

**CAROLYN SANSOM**

**IN LOVE AND LIFE: TOWARDS A QUAKER THERAPY AND THE PASTORAL CARE OF THOSE IN  
MENTAL DIS-EASE**

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The theme of this thesis is the centrality of relationship to individual well-being; its focus is the help offered to those who experience mental 'dis-ease' by the theory and practice of 'therapeutic Quakerism'. It argues that a different model of care to that of the current biomedical one is required, a model centred on 'the establishment of loving relationships' rather than the application of medical theory and knowledge in the treatment of those 'in mental dis-ease'. The author believes that psychiatric theory and practice continue to be dominated by a dualistic understanding of 'Be-ing' (she uses Daly's (1986) term 'Be-ing' to infer the dynamic nature of existence), and turns to the theory of 'holistic nursing' for a cogent critique of its failure to consider all aspects of the individual – physiological, psychological, emotional and spiritual – in relation to their wider environment. She supports her contention that the alleviation of mental dis-ease requires a far greater recognition of the key role relationship plays in the healing process with an overview of Christian theological anthropologies, investigating whether religious theories of pastoral care – particularly Quaker pastoral care – offer effective theoretical frameworks for the practice of holistic nursing. The author concludes that a synthesis of these approaches in what she terms a 'Quaker therapy' could represent a new paradigm for psychiatric care.

**Key words:** mental dis-ease, Be-ing, medical model, psychiatric theory, Christian anthropologies, holistic nursing, therapeutic practice, pastoral care, Quaker pastoral care, 'Quaker therapy'

**Key themes:**

The failure of the theory and practice of the biomedical model of psychiatric care

The need for a therapeutic approach centred on helping the individual achieve a sense of 'wholeness' through relationship with the 'other' (other people, the environment and the divine)

The unique nature of the Quaker approach to the therapeutic relationship

**Useful for:** researchers and those with a general interest in the Quaker approach to mental illness, the practice of therapy, pastoral care, the care of the mentally ill in general

## **Introduction: the theoretical grounding of the research process**

The author states that the primary influences for her research are to be found in Quaker thought and practice, feminist theological analysis, and the recent paradigm shift in scientific thinking, specifically in terms of its relation to the theory of holistic nursing. The motivation for the research lies in her experience as a psychiatric nurse and as a Quaker. She therefore views the theoretical paradigms behind the practice of therapeutic care through a Quaker lens, employing the foundational tenet of 'experimental knowing' (the experience of spiritual enlightenment or inspiration) in her analysis of their propositions. In this sense, her approach is based in existentialist philosophy (the premise that knowledge about the nature of existence arises not from abstract theorising or impartial observation but from lived experience) and the sociological/philosophical perspective of phenomenology (which focuses on how we make sense of everyday experience in a social context). Thus when analysing the phenomenon of what she deliberately terms mental 'dis-ease', the author believes that a theological, and specifically Quaker, approach holds a theoretically viable way of exploring its existential implications. However, she states that it is the process of reflection informing her research, rather than its content, that illustrates her adoption of a Quaker approach. The view she presents 'cannot be taken as a representation of Quaker "orthodoxy" in its content but only in its methodology' – particularly in relation to its Christological orientation. The other influence on the methodology is that of feminist theology, whose emphasis on subjective experience and personal reflection represents a challenge to the orthodox split of subjective/objective knowledge; it holds that praxis (the creation of knowledge out of experience) offers the primary theological resource for considered reflection. This outlook is paralleled by the recent paradigm shift within psychiatric nursing towards a more holistic understanding of mental dis-ease. The thesis encapsulates these insights in a number of themes: knowledge is not static but open to dialogue and challenge; it should aid the transformation of society through its ethical application; and each individual is responsible for the part they play in aiding understanding of the interconnected, sacred quality of life.

## **Chapter One: The Importance of Relationship in Considering Mental Dis-ease**

### **Overview**

This chapter explores the therapeutic relationship between the nurse and the person in need of care, and analyses to what extent the nature and quality of this relationship help overcome the inadequacies the biomedical model reveals when addressing the needs of those 'in mental dis-ease'.

