

## SPIRITUALITY IN THE PRACTICE OF CARE

This educational CAPPE module is part ii in section II – *Practices in Spiritual Care*  
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### Introduction

More recent and prominent therapy approaches such as the brief therapies and narrative therapy are increasingly incorporated in the practice of spiritual care. In view of the expanding range of the schools of therapy, the role of spirituality has become more varied and differentiated in contemporary practices of religious and spiritual care. This module will explore the correlation between essential therapies and approaches in spirituality and spiritual care. The map *Spiritual Care & the Therapies* (see Appendix I)<sup>i</sup> includes main therapies in use in the practice of spiritual care and distinguishes four quadrants of therapy styles:

1. two are largely theory and care-provider driven
  - insight-therapies
  - action-therapies
2. two are largely relationship and care-receiver driven
  - relational encounter
  - relational collaboration

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### *Discussion Questions:*

- Which one of the above therapy orientations do you see best suited to the practice of spiritual care?
- When providing spiritual care, in what quadrant of the map do you feel most comfortable?

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### The Diversity Challenge in Spiritual Care

Spiritual care has been envisioned through the trifocal lenses that represent *premodern*, *modern* and *postmodern* perspectives:<sup>ii</sup>

- The premodern lens shows how people in an immediate and convincing way experience God's presence or the Sacred through prayer, religious texts and traditions, personal devotions and communal worship.
- The modern lens utilizes the critical studies of sacred texts and theological perspectives, as well as the knowledge of the medical and social sciences in appropriating spiritual insights and directing spiritual care.
- The postmodern lens shows the limits of external, authoritative, "objective" sources of knowledge, and the potential distortions of social conventions and cultural images that shape our world and life views. In this postmodern context, spiritual care seeks out new possibilities through collaborative learning that is strength based and case specific for each situation.

The diversity challenge for the spiritual care-provider entails both a discriminative perspective honouring the distinctiveness of each of the trifocal lenses as well as the flexibility in using the three lenses interchangeably and simultaneously.

### I. The premodern lens

In the premodern context religious or spiritual experiences come in ways that appear immediate, intuitive and unquestionable as apparent in the following case illustration:

William James in his classic *The Varieties of Religious Experience* recounts the moment of dread "when suddenly there fell upon me without any warning, just as if it came out of the darkness, a horrible fear of my own existence. Simultaneously there arose in my mind the image of an epileptic patient whom I had seen in the asylum, a black-haired youth with greenish skin, entirely idiotic...moving nothing but his black eyes and looking absolutely non-human. This image and my fear entered into a species of combination with each other. *That shape am I*, I felt, potentially." James adds that "the fear was so invasive and powerful that if I had not clung to scripture-texts like 'The eternal God is my refuge,' etc., 'Come unto me, all ye that labor and are heavy-laden,' etc., 'I am the resurrection and the life,' etc., I think I should have grown really insane."

In these words James describes the panic of existential dread and the intervention of spiritual resources in scripture. These texts are not open to exegetical interpretation or critical analysis but come with immediate and ultimate authority. In institutional care the spiritual care provider often encounters moments of anxiety that press for instant comfort and assurance. The premodern perspective connects with a person-centered approach in spiritual care, frequently in the *relational encounter* quadrant, offering a compassionate and confirming presence through sacred texts, religious rituals and prayer.

#### A Case Scenario

In visiting a dying mother, the spiritual care-provider hears the woman speak in glad anticipation of seeing her deceased parents as well as meet the son she lost in childbirth. Even in the context of a *relational encounter*, there are gradations in balancing confirming the person's experience with the interpretation of its meaning:

- A confirming response: *I really admire your faith in being able to look at what is going to be new and exciting for you.*
- A facilitative response: *You really look forward to see them again.*
- A low-level inference: *With all the losses that you experience now, it is a blessing to look at what you are to gain.*
- An existentialistic encounter: *I think that this must be for you a time when you can feel very alone, and now you reach out to those whose loss you have suffered all these years.*

*Questions:*

- What other spiritual care scenarios come to mind that would fit a premodern perspective?
- How could these be illustrated in a role-play or verbatim?

## II. The modern lens

In the modern mode the spiritual care-provider functions as a professional in accordance with set standards of knowledge and skill competencies. Presently professions emphasize an evidence-based approach that links valid knowledge to effective clinical practice outcomes. One common concern has been that in doing so spiritual care-providers exchange their unique spiritual/pastoral care identity for models of care in use with other professions.

