a segment of the fibula bone in the leg, along with tissue and blood vessels. After harvesting, surgeons can then cut and contour the fibula to match the outline of the original jaw, inset the fibula into the remaining jaw and reconnect the blood vessels, and fix the bone in place with the remaining jaw using a titanium plate. A variety of designs can be used to restore the jaw's contour as much as possible, including a double-barrel method to restore continuity of height in the native jawbone and the neo-mandible (Jacobson et al. 2015; Monaco et al. 2016). It is also possible to integrate implants with the neo-mandible to eventually restore full dentition. Now there are increasing reports of successful use of 3D computer planning to perfectly contour the fibula for insetting and to ensure the best possible contour for the new jaw (Toto et al. 2015; Okay et al. 2016; Rodby et al. 2016; ).

## The Biological and Spiritual Significance of Microvascular Reconstruction

In terms of attention to wholeness, there are two things we can take away from this method. First, as we can imagine, the promise of cutting out a tumour or diseased portion of the body and simultaneously reconstructing the affected area is a tremendous source of hope for a patient. Patients with head and neck cancer have well-documented concerns about body image, quality of life, and functional capability (Singer et al. 2012), and their emotional distress is often higher than that experienced by patients facing other kinds of cancer. Microvascular reconstruction has the promise of retaining such quality of life (Fingeret, Teo, and Goetsch 2015), which can foster a fighting spirit in the patient. As Dr Mark Urken notes,

The enthusiasm or willingness of patients to continue to fight their diseases may very well be tied to the ability to offer a reconstruction that has the potential to preserve their function and appearance after the necessary ablative procedure (Urken 2010).

Accordingly, one may identify in microvascular (and regional) reconstruction remarkable attention, often understated on the part of clinicians, to the wholeness of a person. Clinicians tend to couch this sensitivity in terms of "quality of life," but even at that, one wonders whether "quality of life" does not perhaps vastly understate what can be given back to patients through this kind of reconstruction, for what is restored is the ability to live and relate to others (and in the religious patient, to God) by the preservation or restoration of the senses, the organs through which we know and are known. Therefore, what is given, above all, is hope; we might recall Thomas Aquinas's paradigmatic definition of hope as the theological virtue by which a person attains an arduous but possible goal (Aquinas 1947, *Ila Ilae* Question 17 Articles 1 and 7, *respondeo*).

Additionally, we ought to remark upon what one might call the "organic" approach inherent to microvascular surgery. Many of the innovators in microvascular surgery have taken the view that the patient's own body can provide the material needed for reconstruction, and that this is in fact a better alternative if we are concerned with long-term quality of life. In this regard too, Dr Urken notes that because of free flap surgery a physician can "view the entire body as a reservoir of tissue to accomplish [one's] reconstructive goals" (Urken 2010). Put simply, microvascular surgery involves remarkable ingenuity and creativity on the part of the surgeon in seeing, treating, preserving, and utilising the body as a whole in order to preserve human wholeness. For example, the fibula is not a

weight-bearing bone, so performing a fibula free flap does not usually leave any significant deformity or deficit to a patient's ability to walk. Physicians have also come to recognise that a well-vascularised free flap such as the fibula flap is quite amenable to bone-integrated implants, and that using such healthy tissue also helps in withstanding radiation therapy if it is needed after surgery. This thoughtful and creative use of the human body also demonstrates attention to the wholeness of a person by doing as little harm as possible given the circumstances. To be sure, even in the methods described above (particularly the fibula free flap), there is still the risk of a failed flap. But it is truly remarkable that surgeons can and do find ways to make use of the native body to heal and restore in a reliable and "organic" manner.

### **Spiritual Connections: The Dry Bones**

This attention to bodily wholeness has a remarkable resonance with a passage in the Book of the Prophet Ezekiel (Ezek 37:1–14), a text that as a whole can be rather strange and disturbing. Yet here we encounter a clear appeal to bodily wholeness and integrity in a bizarre vision. I would like to summarise and situate this passage to help establish its affinity with microvascular reconstruction. Ezekiel, a prophet during a time of crisis in the history of ancient Israel, is granted through the Spirit of God (*ruah*) a vision of a valley full of dry bones. A dialogue ensues in which God asks Ezekiel, "Can these dry bones live?" Ezekiel replies that only God knows. God then commands Ezekiel to speak to the bones and prophesy that God will grant new life to them. Ezekiel follows God's instruction, and sure enough, the bones come together before him: first, the bones come together to reform the skeletal structure, then muscle and skin regenerate, and finally whole bodies are reanimated when God commands Ezekiel to breathe on them. Ezekiel then hears God explain the significance of all of this, namely that God will grant new life to Israel through God's Spirit.