### **Critiques of the biomedical paradigm**

The author begins by pointing out that Simone Weil's description of the isolation and stigma attached to mental illness raises profound questions about the nature of psychiatric intervention. In particular, it challenges the explanatory framework and treatment focus of most current practice, which tends to revolve around medical knowledge and its categorical power. Weil suggests the adoption of a model of care that emphasises the nature and quality of the relationship between the care-giver and the person in need of care. R.D. Laing (1965) similarly argued that the language employed by those who adhere to the biomedical framework of psychiatry hinders their understanding of mental dis-ease by treating the person as an isolated entity, ignoring their relation to the 'other' and the world. He proposed that 'psychosis' arises from a sense of ontological insecurity – that is, concern about the nature of being and the purpose of existence. Laing's critique widened the parameters of psychiatric thinking. Yet, despite his influential theories, the author believes that psychiatric practice remains open to the same criticism. She cites the example of the complex relationship between brain biochemistry and the mind, and quotes Kennedy (1983) as saying that even if 'biochemical malfunctioning' could be identified, it is not clear that labelling it as 'illness' and treating it by medical means constitute an effective strategy.

### **The influence of the scientific paradigm shift**

The author argues that exploring the individual's consciousness of their lived experience, which is rooted in relationships, represents a far better paradigm of care than a clinical definition of dis-ease that places the emphasis on the body. The theory of holistic nursing represents such an approach. It arose in the context of the 20<sup>th</sup> century's paradigm shift in the field of physics, with its recognition of the interconnectedness of the process of 'Be-ing' (see Abstract for a definition of this term). Its 'systems view' of life stresses that the focus of scientific enquiry should be the relationship between the parts and the functioning of the systemic whole – that is, it should concern relationships and integration, in a recognition of what Capra (1983) terms 'the web of life'. Holistic nursing, in its focus on relationship rather than the 'pathology' of the individual, is based on this understanding.

### **Holistic nursing and the importance of relationship**

The biomedical approach has wider social implications – for example, its models of health/illness are interwoven with specific definitions of selfhood and society. As Richman (1987) shows, ‘...to become sick means a deviation from accepted standards of well being’. Dis-ease is seen to ‘invade’ the body or mind, entailing a breakdown of its normal functioning. Medical intervention seeks to correct this malfunction, and the health/illness status of the individual is dependent on the success or failure of this ‘cure’. In contrast to the depersonalisation and medicalisation of the individual through technologically/pharmaceutically driven interventions, holistic nursing stresses the person’s uniqueness and value, and is based on a reciprocal partnership between nurse and ‘patient’. At its heart lies the concept of ‘homeostasis’ (the ability of an organism to adapt to changes in its environment in order to maintain an equilibrium). Thus breakdown or stress at one level of the human body or mind affects all levels of being, and the sense of disruption is reflected in an innate yearning towards a ‘feeling of unity’. Therefore, ‘the author argues, ‘healing’ is a far wider phenomenon than ‘curing’ – it is a shared, ongoing process in the search for a relational ‘wholeness’.

## **Chapter Two: Christian Theological Anthropologies of Relationship**

### **Overview**

This chapter examines Christian theological anthropologies, which acknowledge the importance of relationship to wellbeing and dis-ease. The author uses theologian Martin Buber’s (1959) ‘I-Thou’ model to analyse these theoretical frameworks in relation to mental dis-ease.

### **Buber’s ‘I-Thou’ framework**

Buber’s model was based on a threefold ‘dialogic relationship’ (or ongoing dialogue) between the individual and God, other persons, and the environment. The ‘I-Thou’ motif, the author claims, ‘crosses the boundaries of existential and metaphysical theology’ with its proposition that the nature of human existence is inter-relational: human beings perceive, understand and function in their social world through awareness of the ‘other’, whether it be the divine, the physical environment or other human beings. This model has since been adapted to incorporate further understandings of human nature, including those of ‘creation spirituality’. The author, however,

limits her analysis to the Christian theological anthropologies that underpin pastoral responses to mental dis-ease (see Chapter Three).