This was the concern addressed by Paul Pruyser in his popular book *The Minister as Diagnostician – Personal Problems in Pastoral Perspective* (1976). Pruyser, a psychologist and clinical educator, advocates for a pastoral perspective that, similar to the other professions, is informed by the critical, scientific resources of modernity yet maintains its own integrity:

*The thesis of this book is that pastors, like all other professional workers, possess a body of theoretical and practical knowledge that is uniquely their own, evolved over years of practice by themselves and their forbears. Adding different bits of knowledge and techniques by borrowing from other disciplines, such as psychiatry and psychology, does not undo the integrity and usefulness of their own basic and applied sciences...Thus with this thesis, the book appeals to pastors to reflect on their special heritage and use its theoretical foundations and practical applications to the full. (p.10)*

In his “guidelines for pastoral diagnosis” Pruyser uses theological and biblical language such as *awareness of the Holy*, *faith*, *providence*, and *repentance*, but not in a dogmatic or literalistic sense. He sees them as “multidimensional themes which, in the mind of the pastoral interviewer, provide vistas of the person’s organization of meanings.” These are perennial and universal themes that function as ordering principles in understanding personal problems in an existential perspective that draws both from theology and the psychology of religion. Accordingly, the theme of *awareness of the Holy* raises questions of what, if anything, is sacred to the person or can elicit a sense of *awe*. The theme of *providence* is about the ability to trust, illustrated in the difference between hoping and wishing: “The hoper refers and defers to a transcendent power that has its own unfathomable purpose; the wisher bends it down to conform to himself.”

From this perspective, authentic spiritual care is steeped in the traditions of religious care and informed by current clinical research and the social sciences. This view of spiritual care clearly fits the mode of modernity and defines the philosophy and practice of *clinical pastoral education* in CAPPE as a multifaith organization committed to professional practice and education. A modern approach in spiritual care will seek out

proven clinical resources including the more directive action- and insight-oriented therapies.

### A CASE OF DIFFERENCE ?

Sometimes the difference between spiritual care and the professional practice of care is perceived as a matter of seeing through two different lenses: professional practice through the modern lens and spiritual care through the premodern lens. The premodern mode emphasizes an immediate connection with a transcendent, spiritual reality. This premodern perspective is expressed by noted psychologist Allen Bergin, who is also a popular author on spirituality and therapy. He describes the experiential link between the human person and the Divine as follows:

*“God exists, that human beings are the creation of God, and that there are unseen spiritual processes by which the link between God and humanity may be maintained... We define spirituality as attunement with God, the Spirit of Truth, or the Divine Intelligence that governs or harmonizes the universe... We assume that human nature includes spiritual capacities, i.e. ways of responding to, harmonizing with, or acting on the promptings, enlightenment, or sense of integration that may be associated with the Spirit of Truth”<sup>iii</sup>.*

In the practice of spiritual care the care provider in a similar fashion experiences an immediacy of spiritual inspiration and guidance. Bergin, a one-time research associate of Carl Rogers, has coined the term *meta-empathy* – denoting the presence of a transcendent spiritual guidance and enlightenment for the pastoral care provider. He defines it as “an openness to inspirational impressions that convey spiritual insights or convictions about the individual that differ from ordinary diagnostic categories or treatment hunches.”<sup>iv</sup> In *meta-empathy* not only the patient/client but also the spiritual care-provider finds a spiritual grounding, a therapy-friendly universe that fosters a sacred alliance between therapist and Spirit in co-therapy. Prayer and silent reflection are often relied on as the traditional tools in this premodern perception of the process of attunement to a spiritual presence.

### For Reflection and Conversation

- Do you think that spiritual care is by its very nature more closely situated in the premodern than in the modern context?
- On a continuum from premodern to modern, where would you locate your own practice of spiritual care at this point of time? (and where 5 years from now?)

### III The Postmodern lens

In the modern mode of majoring in scientific research and theoretical knowledge, care-providers can be seduced into believing or pretending that they know more than they actually do. In contrast, in the postmodern, constructivist world of multiple perspectives, care-providers pretend not to know. In claiming ignorance care-providers elicit the strengths and resources of the care-seeker, thus sharing the care-giving. This "not seeing"

and “not knowing” style, however, is more directive than the classic, largely premodern, listening presence by setting the stage for an active, *relational collaboration*.

A postmodern perspective focuses on the internal, subjective process through which people make sense of the world and find their place and purpose in life. This is the concept of constructivism where people are not passive recipients of general knowledge that corresponds to external, objective realities. People rather are seen and treated as active agents generating their own particular maps of idiosyncratic meanings and values by which to understand the world and live their lives.

Spiritual care in the postmodern mode attends to a person’s process of meaning-making – a process that is embedded in larger cultural, religious and family contexts. Care-providers invite themselves as participants in these personal quests for meaning while identifying and, hopefully, deconstructing and reconstructing destructive themes. The role of *narrative therapy* in spiritual care is to listen to the stories that bind and limit with a view to collaborate in the creative writing of more generous stories that spring free from old plots into new possibilities.

