CHAPTER 26

Models of spiritual care

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Introduction

We use models intentionally to simplify complex situations in an attempt to grasp them more clearly and respond more appropriately. Sometimes modelling simplifies by choosing out of many possibilities to focus on one dimension or one set of priorities alone. Sometimes complementary models are used (in physics the wave-particle duality is the classic example) to highlight the utilitarian aspect of using models. A 'horses for courses' approach is taken; we choose the model that best fits the questions we wish to ask and the answers we wish to obtain.

The use of models

Models are to be taken seriously, but not literally.[1] This is less a problem in areas of human endeavour where model making is intentional and overt, more so in areas where it is not. Physics' mathematical representation of fundamental atomic processes is an example of the former; religion can be a prime example of the latter. Theological statements and even doctrinal propositions are models intended to allow us to represent and discuss a spiritual domain that transcends us and clearly cannot be captured in its entirety by human thought forms and in human language. Statements and propositions need to be revised to ensure that they continue to speak to new situations. Yet there are many, believers and non-believers, who regard these statements as 'truth' or 'fact', and see attempts to negotiate or reformulate them as a rejection of faith, rather than an attempt to develop a better representation of complexity.

Models are developed both within and across paradigms. Paradigms are perspectives characterized by a distinctive ontology and epistemology, which is, in turn, expressed in particular methodologies and axiologies.[2] To translate these terms, a paradigm offers a particular understanding of what reality is and what can be known about it (ontology), of the nature of the relationship between the knower and what can be known (epistemology), of strategies for finding out what can, according to this paradigm, be known (methodology) and ideas about what's worth knowing (axiology). Guba and Lincoln, in a research context, identify five paradigms: positivist, post-positivist, critical theory, constructionist and participatory, each distinguished from the other by substantial differences in several of these characteristics.

Paradigms may be regarded as incommensurable, but may be linked by models that find common ground in a set of observations and statements on which they can concur.[3] The power of such models is their capacity to transcend at a practical level the conceptual difficulties that underlie them. At their best they can lead to re-conceptualization of the issues they address; at their worst they simply confound the issue.

Turning more specifically to the topic of this chapter, models for spiritual care must thus relate not only to ways of understanding spirituality, but also to ways of implementing those understandings in particular practice domains. A spiritual care model that is appropriate in, say, a religious community may not be appropriate for a secular institution. A different practice model will be required, even if it draws upon similar understandings of spirituality.

In this chapter I will explore both conceptual and practice models, with particular attention paid to different models of spiritual care that relate to different models of health. This approach will I hope provide some insight into the multiple variations of perspective and language concerning spiritual care. These variations arise from the conceptual differences between paradigms, driven in part by research studies that commit themselves to paradigmatic purity, and from practice models that negotiate paradigmatic truces in pursuit of good patient care.

Models of health

In any public conversation between spirituality and healthcare today, certainly in any policy making conversation, healthcare has the dominant voice. Thus, spiritual care models need to be expressed in terms commensurate with the model or models of health on which healthcare provision is based.

Three basic models of health inform contemporary discussions. These models are complementary, as we shall see, although in most societies a version of the biomedical model remains most prominent. I'll first outline the three models, then discuss in more detail how spirituality might engage each of them and what this might imply for practice. Rather than continually qualify my statements I'll simply remind you at the start that these are models: the actual construction and implementation of each perspective is more complex than can readily be represented in the schematic way I'm attempting here. In practice most health systems incorporate at least aspects of all three.

The Biomedical model: healthcare as a science

A biomedical understanding of health is at the core of most contemporary health systems. This model is, however, much clearer and more knowledgeable about disease and illness than it is about health. In essence, it treats health as the absence of disease and sees the goal of healthcare as the cure of illness.

The language that characterizes this model reflects this knowledge and aim. Diagnosis, prognostication, treatment, referral to specialists, clinical management, quality assurance, discharge are all key strategies, and the stories that are told by healthcare providers in particular—but also by recipients of care—are about assessing, referring, diagnosing, prognosticating, treating, managing.