### **Discerning meaning in the world**

Christian theological anthropologies suggest that life is a journey towards discovering meaning in existence. The individuality of each person's relationship with the Thou entails that this meaning will differ for each person, but implicit in all theological discourse is the idea that every insight contributes to a clearer picture of the whole – hence each human life has equal value. The author cites the feminist theologian Daly (1986), who modifies Buber's understanding to fit her 'post-Christian' perspective (she claims Christian theological anthropologies have adopted patriarchal definitions and thus fail to envisage the true possibilities of Be-ing). Daly defines the Thou as 'ultimate meaning and reality'. In contrast, other feminist theologians have called for a 'resacralisation' of the concept of Be-ing – a recognition of the immanence of the Spirit of God, defined as the meeting point of the I and the Thou. The author believes these insights have profound implications for the concept of wellbeing; a sense of interconnectedness with the Thou provides the means to integrate and transcend the experience of mental suffering.

### **The process of developing a sense of self**

These insights can be incorporated into a socio-psychological outlook: self-identification can be described as a social process because the individual gains a sense of self through interaction with others. The theological perspective on this process posits the prior existence of a soul, seen as the aspect of human Be-ing that comprises a part of the Thou. In Quakerism, the term used to refer to this is the 'Inward Light' – 'a recognition of the possibility of sharing in the Christ consciousness if we choose to attune to it'. Individuals engage in an interplay of action and reflection in relationship to themselves and others – each part of this interaction must be given full attention to achieve 'true Be-ing'. The author quotes Israel (1982), who suggests that human existence is often fraught with 'existential loneliness' because of a failure to give adequate attention to all aspects of the self. The answer lies in 'silent attentiveness', to deepen the connection between the 'I and the Thou'. This process encourages the development of altruistic relationships, thus benefiting the whole of society. The author believes this reveals that revelation and self-identity are fundamentally interrelated.

### **'Experimental knowing'**

In light of this premise, she analyses the emotional 'relational transaction' between persons, and how such activity structures the social world. A lack of understanding of the interconnectedness of

all Be-ing – a sense of wholeness – leads to individual and collective disintegration, a general feeling of alienation and meaninglessness, and the experience of ‘existential loneliness’ so familiar to those who suffer mental illness. By disregarding the fundamental I-Thou relationship, modern society has encouraged the objectification and dehumanisation of selfhood. The way to counteract the existential pain this brings is through interaction on a face-to-face level, enabling the individual to confront their pain, and come to the realisation that they contain the potential to reach a sense of wholeness. The experience of relatedness needs the support of a community based in equality, mutuality and an acknowledgement of the dialogic nature of Be-ing. A sense of reciprocity and co-responsibility in the journey to spiritual understanding is the basis of the holistic nursing process.

### **Chapter Three: The Pastoral Response to Relationship and Dis-ease**

#### **Overview**

This chapter explores those theological aspects of pastoral care that address the centrality of relationship to the attempts to alleviate mental dis-ease. The author places her emphasis on pastoral care theorists, but also refers to secular theorists.

#### **Pastoral care models**

Pastoral care attempts to relate to the person’s three-dimensional being, implying a concern with social structures and community cohesion. The author begins her analysis by considering the two main paradigms that form the basis of its approach. The first is the secular counselling model, which focuses on drawing out an individual’s underlying assumptions about human nature. Those who see pastoral care as a way of engaging with a deeper search for meaning in life situate themselves within this model. The second, the theological model, contains the feminist and liberationist approaches, which emphasise the importance of the collective in relation to the individual.

#### **The secular counselling model and theologies of pastoral care**

Pastoral care draws on psychological and psychoanalytic theory, but its point of departure from these lies in the difference between psychiatry, which is essentially an analytical process, and theology, which is a synthesising one. The author relates that there has been a call for a redefinition of pastoral care – for example, Campbell (1981) believes that it has succumbed to an overdependence on secular thought and practice, with the consequence that there is a lack of