For scripture scholars, this passage can have a variety of meanings, from a glimpse of the Resurrection of Christ and belief in the resurrection of the body to the promised corporate reconstitution of Israel. More basically, the vision of the dry bones represents the "bringing back to life (of) a community that thought it was dead, and in a sense was dead" (Goldingay 2003). For our purposes, I want to underline other components of the passage and draw out another meaning. First, I wish to draw attention to the theme of whole bodies here, in that God's attention to these cadavers signals not simply a plan of hope and promise of new life to Israel as a whole as indicated in the text, but also an underlying

profound message about God's care for the human body itself, and God's desire to bring healing and wholeness out of piles of bones and anonymous corpses (and by analogy, what this means for the wholeness of Israel). To the patient, the bringing together of the fibula bone with the diseased jaw is a realisation of "bringing back to life" that which is dead, both biologically (the jaw) and existentially (the person). The Spirit's role in particular is singled out in this passage as the power through which God brings new life. This is consonant with a survey of the entire Hebrew Bible and the New Testament as well: wherever the Spirit is, life is either created or renewed.<sup>3</sup>

Second, it is essential to note that this reconstitution of the dry bones requires human cooperation. Another pattern throughout the whole of scripture is that the Spirit empowers a particular person or group of people. We have the tradition of Israel (and ultimately of the early Christian church) that prophets are people marked and inspired by the Spirit and equipped to perform various signs, which can include healing. Christians will also point to Jesus as the Christ (anointed one) who through the anointing of the Spirit performs various signs and wonders, including many acts of physical and emotional healing.

What does this have to do with microvascular reconstruction? While free flap reconstruction is not a matter of reanimating cadavers as in the passage in Ezekiel, and while it certainly has nothing to do with bringing to life a community in antiquity, I believe that free flap reconstruction brings to life the vision articulated in Ezekiel in its own way. Indeed, for patients with head and neck cancer, the hope of reconstruction is in fact new life in the face of death. One can have a new heart, a new spirit, precisely because reconstructive surgery preserves the wholeness of the face and its structures. And the process, involving the Spirit's action and the cooperation of a human agent, involves the careful reattaching of limbs, sinews, and bones to realise that wholeness.

There is another dimension to this vision of the dry bones that is worth highlighting. According to the passage, the Spirit of God is the primary agent: the Spirit enables the vision, and the Spirit is the power through which the bones come to life. Christians and Jews believe that God desires healing and wholeness. Our conviction in this is rooted largely in texts such as the valley of the dry bones. Thus, I argue that the development of microvascular reconstructive surgery ought to be attributed to the Spirit as the one who inspires authentic progress in human

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<sup>3</sup> One might recall Psalm 104:30: "When you send forth your spirit, they are created, and you renew the face of the earth."

creativity.<sup>4</sup> This is to say that microvascular reconstruction, understood theologically in light of Ezekiel's vision of the dry bones, can be a remarkable resource for articulating a *Spirit*-uality of healthcare, and that in our striving to preserve bodily wholeness in healthcare, we do so in cooperation with the Spirit of God. To develop this claim, and to begin to lay the groundwork for the final component of my project on the significance of such a *Spirit*-uality, I will now turn attention to a theology of the Holy Spirit as *Parakletos*, or Comforter.

### The Comforter

In what scripture scholars call the "Farewell Discourses" in the Gospel of John (13–17), we encounter a sustained theology of the Holy Spirit as *Parakletos*, or Comforter and advocate. The context is the impending Passion of Christ, his Resurrection, and his Ascension – and thus, his departure from the disciples and existence “in the flesh.” Thus, the Farewell Discourses have the purpose of outlining how it might be that the disciples can abide in the Risen Lord, no longer bodily present, as branches of the one Vine. The key is the promised gift of the Spirit, who is defined primarily as *Parakletos*, a term that is seemingly inexhaustible: it conveys a sense of comfort and consolation when we are in distress, and it also has legalistic connotations, that the Spirit is our court advocate. In John's Gospel, Jesus teaches that even though he will “go away,” the Spirit/Paraclete will abide with believers forever (John 14:15–17), will guide them into the truth (John 16:12–14), and will give them peace (John 14:26–27). Then, in John 20, at the Resurrection, Jesus bestows that Spirit upon the disciples by *breathing* on them (which should remind us of the *ruah* who gives life to the dry bones). What do they become as a result? If the disciples are to be branches of the Vine, the gift of the Spirit in John 20 should lead us to believe that the disciples become agents of *paraklesis*, since they are filled with the Paraclete.

So far I have described how the Spirit is at work in the hands of surgeons, but now I want to develop how healthcare workers can appropriate a *Spirit*-uality of healthcare. Chiefly, the healthcare worker can offer the encouragement, comfort, and advocacy (*paraklesis*) of the Paraclete. This can help retrieve a sense of medicine as a realm where the Spirit of God is active. Perhaps it may be helpful to draw on an insight of German

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<sup>4</sup> This is a point I hope to develop in subsequent writings, but it deserves noting here.

theologian Jurgen Moltmann, who has argued in numerous works that God is a God of life, and that the principal work of the Spirit is therefore to give or renew life and promote human flourishing: “The sending of the Holy Spirit is the revelation of God’s indestructible *affirmation* of life and his marvelous *joy* in life... Where the Holy Spirit is present there is life” (Moltmann 1997). Since the purpose of medicine is to affirm life by treating disease, healing people, and preserving or increasing quality of life, one can argue that behind all true advances in medical care is the work of the Spirit of God. As Haynes and Kelly remark in their important work on a new spirituality of medicine,

To suggest... that health care is accomplished through power of the Spirit is to profess that, at the core of all achievements of modern medicine and all the technological breakthroughs in healthcare, there lies the mysterious, often hidden, power of God (Haynes and Kelly 2010).