The model assigns particular roles to those who participate within it. The identity of the sick individual is that of a patient. As in Parson's classic description of the sick role,[4] people who believe themselves to be sick are obliged to consult experts for diagnosis and treatment, and to accept those experts' opinions and recommendations. Through this process a person becomes a patient; his or her illness is legitimated, and the person is provided with certain benefits (care, time off work to recover, reimbursement for at least some of the costs incurred). Having followed correct procedures the person is then expected to recover and resume his or her social responsibilities. The health professionals' role, legitimated and regulated by society, is seen to serve the interests of both individual and society.

The biomedical model is based upon knowledge developed in the nineteenth century, particularly the anatomical and the biological sciences. The key practice disciplines are those with the greatest expertise in this core knowledge. Doctors are central in allocating resources, and other disciplines (nursing, allied health) co-operate in addressing priorities determined primarily by medical practitioners.

The strength of the model is of course its capacity to treat disease. The understanding of physiological processes that is at its core continues to deliver solutions for infectious disease in particular, but also for many of the conditions that in previous generations brought to an end the lives of otherwise active individuals. Stents and statins have substantially reduced mortality in later mid-life, while other previously fatal illnesses have become in effect chronic conditions.

A weakness of the model is its narrow focus upon pathology as the explanation for and cause of disease, and the instrumental relationships it encourages. People who are caregivers are professionals trained to relate in terms of their expertise. People who are cared for are patients, a role that focuses around receiving care. The model treats isolated individuals, on the one hand depriving them of agency while on the other ignoring structural constraints that shape their capacities to respond and decide. The ambivalence and ambiguity inherent in the model can be seen from Parson's description. People must have sufficient knowledge and autonomy to identify that their symptoms require attention, but thereafter as patients relinquish their care to experts. The experts are assumed to be motivated solely by altruism and to be unlikely to misuse the power they have over others.

The biomedical model works best for acute illness where medical expertise is essential to resolving the problem and patients are willing to relinquish control for the period it takes to do so. It does not work well for chronic illness, disability or mental health conditions where the questions are not so much about resolution as living with the condition. Yet the biomedical model continues its cultural dominance, reinforced by the medical soaps and reality shows that focus on medical triumphs, but seldom convey the continuing erosion of compassionate care that characterizes health systems today.

The Biopsychosocial model: healthcare as a practice

In 1977 George Engel put forward what he called a biopsychosocial model intended to broaden the horizons of the biomedical model.[5] As a psychiatrist, Engel saw the need for medical practice to take account of factors that influence whether people present themselves for biomedical care in the first place, whether they comply with treatment, and whether they have adequate support to change their behaviour. That is, the focus remains essentially upon the individual, but attention is given to determinants that address health behaviours and thus influence the physiological processes that are the core interest of a biomedical approach.

In contrast with the biomedical model, which is a theory-driven model constructed around a scientific understanding of human biology, the biopsychosocial model is a practice model of particular relevance to clinicians. It deals not only with the science of disease, but also with the issues that present in clinical relationships. Not surprisingly, this approach is now reflected in all major medical association journals and most health service provision.

The strength of the model obviously is its inclusion of perspectives relevant to clinical encounters with individuals, not just the disease process within them. The model remains however a variant of the biomedical model. It continues to be based in a positivist scientific paradigm, where biological explanations and solutions are preferred to the 'softer' science of psychology and its explanations of behaviour. While 'social' is included in the title, it is 'social' as psychologists tend to use the term, referring to personal relationships, not the social determinants that are structural constraints upon individual agency.

Nevertheless, the biopsychosocial model is one that begins to cross the borders of conceptual paradigms. It begins to open up the positivist biomedical framework to questions and insights that are not directly suggested by, or answerable within, that paradigm. By focusing more upon the realities of practice and less upon scientific purity, it also lays a foundation for the evidence-based medicine movement of the next decade where outcomes, not scientific orthodoxy, become the arbiter of practice.

Spirituality in the biomedical and biopsychosocial model

The biomedical model in its days of dominance had no place for spirituality. There was thought to be no biological basis for taking spirituality into account, and it was seen as a private matter for individual patients, not something to be taken into account in their treatment. The expanded framework of the biopsychosocial model provided room for this assumption to be questioned. It became clear that people's religious or spiritual commitments had significant effects upon lifestyle and decision-making, and that this in turn had clinical relevance.