### A Narrative Theology of Spirituality<sup>v</sup>

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A narrative perspective sees the human person as a performer in a story: a person in interaction. Rather than a fixed internal and timeless identity, a person constructs a self from moment to moment in a continual process of interacting with her or his world. Identity is not self-contained but relational and spirituality is about the perennial human experience of both finding and losing one’s place in a transitory world of change.

The existentialist theologian Paul Tillich describes the process of finding one’s place in the world through the polarity of individualization and participation. It depicts the circle dance of the self and the world in connecting to and disconnecting from each other. This graphic description depicts the cyclical movement of the self reaching out, participating in its world, connecting with its possibilities and being changed in that encounter, then returning to its center of identity. One’s place in the world is not static but a dance of constantly balancing one’s participation in the world with one’s personal center of identity. The self never returns to the same center after having connected the outside world and the world is never the same as the self returns to it.

In this spirituality perspective the self creates a narrative identity: a series of self-world interactions over time in a variety of settings with an organizing theme. Such a process is articulated in a story or script that maps and highlights the marker events of a life. Our story is not a factual listing of events that happened to us in the past. Life stories are intensely present, active and creative realities. In our stories we selectively and subjectively organize our life experiences, sorting them into chapters and titles, introductions and conclusions. Stories are meaning-making constructs by which we write up and view ourselves in our relationships and world.

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### A Case Study<sup>vi</sup>

Maria, at the age of 28, suddenly became a widow when her husband John at 50 died of a heart attack. An immigrant from Greece, John had come to Canada in his early thirties. After ten years of hard work in construction, culminating in building his own house, he returned to his native country to marry a young woman from the village where he grew up. He brought his bride, Maria, to Canada where in another year their son was born. John's unexpected and untimely death left Maria reeling, lonely and abandoned in a strange land to which she felt now bound through her 6 year old son.

Maria referred by her priest came to a counseling service offered by a downtown church just a few weeks after her husband's funeral. She was in a state of shock, in the rawness of her pain, unable to grasp the enormity of her loss. John had been much more to her than a husband. As a prince he had come to take her from her little village to a big and exciting world where he had built a house for her. A father figure, he took care of everything- from looking after the bills to getting the groceries – her only link to the world outside the home. Maria's initial question and concern was: "Will I ever be able to look at his picture, without feeling this terrible pain?"

Maria became a client of Nancy, a young pastor enrolled in the early 1970's in a clinical education program at the church. Initially she responded as a pastor responding to Maria's acute grief experience through empathic identification, supportive prayer with the reassuring message that John could be a special presence in her life even though he had died, and become a source of living memories. Nancy's main source of information about the grieving process came from Kubler-Ross' *On Death and Dying*, (1969) at the time an immensely popular book. It proposed a progression of stages by which terminal patients deal with their impending death: from denial, anger, bargaining, depression to, when all goes well, final acceptance. These same stages were generally applied to the grief experience of those facing not their own death but the death of a loved one.

Both Maria and the pastor were shaken by the startling shift when Maria's adoration of John turned to anger. As a student therapist Nancy experimented with the *Gestalt* technique of the "empty chair," asking Maria to face John in the other chair. Soon Maria began to confront John with her "unfinished business." Her rage surfaced: he had cut her off from her own people only to desert her now in a foreign land, and left her with a son, also called John, to keep her from returning home.

Eventually the anger led to moments of sadness and a sobering realization that she was now on her own in new territory. Spiritual care became practical care as Nancy assisted Maria in planning for her and her son's future. Maria explored her financial situation, decided to get her driver's license and enroll in a course in English. Psychologically she began her own immigration to Canada. By mutual planning the counselling was terminated as Maria became increasingly involved in her new life. In the final evaluation Nancy praised Maria for redefining herself as a new person while honoring John as a model inspiring her own immigrant story.

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### Question:

Where are the premodern, modern, and postmodern threads in this spiritual care story?



## A BRIEF ANNOTATED BIBLIOGRAPHY

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- VanKatwyk, P. 2003. *Spiritual Care and Therapy*. Wilfrid Laurier University Press.  
This module has incorporated materials from Part I – Spirituality in the Practice of Care, pp.11-43.

## Endnotes

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<sup>i</sup> See module II,i – *Caring Conversations* for a similar map with quadrants.

<sup>ii</sup> Carrie Doehring. *The Practice of Pastoral Care – A Postmodern Approach*. 2006. Westminster. pp. 2-6.

<sup>iii</sup> In his unpublished *Oskar Pfister Award Lecture* of the American Psychiatric Association, in Toronto, June 3, 1998.

<sup>iv</sup> Richards, P. & Bergin, A. (1997), *A Spiritual Strategy for Counseling and Psychotherapy*. Washington, DC: American Psychiatric Association.

<sup>v</sup> See Paul Tillich. (1963). *Systematic Theology*, Vol.3. University of Chicago Press.

<sup>vi</sup> Adapted from Peter L. VanKatwyk (2003), *Spiritual Care and Therapy*. pp.105,106.