If this holds true, then reconstructive surgery of the head and neck by free flap reconstruction – indeed all health care – ought to be linked with the work of the Holy Spirit. The consolation and advocacy of the Spirit is especially evident in the constant effort among physicians, scientists, and allied health professionals to both seek new and better ways to heal and test and to perfect the current methods, in their self-effacing work ethic, in their patience, and in their love for those they care for. The power of the Spirit is reflected in the new life that microvascular reconstruction can offer to those who feel like “dry bones” because of the existential disarray that cancer places them in.

Healthcare workers can also contribute by naming and working according to that hidden power of God in medicine. Doing so depends on a “spirituality” in every sense of the word, in terms of a “lived experience of faith” (Holder 2005), a “naming of the sacred” or “the coexistence of the inner realization of something bigger than ourselves and the inner ontological drive to make sense and meaning of our existence within the physical, sociopolitical, environmental, and intrapsychic world in which we find our existence” (Sorajjakool 2006), and above all, on recognising the Spirit of God at work in our work. Therefore one of the benefits of this approach is to try to change the optic through which the healthcare worker views the healing work of the physician. As Philip Sheldrake remarks, “Spirituality offers a sense of purpose and hope... [it] broadens how we *understand* healing but thereby expands the *experience* of healing” (Sheldrake 2010).

The main task, then, is to become aware of the palpable presence of the Spirit in the work that we do, to have an expansive experience of

what healing consists of, and to realise that all team members participate in the healing task. What I have attempted to outline here is a specifically biblical spirituality for the healthcare worker by pointing to the Spirit of God in Ezekiel's vision of the dry bones and in the Gospel of John. When the presence of the Spirit is brought to their consciousness, healthcare workers are both challenged to give their best effort, and also comforted in knowing that at work behind the scenes is the creative Spirit of God. Indeed, Haynes and Kelly point out that:

We have affirmed in our common faith that the Holy Spirit moves us to break out of the stifling air of a stale routine... When we are led by God's Spirit, our ways of thinking about people, events, and things of nature are changed. We become convinced that our life as God's children is stronger than sickness and even death and that new beginnings to physical, spiritual, and emotional health are possible where, before, one may have run into only dead ends where hope seemed to wither (Haynes and Kelly 2010).

It is the promise of "breaking out" of the "stale routine" by naming the work of the Spirit that I now wish to draw attention to, so that there is conscious cooperation and collaboration among physicians and all healthcare professionals. Recall the dynamic of the passage in Ezekiel: the reconstitution of the dry bones requires the human cooperation of Ezekiel. Similarly, the Spirit invites us to cooperate in providing the same healing. Returning to the theology of the Spirit in John's Gospel, the Spirit is the abiding gift who connects us to the Vine, such that we do the work that Christ does. In this way, a biblical spirituality for healthcare workers can evoke a sense of awe and responsibility on the part of the healthcare worker – that sense that one is somehow caught up in the breathtaking promise of new life and consolation and comfort.

### **Illustration: Discovering the Spirit at Work**

Allow me to illustrate this further by sharing some of my experiences as a patient advocate. As was noted above, patients with head and neck cancer report significantly higher levels of stress than other patient populations. Their stress can be easily exacerbated by the tedium of navigating phone trees, reading between the lines of one's health insurance benefits, and managing all the testing that needs to take place prior to surgery. The patient advocate position was created in my practice to allow a person to be an extension of the surgeon's compassionate care by being more readily available to coordinate and troubleshoot. As an intermediary, the patient

advocate can help “make things happen” for the patient. In many instances, this is manifested in the patient advocate “pushing paper” to the right place, however banal that figure of speech may seem. It is perhaps more accurate to say that the healthcare workers who “push paper” are really “passing the baton,” allowing the process of caring for a patient carefully and swiftly to continue, hopefully without a hitch. In practices where the handoff is smooth, patient satisfaction is naturally higher. This allows the patient to be certain that both medical and emotional needs can be attended to as they face surgery.

I think that more often than not, surgical oncologists and clinical professionals are already attuned to the reality that they must treat the whole person. However, for the whole team, and especially for me, it can become too easy to get distracted or discouraged by our office duties: the tedium of phone calls, booking appointments, and compiling or completing vast amounts of paperwork to successfully allow patients to proceed with surgery. We don’t really comprehend what our surgeons are up to in the operating room. Therefore, for the healthcare worker, attention to the whole person demands that each part of the healthcare team approach their work with diligence. Speaking personally, once a theological connection emerged between the care my practice provides and the vision of the valley of the dry bones in Ezekiel 37, it became more natural for me to approach the job with greater diligence, and I became aware that I always had a ready resource to turn to in order to refocus whenever my attention or energy slipped.