Discussion of the impact spiritual belief and practice has upon illness, and debates about healthcare professionals' potential role in spiritual care, began to appear regularly in healthcare literature around the end of the 1980s. These discussions, as this book evidences, have both established common ground and identified key points that continue to be disputed.

One prime example of common ground is the way spirituality has been incorporated in healthcare discourse in ways consistent with the biopsychosocial model. Swinton refers to this as a generic approach.[6] Spirituality is identified as a universal human characteristic, stripped of any particularities of content, class, culture, and religion. Just as psychological and social needs should be attended to in healthcare, so should spiritual needs be included. Spiritual care becomes something that should be available for all, for people of all faiths or none. As with 'psychosocial needs', spiritual needs are of interest because of their effect: they can shape patients' response to care, their decision-making, even perhaps the outcome of their treatment.

Generic spirituality opens up fresh possibilities of attending to aspects of experience that have been marginalized or neglected in the healthcare models of the twentieth century. However, we need also to remember that this generic spirituality is a model adapted to healthcare thinking. It may bear little resemblance to the thinking of patients and families, or the religious traditions to which many still belong.

We will return to this discussion later in the chapter in considering Sulmasy's biopsychosocio-spiritual model which, as the name suggests, is an intentional amplification of the biopsychosocial model.[7,8]

Social models of health

The focus of the biomedical model and its biopyschosocial extension is primarily upon what can be controlled and delivered by the health system. The boundaries of the conversation about health are the boundaries of that health system. A social model extends the horizons of the discussion to include not only the health system, but also other social institutions that influence the health status of individuals, communities and whole populations.

The social model sees health in terms of participation—having a place in your community. The goal of care is to support a person's capacity to participate as fully as possible in society, thus maintaining their social identity as a citizen. The language of social care reflects this—policies and mission statements talk about belonging, participation, and support. The key strategies are supporting, normalizing, educating, resourcing, and the core stories are about networking, negotiating, allocating, prioritizing, mediating, and counselling.

Social models are supported by social science disciplines, particularly psychology and sociology, and the central healthcare practitioners are social workers and health promoters.

Social models are particularly important for people living with chronic illness or disability. Caplan puts it succinctly:

> To argue that we need more medical specialists in chronic illness or disability, more hospitals and long-term care facilities for the chronically-ill and disabled ... is to miss the point. What many of those with chronic illnesses or disabilities need is equal opportunity, not ... charity. The acutely ill or those facing catastrophic health care emergencies require our beneficence and charity, but those with chronic illnesses and disabilities who are not facing an acute medical crisis deserve something radically different - the right to equality of opportunity. [Republished from Caplan H, *If I were a rich man could I buy a pancreas? And other essays on the ethics of health care*, Indian University Press, Copyright © 1992. Courtesy of Indiana University Press.]

In recent years, Caplan's point concerning the structural injustice that can result from treating illness rather than attending to the rights of the person has been radically extended and deepened. The work of the WHO Commission on the Social Determinants of Health has consolidated a huge volume of epidemiological data at a global level to show the health gradient that exists within every society, as well as between societies.[10] The steepness of the gradient is a function of social inequality—the more unequal the society, the worse the health of those of lower socio-economic status. Increasing healthcare expenditure and providing further health services may benefit some individuals of higher status; however, improving the health of populations depends upon a just and reasonable distribution of the nation's wealth, fair work, affordable housing, and opportunity for all citizens to realize their capabilities—even if they choose not to take up that opportunity.[11]

A major strength of the social approach is that it represents health as something that can be pursued even in the midst of illness and disability. In this respect, the situation of 'nothing more to do' that occurs in a curative model at the point when treatment options run out does not occur, or occurs much later, in a participation model. A weakness of the model until recently was its inability to produce hard data in support of the social theory that informed it. That problem has largely been overcome but, in so doing, the model itself becomes a problem to society at large. Pursuing health in a social framework requires fundamental change that few seem willing to contemplate. Not only do health systems (that is, systems for dealing with illness) need to be overhauled, but also all other social systems must be reviewed in terms of equity and justice. Health is to be created outside, and in some respects in spite of, our current health systems.