recognition of the role 'moderated love' plays in the restoration of self-value. However, Jacobs (1982) outlines how counselling skills can be used to enable the individual to hear, in Quaker terminology, their 'still small voice'. In this respect, the interactive dynamics of the relationship between the care-giver and the individual in need of care is the same for secular and religious counsellors, as they are both dealing with conscious and subconscious cognitive processes. A major insight of the counselling model is that the experience of illness is a learning process (this realisation can help overcome the stigma of mental dis-ease), which is based on the understanding that the person is destroyed not by suffering but by the sense of its meaninglessness. The healing process concerns a 'journey to wholeness' and 'realised potential'. In both models, the personal journey is relational and dynamic. However, as Jung showed, 'individuation' (the process of psychological integration) is connected with the experience of the numinous. Thus, in pastoral care, there is a vital connection between personal meaning and the relationship with the Thou. As individuals are part of a complex social environment, interactive social relationships are key to spiritual reconnection. In terms of practical intervention, pastoral care addresses the lack of personal dignity, distorted sense of identity and feelings of purposelessness indicative of mental dis-ease through a theological recognition of the sense of separation (or 'spiritual malaise') afflicting all participants in the process. The risk inherent in this practice is that the process increases the awareness of pain. When this happens, the differences between secular counselling and pastoral care are clear: in pastoral care, the emphasis is not on finding a solution, but on 'being with' the individual concerned, waiting and listening, in the belief that existential fear can be overcome. This process of waiting upon the 'intervention of the Spirit' is the way healing is mediated. Pastoral care, therefore, is intended to help persons overcome their blocks to awareness of life's meaning.

### **Feminist theological models**

These models shift the frame of reference of pastoral care to include both marginalised and excluded voices, as well as a critique of the socio-economic inequalities that contribute to such marginalisation. They challenge pastoral care to focus on praxis (see Introduction) and acknowledge that social, political and cultural factors impact the relational dynamics of the counselling process. Pastoral care, in itself, cannot be value-free: theories inform practice, and the practitioner must acknowledge their allegiances – for example, in relation to the political nature of health care provision. To be disengaged from the wider socio-political and economic environment is to support of the status quo. The feminist model widens the discourse of theological reflection by ensuring that interventions are not considered in isolation but informed by an awareness of the wider context; the causes of dis-ease must be addressed as well as possible solutions.

### **The liberationist response**

According to the liberationist model, this process depends on the creation of true community, as opposed to the a-political individualism it perceives to be prevalent in pastoral care. This means considering the effects of cultural and social factors, and recognising that feelings of powerlessness in the face of injustice and exploitation can be causal factors in mental dis-ease. The political context of health care provision in Britain today ('community care') leaves many of those in mental dis-ease marginalised and isolated. To counteract such experiences, the carer – as part of their theological reflection and practice – needs to question the wider picture; they need to be aware of service provision shortfalls in relation to the person in need of care and be willing to intervene to remedy the situation. Such engagement with ethical issues in relation to the pastoral encounter entails questioning the origins of mental dis-ease and envisioning alternative ways of Be-ing.

## **Chapter Four: The theory of Quaker pastoral care**

### **Overview**

This chapter presents an overview of the Quaker understanding of mental dis-ease, and illustrates how an effective therapy, practiced in accordance with Quaker principles, is achievable.

### **Quaker theological anthropology in relation to mental dis-ease**

From the outset, healing was regarded as a part of Quaker spiritual practice – The Friends Fellowship of Healing (formed in 1935) was specifically focused around this understanding: 'all efforts [are] directed toward ... bringing those who are ill ... into the Divine Presence and upholding them there in God's love, light and healing power'. The belief is that the community in prayer acts as a channel for 'healing and wholeness'. The concept of 'wholeness', the author explains, is based on the theory that the individual needs help to become attuned to their own rhythms – a prerequisite of gaining balance and harmony. Health, in this understanding, is a process, a state of becoming, not a singular event. However, 'healing' is not analogous with 'curing'; it requires an acceptance of pain, as well as an awareness of the power of God, and these are developed through prayer, in the presence of others similarly seeking wholeness. The idea that the therapist holds all the answers, therefore, does not enter into this schema: the most profound way of helping someone to self-awareness is to 'hold the other in prayer'. If the imbalance that is manifest in mental dis-ease is an indication of a 'lack of

oneness with God', then removing the symptom is not the most healing action. Hence, Quaker therapy does not believe in specific outcomes. Furthermore, there is no rigid dichotomy between 'patient' and therapist, as the therapist is simply seeking to bring the other into the presence of God. The central tenet of Quaker healing – an understanding of the interaction of the emotional, spiritual and physical aspects of Be-ing – is gaining acceptance within Western medical circles. For this reason, and in accordance with the Quaker acceptance of diversity of belief, 'therapeutic Quakerism' believes that inner development can be achieved through many different paths.