As I became aware of the Spirit’s presence and desire to heal, I came to see my office and my tasks as a realm in which the Spirit of God was palpably at work and inviting me to do my part, much like Ezekiel was invited and empowered in that valley to be an instrument of the Spirit’s work. A surgical reservation form, for example, became more than a sheet of paper. With the dry bones in mind, I recognised how everything depends on that one sheet. There are medical and financial repercussions if that form is not carefully and promptly submitted. So, in a sense, that form too came to life as an instrument, and my participation in the system of care took on new value.

More important, interactions with patients took on new meaning. Seeing my office and my duties in light of the Spirit’s presence drew attention to the need to be patient and attentive to every patient I encountered, and to be especially patient with those who were particularly distressed. Although it seems obvious, many know from experience that listening to another person carefully takes tremendous energy. My spirituality of work underwent a profound conversion as a result: I

discovered a deeper design and meaning, and came to encounter the transcendent through work. This helped give me a resource to refresh myself as needed in order to return to the work that I do, and thus allowed me to function more effectively as an interpersonal link who is attentive to the wholeness of care that is required when one is facing head and neck cancer.

### **Conclusion: Wholeness in Form, Function, and Spirit**

Towards the end of my time at Mount Sinai Beth Israel, I saw a long-established patient at a follow-up visit who, as a result of three ablative surgeries for recurrent parotid cancer over twenty years, had an obvious facial deformity and paralysis on one side. He was known to our staff to be particularly gruff (and who wouldn't be, after having multiple bouts with cancer?) but during this encounter, he was different. He had just undergone the second stage of a facial reanimation procedure, and when I greeted him, he smiled broadly. The vision of the dry bones came to mind on innumerable occasions as I worked with our patients, but at that moment, the hope expressed in the passage became especially evident.

The work that head and neck surgical oncologists do to treat patients with head and neck cancer is remarkable, and should be considered to be a sign of God's desire to bring healing. But healthcare workers have a major role to play too, and perhaps the more we see medicine in light of the Spirit, the more our work can change. My hope is that the Spirit allows us to "break through the stale routines," as Haynes and Kelly demonstrate. If we see ourselves as agents of *paraklesis* in collaboration with the Paraclete, as collaborators with the Spirit in giving life to dry bones, everything can change, and then we will be able to truly attend to wholeness in healthcare: treating the disease and caring for the person, attending to body and spirit.

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# THE IDEAL BODY AND THE CELEBRATION OF HEALTH IN THE SONG OF SONGS IN THE HEBREW BIBLE<sup>1</sup>

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## Abstract

The biblical book the Song of Songs is usually associated with either sexuality or, if it is understood allegorically, spirituality. Yet a key word in the Song, *shalom*, which is usually translated as “peace,” has several other related meanings as well, one of which is “health”. If this latter meaning and the others are taken seriously, the book would resonate more widely and deeply and at the same time would suggest a more profound sense of health, especially in the context of a text which explicitly speaks of being “sick” (with love). The celebration of health in the Song can then have a practical application in a setting where it is probably least expected: the hospital and other healthcare institutions.

## Keywords

Song of Songs; *shalom*; health; celebration; healthcare institutions

## Introduction

Generally people associate the Song of Songs with sex, or with the relationship with God, if one has been taught to understand it allegorically as a non-bodily spirituality, but not with health.

Yet, the main image in the book is that of the body, irrespective of the way the Song is understood. What kind of body then? A sinful one,

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<sup>1</sup> This article forms part of a post-doctoral programme made possible by the NRF, for which the author is extremely grateful.

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as one would expect in a biblical book? And therefore a body threatened by suffering, illness and, eventually, death, if it is real?

Both birth and death are mentioned in this erotic poem, but the bulk of the text is about the body celebrated for its beauty and pleasure – the body viewed positively, which is something of an exception in most of the world’s religious literature, and unique in the Hebrew and later Christian Bible. Those who research health in the Bible usually do so to find ethical direction, and do not expect to find it in a Song celebrating the body.

After a brief discussion of the concept of health, this study will first outline how the two loving bodies in the Song are idealised as perfect, despite their struggle with reality (my second point of discussion), and that there is (my third point) a related subtext dealing with health. The discussion will be offered with reference to other biblical texts to broaden the context and therefore emphasise the impact of the Song.

## **The Concept of Health**

Despite its being a common concept in the Western setting, the notion of health has become controversial in circles of expertise. The definition by the World Health Organization in its 1948 constitution of health as "a state of complete physical, mental, and social well-being and not merely the absence of disease or infirmity" has been criticised because it lacks operational value and because the word “complete” sounds unrealistic and elusive.

Two corrections have therefore been proposed: that it be linked to personal satisfaction (Bellieni and Buonocore 2009) and that it can include so-called disabilities (Bellieni 2013). Both of these elements relate better to the concept of שלום (*shalom*, peace, but also other meanings) as it is used in the Hebrew Bible or Old Testament and, in this study, more specifically in the Song. Personal desire and enjoyment constitute one of the themes of the Song, and “disabilities” or rather “blemishes” are explicitly denied.