While the social model expresses health through a different paradigm it is interested in relativizing, not replacing or opposing, a biomedical perspective. The biomedical model is embedded within the social model. Thus, the social model still incorporates the conversation of biomedicine, but adds a further relativizing dimension of social and cultural realities. These bring personal and cultural variation and colour to biomedical evidence, showing that there is more to health than is revealed through the study of illness.

Spirituality in the social model

Spirituality finds a place within this model in at least two ways. One is functional, in that spirituality, at least in its organized forms, fosters social support and participation that improves health. Spirituality can contribute to the social goal of this approach. The other is substantive. Spirituality is seen as an integral aspect of culture, at least of cultures that distinguish themselves from the mainstream of western culture. Such spiritualities are to be respected and included in care because they are an integral part of cultural identity.

This model operates more readily in critical theory or constructionist paradigms. It notes how knowledge is selected to protect the interests of powerful social groups, or constructed to reflect and legitimate the experience of particular communities. What matters is the opportunity to participate in society and live out one's citizenship. If spirituality can contribute, that contribution is welcomed.

The value of participation is primary and with it the social model bypasses the truth claims of spirituality or religion, treating these more as cultural artefacts. Belief—any belief—can be treated as a social fact and evaluated in terms of its social utility. The meaning of a belief may be of vital concern to a patient, but for a healthcare provider what matters is the way it contributes to clinical or social goals.

Interestingly, while social constructionism most often relativizes the truth claims of spiritual and religious discourses, thus reflecting a post-Enlightenment secular analysis, the process has been turned

neatly on its head in the work of Hay and Nye[12] on children's spirituality. They argue that a child's biologically-innate spirituality is compromised or eliminated through the training received from the contemporary education system. As Swinton[6] points out, from their perspective it is secularism, not spirituality, which is socially constructed.

Holistic/ecological models

Holistic and ecological models of health further expand the boundaries of the health conversation to include not only the social system, and the health system within that, but also the wider systems of the environment and of cultural worlds. Health is seen as a quest for humanness, for wholeness. The goal of healing is becoming one's self. As with previous models, language reflects this: quest, meaning, companionship are key terms. The core stories are about healing, sustaining, guiding, reconciling, nurturing, liberating and empowering, and a primary strategy is companionship in the search for meaning. To the enquiry disciplines that have supported the previous models, the holistic model adds the arts—literature, philosophy, religion, fine arts. The healthcare practitioners most closely aligned with this perspective tend to be pastoral carers, arts therapists, transpersonal psychologists. They operate at the margins of the health system, linking patients with resources that have nurtured them in the past, or introducing them to fresh sources that will nurture their essential humanity.

Ecological models are now attracting global attention as a consequence of climate science predictions concerning the fate of the planet and the survival struggles that are likely to ensue within decades as resources (water, energy, food) become scarce, and more and more populations find themselves under pressure from an increase in unpredictable climate events and climate shifts that town planning and infrastructure development of the past had never envisaged. Implications for health systems are enormous, but are only now beginning to be explored.[13]

The new public health also engages with these models.[14] At the core of this expansive understanding of health is a commitment to values concerning what society should be like, what global justice requires, how health for all should be pursued. The perspective of the new public health is thoroughly holistic, although for the most part its debates with the clinical and social models of health are conducted on their territory and in their language rather than in terms of underlying values and assumptions about the world.

The strength of the holistic and ecological models is their inclusiveness. A variety of voices that have been systematically marginalized in the other models can now contribute. The weakness of the models is also their inclusiveness. The narratives of health that emerge are varied, complex, products of synthesis and negotiation. The variety that can offer a place to many perspectives can also find it difficult to influence, convince or persuade. Recent public debate on climate change, for example, demonstrates little understanding of how models of complex situations work, in particular that a few variant findings do not invalidate an increasingly-solid predictive model with profound implications for current action.