### **The Swarthmore Lectures**

The author highlights two Swarthmore lectures (delivered at Yearly Meeting) that concentrate on the Quaker response to mental dis-ease: John Lampen's in 1987 and Jocelyn Bell Burnell's in 1989. Both address the problem of confronting pain. Lampen considers the most corrosive element of pain is its loneliness: this can be overcome, he suggests, through a process of 'creative listening'. He refers to the Quaker use of silence as a two-way communication with God and with one another as part of a communal process. In this way, pain can be explored without the individual being destroyed by the experience. For Burnell, the issue is the need to accept that painful experiences are a part of life; suffering must be 'lived with and transcended' through 'thought, searching and prayer', with the support of others. Both Lampen and Burnell suggest that the essence of healing lies in enabling the individual to find ways of integrating the experience of pain with their sense of self, transmuting chaos and confusion into 'a restoration of harmony'.

### **Quaker therapeutic responses**

The author describes Quaker therapy as an element of pastoral care that represents a bridge between the content of Quakerism and psychological thought and practice. Its bedrock is the tenet that everyone has intrinsic value, and that loving social interactions enable individuals to realise their own worth and acknowledge that of others. This belief diverges from traditional psychology in its rejection of labels that imprison the individual in negative patterns; it holds instead that the apparent irrationality exhibited by individuals in mental dis-ease is but a distorted form of rationality, as personal myths are rational in a personal context. They need to be counteracted by the development of new thought patterns, through nurturing spiritual growth. Labels concern defects rather than individual potential, whereas Quaker therapeutic intervention is concerned with identifying the non-dysfunctional aspects of the person's Be-ing. The only way the individual can return to their true nature is to experience the fact that they are inherently 'loveable, sociable and non-violent' – an example of the belief in the value of 'knowing experimentally' (see Introduction).

### **Silence as a resource**

Quakerism's absence of a religious creed is one of its most striking aspects. Its lack of credalism can be equated with a belief in the plasticity of the human mind, and its refusal to interpret an individual's experience according to a rigid psychiatric schema. The Quaker query 'What canst Thou say?', which seeks to draw out each person's 'experimental knowing' (see Introduction and Chapter Two), is given centre stage in the psychotherapeutic process. This allows both for the development of theories and therapies rather than adherence to any single form of practice, and for an 'openness' to the thoughts of the individual in need of care, 'hearing their story'. Of course, the individual will interpret their story in the light of their social and cultural conditioning. It follows that reaching towards a more integrated perspective requires both therapist and 'patient' to let go of their interpretative frameworks. At the heart of this process lies silence. Often the individual has no access to words that will explain their experience; in such a case, silence is a resource for both therapist and 'patient', not a failure of the therapeutic process. The Quaker spiritual tradition is witness to the riches of silent communication, where the individual can access knowledge and power, and receive guidance. Quaker therapy, therefore, aims to avoid the pressure to label and analyse: when the individual has experienced words used as tools to belittle, label, condemn and confuse, then silence is a clearer and safer way of seeking 'wholeness'.

## **Chapter Five: Quaker pastoral care in practice**

### **Overview**

In this chapter the author argues that Quakerism's unique approach to the care of those in mental dis-ease is clearly identifiable in its institutions, beliefs and practice.

### **Quaker organisational responses**

The Quaker approach is exemplified by its 'testimonies' or sets of principles, and its injunction to 'let your life speak', meaning that these testimonies are to be lived in the world. In relation to pastoral care, this is encapsulated in the tenet of 'watching over one another for good'. The Quaker Pastoral Care group, for example, established in 1988, was initiated as a response to concerns around the experience of pastoral care. Its approach is illustrated in the group's general principles, which include the belief that pastoral care depends on the depth of spiritual life in all those involved in the

pastoral encounter, that its priority is to address expressed need, and that the process through which it does this is as important as the outcome. The 1985 'Caring for One Another' document similarly represents not a blueprint but advice, while the 1989 report on community care, although based on a critique of the whole ethos behind current social policy, concentrated on practical issues, such as homelessness and welfare benefits, and suggested remedial action. These interventions illustrate how the Quaker approach is based on an understanding that pastoral care springs from the spiritual well-being of individual Friends, and must be considered with reference to both the tenets of Quaker belief and action, and to the wider socio-political context in which these are situated.