## **The Ideal Body**

Typical of the intense aesthetic and emotional investment not only in the body of the beloved, but also in each lover’s own body, hyperboles are found right from the superlative in the title of the Song (*the* Song) to the claims to perfection made for the bodies of each of the lovers. This comes despite the female lover having reservations about her own black skin in

1:5, which would probably be indicative of a lower-rated class rather than a lower-rated race. According to Fisher (1974, 170), the deprecated black skin ironically also symbolises greater and therefore envied sexual potency, explaining something of the former discrimination against and criminalisation of interracial sexual intercourse in South Africa.

The exceptional quality and beauty of the female lover is praised when she is called תְּמִתִּי (my perfect or undefiled one) in 5:2 and 6:9, and it is stated כָּלְךָ יָפָה (all of you is lovely) in 4:7. The word תְּמִי, is derived from תָּם (complete, perfect), but related to תָּמִים (complete, whole, healthful, unimpaired, having integrity) (Brown, Driver, and Briggs 1951, 1071), which shares the same root. It could be opposed to מוֹם (blemish, imperfection), which has been denied earlier in the poem.

In 7:3 a litotes is used in אֵל-הֶחָסֵר הִמְצִיג (there is no lack of mingled wine) in her “navel”: here a negative is used to emphasise a positive, while at the same time revealing that in the unconscious the idea of “lack” is indeed present. The same stylistic feature occurs when her teeth are compared to the symmetrical perfection of the descending ewes expressed by וְשִׁבְלֵיהֶן אֵין בָּהֶם (and none fails among them) in 4:2, echoed in 6:6, and כָּךְ אֵין וּמוֹם אֵין (and there is no blemish/imperfection in you) in 4:7.

These claims to perfection are reminiscent of how it is regarded in cultic contexts such as in Leviticus 21:17ff (especially verses 18, 21 and 23, where מוֹם (blemish) occurs four times) and 22:19–21, 25 (where מוֹם occurs three times and is repeated in an abbreviated way in Numbers 19:2 and Deuteronomy 15:21; 17:1), referring to (Aaronite) priests and sacrifices respectively otherwise not being acceptable to God in the Holy of Holies. In these texts מוֹם always refer to males, but in the Song it refers to the female who is devoid of it.

These are also the two texts in which the word מוֹם occurs the most frequently and then as clusters in the Hebrew Bible. Abrams (2007, 77) counts twelve such defects relating to both priests and animals, five of which overlap. In these texts the disabled, such as the blind, the lame, those with facial irregularities, those with anything else exaggerated or with a broken foot or hand, hunchbacks, dwarves, those with an eye or skin problem, with “crushed testicles” (perhaps because they then cannot procreate?) – in other words, things for which they probably cannot take responsibility – and those who have made any incisions into their flesh, shaved their heads or cut the corners of their beards during mourning, those who have slept with a non-virgin or have had contact with a corpse – in other words, things for which they can take responsibility – are all disqualified from entering the sacred space and from presenting fire sacrifices to God. Carmichael (2003, 240) believes that the tradition about

Eli, the high priest, whose lineage was excluded from the priesthood due to the sins of his sons in 1 Samuel 2–4, was the background motivation for some of these bodily features leading to exclusion. On the other hand, some of the listed features might be only temporary disqualifications. In some ways they are reminiscent of the Nazirites, who also let their hair grow and avoided contact with the dead, in addition to abstaining from products of the vine.

These lists of requirements can surely not be exhaustive as conditions for perfection, a concept which might even be an anachronism imposed by modern Western thinking on earlier conceptions, where it might be foreign. This idea represents an extreme and points towards elusive infinity. Therefore, there is something naïve, unrealistic and even anal in it, as it could be a sign of ingratitude regarding all that is not perfect, which is, objectively speaking, everything and everyone. More realistically, it may instead be an expression of an experience of the unexpected: that reality is ironically more than the ideal.

By implication, the aged, who would have developed some of these imperfections, are also excluded and, in our postmodern parlance, “discriminated against”. Only men are dealt with, because women were automatically disqualified from the priesthood.

The view that the male per se has a better body and can thus attain perfection seems to be true for animals as well in Leviticus 22:19. This is even the case when an otherwise imperfect animal is acceptable in the case of a freewill-offering except when this imperfection involves its testicles, according to Leviticus 22:24. Logically that means that the testicles are the most important feature even when the animal is to be slaughtered and will therefore no longer be able to procreate. One wonders immediately whether the female body is by implication imperfect and perhaps even disabled because it lacks a penis, the norm for “perfection”, as Freud (1955, 273) seems to suggest. This assumption is confirmed by the anthropologist, Mary Douglas (1966, 51–52; 1972, 76–77), who regarded wholeness (תְּמִיּוּם in Leviticus 22:19) as the hallmark of holiness. That is why even the stones of the altar in Exodus 20:25, Deuteronomy 27:5–6 and Joshua 8:31, the latter two of which use the verb שָׁלְמוֹת (unhewn, sharing the same root with שָׁלוֹם (wholeness)), and of the temple in 1 Kings 6:7 were to be whole or uncut. Psychoanalytically this makes sense, as buildings often reflect the body, according to both Freud (1929, 128f; 1986, 85 and 225) and Jung (1984, 116).