### **The Retreat: Quaker principles in action**

The Quaker psychiatric hospital, The Retreat, was established by William Tuke in 1792. His grandson, Samuel Tuke, was the first to set down its ethos and practice, revealing the way in which it differed so radically from other contemporary asylums. Its purpose was to reflect Quaker belief in the equality (patients were not viewed as 'other') and perfectibility of all mankind. Its 1989 mission statement reaffirmed these principles, stressing that the provision of care should be on an individual needs-led basis and focused on the belief that 'there is that of God in everyone'. In this respect, the Retreat represents an understanding of the need to take into account the psychological, social and spiritual aspects of the treatment environment, with democratic rather than hierarchical working practices, in accordance with its idea of itself as a 'therapeutic community'.

### **Informal responses to mental-disease**

The Quaker approach has certain unique aspects, such as the ideas of 'spiritual friendship', spirituality being the ground of Be-ing and the source of all caring action. This informs the ethos of the Quaker Retreat Group, an informal aspect of pastoral provision, which was established in 1989 to share individual experiences of receiving support in mental illness and of supporting others. It is based on the healing power of the seemingly counter-intuitive but foundational Quaker experience of 'solitude in common', through which the individual can rediscover, as part of a communal process, the spiritual aspect of their lives that is so vital to overall well-being. This is congruent with the core belief of Quakerism in the 'priesthood of all believers' – everyone can be a guide and offer 'spiritual friendship', helping others discern their journey to the Truth. This idea differs from the far narrower focus of the secular counselling model, which is solely concerned with the presented problem, and seeks to provide an answer through expert guidance. The Quaker process is one of 'waiting in the dark' (which includes acknowledging and accepting the presence of mental 'darkness') to arrive at an awareness of the individual's own spiritual resources. In Quaker meetings,

Friends wait in silence for spiritual renewal. Spiritual resources are, therefore, identified in a communal forum of worship, prayer and contemplation. However, contemplation is always translated into action.

## **Chapter Six: Conclusion – A ‘Quaker Therapy’**

### **Overview**

In this final chapter, the author draws together the insights gained from her consideration of holistic nursing theory, Christian theological anthropologies and pastoral care theories, including Quaker pastoral care, into a new synthesis that she calls ‘Quaker therapy’.

### **The content and process of a ‘Quaker therapy’**

A ‘Quaker therapy’ would be based on the principles of ‘therapeutic Quakerism’. Its content would be informed by the Quaker belief in the idea ‘there is that of God in everyone’ and in the importance of ‘knowing experimentally’. Its process would be informed by the Quaker absence of credalism, the use of silence as a resource, and its injunction to ‘let your life speak’. Implicit in the idea of a ‘Quaker therapy’, however, is an acknowledgement of the unequal weighting of responsibility in the therapeutic relationship itself. ‘Both participants will contribute to and receive from the relationship’, but the process will inevitably focus on the person being helped to establish, repair and maintain their sense of relationship through the expansion of their self-perception.

### **The integration of feminist and liberationist models**

The liberationist and feminist strands of theological theory sit easily with the Quaker perspective, particularly in their emphasis on equality and mutuality, their critique of the balance of power in society, and their desire to redress the sense of marginality and exclusion accompanying mental disease. This approach would include rejecting dehumanising psychiatric labels; the more empowered the individual, the more they trust their own judgement. The therapeutic relationship is one where all participants bear responsibility for nurturing the seeds of spiritual growth in themselves and one another through accepting mental pain as a learning experience. Furthermore, a Quaker therapy would be informed by a ‘systems approach’ (see Chapter One) that stresses the inter-connectedness of the individual (in a biophysical, psychological, social and spiritual sense) and the collective (in a cultural, political and social sense), and of the individual with the collective.

**The experience of the divine**

The Quaker perspective is focused on the human/divine relationship. Divine love is seen as a dynamic force, which holds the power to re-animate the individual. Therapy is the process of helping the individual to access that love. Through the experience of being 'beloved' that the therapeutic relationship offers, the individual comes to accept their own 'belovedness'. The author believes such a non-hierarchical model of care, centred on a life-enhancing therapeutic relationship, could provide a credible exemplar for other forms of therapeutic practice.

**Summary prepared by Fran Cetti (2012)**