Furthermore, just as the priest can only be an Israelite, the sacrificial animal should also be an “Israelite” in that it is automatically declared imperfect when it comes from a foreigner according to Leviticus

22:25. According to Milgrom (2002, 1881) this could also refer to theft, and the moral can thus have an effect on the physiological, to which it is closely linked. The perfect body is in this way not only a physiological but also a cultural, and therefore an ideological, issue.

Apart from sex and “nationality” (and class in the case of the priest) there is also an age restriction before which an animal body would not be perfect “enough” for God: according to Leviticus 22:27 it should be at least eight days old. These animals had to be “perfect,” just like the priests, but probably for different reasons. Whereas the priests needed a special, “resilient” body in the dangerous presence focused in the Holy of Holies, the animals should be the best, and not “left-overs,” to prove the authenticity of the sacrificing person, but also perhaps because they were to be eaten, that is, internalised into the body of the priest and the bodies of his core family while they were in a state of purity. If an impure person were to eat from the “perfect” animal bodies, these sacrificial bodies would be rendered imperfect as well.

Not only visible defects, but also hidden ones, such as being a eunuch, are mentioned in verse 20. Any dysfunction therefore rendered one ritually impure.<sup>3</sup> The perfect body was not only healthy but also holy, consecrated by anointment and signified by a specific garment.

These requirements were gradually relaxed after the destruction of the temple (Abrams 2007, 73) and in Isaiah 56:3–6 the eunuch and the foreigner are explicitly included as acceptable to God.

None of these criteria are set for the perfect body in the Song. Both the lovers, male and female, and without any specification as to whether they are Israelites or foreigners, are like the male priests standing above the rest of the Israelites, even when there are no such lists of defects or conditions for purity and holiness, and each beloved is singled out as perfect. As a body free from blemishes is on an even higher level than those with blemishes which could still be pure, the higher level automatically includes purity and therefore it would be redundant to mention it in the Song.

Just like the lovers in the Song, the animals are all portrayed in positive terms, except perhaps the foxes, but they could have been

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<sup>3</sup> Much earlier the speech defect of Moses, just like mutism, deafness and blindness in Exodus 4:10–11, is, however, taken responsibility for by God as the One who gives to each person certain physical attributes, whether humanly regarded as positive or negative. This also goes to the other extreme, where the suffering servant of Isaiah 52:13–53:5 is a disabled, ugly, sick and wounded man, but he serves as healer of sinful humanity and is ironically the opposite of the priest.

mentioned in jest. It is true that others excluded from this intimate love are regarded as thorns in 2:2 and as foxes in 2:15. As lovers embodying the divine flame of love it is as if they are qualifying to enter the most dangerous Holy of Holies, where the priests served as mediators of the otherwise lethal presence of God between heaven and earth. In both the Holy of Holies and in love humans are at risk because of their vulnerability. That does not mean that only those with perfect bodies can (objectively?) embody love, but that those who embody love are (subjectively?) rendered as having perfect bodies.

Perfection is also ascribed to the male lover: וְכִלּוֹ מְהֻמְדִּים (and *all* of him is lovely) in 5:16. Asher-Greve (1998, 10) claims that perfection was something guaranteed by the mother and birth goddesses in the ancient Near East. This would imply that the modern interpretation of its being an exaggeration for stylistic purposes is culture relative and not loyal to the original sense of the Song. This belief in perfection, however, still remains an ideal and even an exaggeration as compensation for troubling imperfections. From a psychoanalytic perspective, the lovers do not see themselves or each other as “perfect” (Van der Zwan forthcoming).

Perfection as the ideal points to another world, is born from suffering and is one of the commonalities between the aesthetic and the religious. The religiosity which music can encourage is well known. Music had a relaxing and healing effect on the troubled and clearly mentally ill Saul when David played the harp for him in 1 Samuel 16:14–23, and one is equally lifted to other worlds and realities by hearing the Song, preferably when it is sung to musical accompaniment. It would seem that this kind of idealism opens one up to a greater possibility of exceptional, and therefore religious, experiences (Stratton 1911, 115).

That is why the body of each of the lovers has been associated with a divine being. Just as the female body is likened to celestial bodies with divine connotations in 6:10, so the male body is likened to the statue of a deity in 5:14–15. In 2:9 (and also in 2:17 and 8:14) he is depicted as being הָאֲזִיָּים לְעֶפֶר אוֹ לְצִבִּי (like a gazelle or a young hart), the same two animals which she invokes in her adjurations in 2:7 and 3:5. This is most probably due to his vitality and virility, but more likely so because these two animals have a divine connotation. In the peak moment of this Song, in 8:5, the loving body is celebrated for being like a flame of God (or a God-like flame), ready to face death: שִׁלְהֶבֶתָּהּ אֵשׁ וְשָׁפִי רִשְׁפֵיהָ (its flames are flames of fire, a God-like flame). The reference here is obviously to a body on fire.

It is ironic that within the Christian religion the Jewish body, traditionally scorned in Western eyes, is the very body in which God chose

to incarnate divinity even when it was mutilated and penetrated before it surprisingly rose from death to become, at least symbolically, ingested in the Eucharist. In South Africa this “body of God” could be the female, black, lesbian body as a combination of the most rejected bodily nature.

## Real Bodies

Despite the peak states in which the lovers find themselves, they remain rooted, limited and therefore stimulated by reality. That makes the portrayal of their bodies convincing, and one with which the reader can identify. This tension between the extremes of the ideal and the real as their desires and wishes stretch them into infinity may actually intensify their experiences and make them aware of how fragile and temporary these peaks are.

In these peak moments there are even times when the healthy body of the female lover actually makes her feel sick because of this discrepancy between her dreams and the temporary absence of her beloved. In 2:5 and 5:8 she begs for help, as she is “sick with love” (אֶהְיֶה חֹלֵה אֶהְיֶה). Yes, love can make one sick and has caused much pathology for human beings when the polarities of experience cannot be reconciled and integrated.

When she is energised enough to transcend this boundary between the real and the ideal in search for her missing male body, she is blocked and wounded by the symbols of the super-ego functioning under the pretext of guardians of morality in 5:7: הַכּוֹנֵי הַבְּעִיר הַסִּבְבִּים הַשֹּׁמְרִים מִצְאָנִי (the watchmen that go about the city found me, they smote me, they wounded me; the keepers of the walls took away my mantle from me). Instead of finding her beloved, *she* is found (out) and exposed, emotionally and physically.

Likewise her body is abused by her brothers and the sun, also both symbols of the super-ego, as in 1:5 they make her work in the Middle Eastern heat to prevent her from celebrating her young, joyful body.

From a psychoanalytic perspective the Song is, however, about health, erotic health, which it has shown to be the solution for much pathology, not only mental pathology, but also the bodily expressions of these psychological conflicts and repressions, the symptoms. With more psychological energy free and available, the immune system is strengthened. No energy is wasted in the Song on dogmas or laws, which is why its religious atmosphere is not easily recognised. The stimulating boundaries are rather those of reality.

In the background, as one subtext, it is about a religion which celebrates rather than inhibits life and love. The Song is no prayer for relief, but praise for the wonder of life within the bigger picture of nature, which is awakening in spring and in which the lovers participate. There is no argument, but rather awe. In this way, the uplifting aesthetic of the Song points towards the religious so subtly present between the lines.

The Song is usually employed for relational problems in pastoral care, but neglected in hospitals, where visions of health and life support the sick towards health. Even death is seen as transcended by love in 8:6a: *כי-עונה כמות אהבה קשה כשואל קגאה* (for strong as death is love, as radical as the grave is passion). This love even looks beyond the boundary of life.

## Hints of Health

One of the most fundamental elements in physical health is that one should have a healthy body image. That in itself is healing, and once again is exceptional in the case of the Song, where both bodies are celebrated and in this way help each other to internalise this and accept it as special. One can extend the intense, narrow focus on the body of the lover to all other people, complimenting and celebrating their bodies.

Another aspect of health is a kind of complementarity and cooperation. This is exceptional in that the Song is well known for alternating the female and the male voices to suggest the gracious dance between the Jungian anima and the animus, which amplify and complete each other in the text to form an unspoken, androgynous person. What can be called an imperfection or lack is rather the missing other together with which it combines to reach health.

A third and significant hint about health is one of the key words in the Song, *שָׁלוֹם*, which we find seven times (1:1, 1:5, 3:7, 3:9, 3:11, 8:11 and 8:12) in the name *שְׁלֹמֹה* (Solomon), and seven times (1:5, 2:7, 3:5, 3:10, 5:8, 5:16 and 8:4) in the expression *בָּנוֹת יְרוּשָׁלַיִם* (daughters of Jerusalem). “Jerusalem” itself could mean “city of peace”, although this is probably according to folk etymology, but even then the sound reminds us of *שָׁלוֹם* and would therefore be associated with it. Four of the occurrences are in the famous refrains of adjuration, and so share the centre stage.<sup>4</sup> The female lover-and-beloved remains anonymous, unless one understands the enclitic use of the adjective *הַשְּׁוֹלְמִיט* (the Shulammitite) in 7:1 as some kind of name for her, adding thus the feminine aspects to this idea of *שָׁלוֹם* to

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<sup>4</sup> “Jerusalem” occurs an eighth time in 6:4, but it does so there without a connection to its daughters.

make it complete; this peaks at the end of the Song by being explicitly stated as the ultimate goal and result of their love-making in 8:10: *שְׁלוֹמֶךָ לָמַדְתְּ לִי בְּעֵינָיו כְּמוֹצֵאת* (then was I in his eyes as one that found peace, that is: found her own “Solomon”, or: found health). To emphasise this idea, *שְׁלוֹמֶךָ* is placed right at the end of the sentence, so that it lingers on in the mind of the reader as the most important element of this message.

The word *שְׁלוֹמֶךָ* is usually translated as “peace”, the grand vision of the prophets (Gushee 2013, 78), but it can also mean “health” (Brown, Driver, and Briggs 1951, 1022), while Gerleman derives it from the verb *לַמַּשׁ* (have enough), which is a more modest and even minimalist condition without any pretence to perfection. In fact, the word means more than both of them and so could add more dimensions to the whole Song, but it has therefore also led to diverse translations depending on where the emphasis is placed (Pope 1977, 684–686). Being at peace with oneself and having all one’s parts operating in harmony is what health is all about. A fuller meaning of *שְׁלוֹמֶךָ* would be “wholeness” (Gerleman 1976, 927), “integration” and “tranquillity,” of which peace is then a component and result. Integration is ultimately what psychological development, health and life are all about. This applies not only internally, that is bodily and psychically, but also socially in the corporate body: parts which work together for the sake of and as a sacrifice for the whole, parts which resonate with each other, which is what the music of the Song embodies.

That the idea of *שְׁלוֹמֶךָ* is associated with spirituality as well, is clear from the way in which it is used by Robinson, Kendrick, and Brown (2003, 34, 43, 106, 151, 178 and 196) to include a sense of right relationships, acceptance of others and belonging within a context of developing holistic meaning. As embodied spirituality, sexuality is integrated in these relationships, even when it always remains ambiguous as both wonder and risk (Robinson, Kendrick, and Brown 2003, 25). It is specifically feminist spirituality which takes the body, and therefore sexual health, very seriously (Ross 2012, 34).

We can finally ask the question whether the two lovers experience their respective bodies as alive and healthy. A realistic, more objective answer than their claims to perfection would be that they are on their way to it, but that health as the delicate balance between the two extremes of the pleasure (idealism) and the reality principles includes accepting and integrating imperfections. In the same manner, by exploring their sexuality they discover more parts of their bodies which the psyche can then incorporate to grow into something bigger and richer than the often narrow confines of the ideal. They are engaged in “removing the psychological blocks to the acceptance of the body”, to use the words of

Lowen (2005, 91), a medical doctor who has studied and written extensively on body psychology.

Even though the Song is usually regarded as being about sex and life, and not immediately recognised as being about health as well, all three themes are connected. For just as Aladdin's magic lamp represents the body which is spoken to with words of love and which is rubbed in order for it to light up and release the bottled-up genie, so the genie of sex can light up the body in health, and vice versa.

### **Relevance for Healthcare**

As has been suggested, health is a holistic state beyond but also inclusive of the physical condition which is interdependent with all the other aspects of health. For that reason, healthcare should liberate not only the patient but everyone from the dominant Western cultural narrative of the so-called perfect body (Meyburgh 2006, II) and its obsession with beauty propagated through the mass media, despite the cultural relativity of its norms, creating a context within which the body is evaluated subjectively (Meyburgh 2006, 3). The majority of the population, if not the whole population, is excluded from this elusive ideal.

The consequences of this unrealistic image on health are discussed in a special issue of the *Journal of Health Psychology*. Not only is body image the result of a certain health condition and health behaviours, it is also a cause of them (Grogan 2006, 525). In this context, the health psychologist can learn from and disseminate the wisdom of the Song by critiquing the current concern with the body by asserting that only the unconditionally loved body is the perfect body. In practice this concerns any health promotion due to medical treatment which affects, for instance, eating, cosmetic change, exercising, weight management, smoking and other drug use.

An American scientific survey conducted in 1986 to investigate the relationship between the body and the self found that men evaluated their fitness and health higher than women, and that men achieved a higher average score for fitness than women, but not for health orientation (Cash 1990, 60). This means that a lower estimation of health (by women) can actually promote health behaviour. Women also demonstrated greater psychological adjustment when they had a positive health evaluation (Cash 1990, 62).

Changes in bodily functions and integrity play a role in the experience of illness, but it seems that only a minority of those with medical problems have body image concerns (Pruzinsky and Cash 2002,

171). Measurement instruments have been developed to gauge not only specific medical problems, but also particular effects of certain drugs and devices with regard to body image. The results should then also be considered to decide which product is efficacious and how the changed body image influences quality of life (Pruzinsky and Cash 2002, 173–74, 176). Any such change in body image would be the result of a combination of factors, among which are cultural and religious beliefs about the ideal body (Pruzinsky and Cash 2002, 177).

Now that the ban on everything religious and spiritual seems to be gradually lifting in these postmodern times from the strictly scientific domain which the clinical environment used to represent, the liberating body images of the Song are also free to facilitate healthcare of a holistic nature and could support the work of HospiVision, for example, within an interdisciplinary context where one should be sensitive to the whispering voices of wisdom and empathy. Only in such a context can one heal from the oppression of the marketing mania and the reduction of scientism and thus achieve wholeness, which includes much more than the body.

## Conclusion

The Song was not in fact meant to be analysed, but rather to be sung and experienced as an invitation to participate in the miracle of a living, healthy body.

This analysis has, however, shown that the Song has a subtext of health, among other things. Between their idealism expressed by their mutual claims to perfection (for example תְּמִתִּי (my perfect one) and the denial of any מִוֶּמֶר (imperfection)) and the seemingly broken reality betrayed by the self-doubts of the female lover, who is self-conscious about her external appearance, feels internally sick in her dependent love for her man and is wounded externally and internally by the symbols of the super-ego, she finds the equilibrium of שְׁלוֹמִים, health, somewhere in the middle.

This sense of health resonates well with the international vision of health as including both satisfaction and disabilities, that is, both pleasure and pain.

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