Spirituality in holistic/ecological models of healthcare

Authority in these models is located in the realm of human experience, beyond the domain of the biological and social sciences alone. Spirituality can contribute 'in its own right' to the multiple conversations that take place. Rather than be constrained by the utilitarian perspectives of the previous models, where health draws upon spirituality primarily for its own purposes, spirituality is free to comment upon health. This commentary ranges from fundamentalist voices railing against the use of healthcare resources for procedures such as abortion, to more liberal voices calling for just and equitable provision of care, through to prophetic eco-spiritual voices drawing attention to the unsustainable nature of our current health systems and the need to prepare for a different future.[15] Behind this diversity is a common theme: spirituality demands that values be overt in healthcare conversations. The implications of any healthcare policy should be evaluated in terms of inclusion and equity, the use and abuse of power implicit in 'clinical judgement' should be explored, the medical industry should be called to account for the ways in which, through public funding of research, private donation, and covert influence, it shapes evidence, practice and policy. The health of the planet, not just of populations, should be of concern, because the latter depends on the former.

Spirituality calls for social transformation, even if the different voices cannot agree on what this transformation should be. The fact, if not the current content, of today's spiritual revival is a sign of hope that transformation is possible. Two decades ago social theorist Anthony Giddens suggested that integral to a new social order will be a new spirituality, a shared way of affirming particular values that will support the new institutions and put bounds on the utter openness of modernity.[16] That new spirituality is needed now.

The tradition of spiritual care

The previous section indicates the capacity for spirituality to lead the healthcare discussion, but health systems are as yet reluctant to engage with these broader issues, just as they struggle to respond to mounting evidence of the profound effects of social determinants of health. The conversation spirituality is able to have with today's health systems is about the contribution spirituality might make to health as healthcare conceptualizes this.

Healthcare became an autonomous institution in modernity and correspondingly less inclined to remember its pre-clinical past. Traditional healing practices, although still surviving, are very much at the margins of today's healthcare. Religious spirituality however continues to live with a consciousness of its past, one consequence of which is that spiritual traditions provide options from which to respond to healthcare. Another is that understandings of spirituality from other eras can continue to confound contemporary conversations within healthcare.

Spirituality and social organization

Western society has experienced two major patterns of social organization, traditional society and modern society, and is currently undergoing a further transition to a post-modern era.[17] Contemporary society is not yet post-modern, but significant changes to social organization foreshadow a different future. Institutions serve different purposes in different social eras. Similarly core beliefs and values, even when the same names are retained, undergo shifts in their meaning. This has been the case with spirituality.

In traditional western society the principal authority was religion. Belief was held in common and spiritual practices involved

rituals intended to anchor that belief in everyday life. Exemplary spiritual lives were lived in community by religious specialists on behalf of the whole society. A spiritual life was characterized by right practice, not necessarily by any capacity to articulate belief—that was the role of the experts. Spirituality was a response to the God who had created the whole social order.

In modern society the principal authority was that of the sciences that catalysed massive technological change leading to new patterns of social organization. In this new social order belief became private and individual, and spirituality was identified with the private piety of religious individuals. Spiritual practices came to involve principally the mind rather than the body—right belief became more important than right practice. Spirituality was concerned with individual salvation.

In today's contemporary society the principal authority increasingly is the self. Belief is each individual's choice, and spirituality focuses on the human spirit: spirituality has a complex relationship with religion. Spiritual practices involve both mind and body, expressing personal preferences and seeking control of one's own life. Individual spirituality focuses on right fit—is it right for me? There is no authoritative institution or discourse that can dictate spirituality's meaning as did religion in traditional society or science/medicine in modern society.

Spiritual care and its changing relationships with health care

Walter outlines, using the hospice movement as an example, how all three of these understanding of spirituality have engaged successively with healthcare to produce different models of spiritual care.

1. A religious community provides total care according to its particular beliefs and practices
2. Only some people are religious, and their needs can be met by referral to the appropriate religious practitioner
3. All people are spiritual, and all staff members are involved in some fashion in spiritual care.

All three of these approaches to spiritual care are still active within contemporary healthcare systems. The first is now a minor presence, associated with religious healthcare institutions that to varying degrees shape care according to their beliefs. The second continues to have a major influence. Despite a growing literature of spiritual care and training in spiritual care there remains at the practice level a default understanding of spirituality as expressed in religious affiliation and therefore the business of the chaplaincy department. No matter that most chaplaincy departments operate out of the third approach: many staff still see this approach as imposing further responsibilities on an overloaded workforce.

Walter expresses reservations about all three models.[18] His conclusion is:

> In all three approaches, the question of vulnerability is crucial. Committed Christians can hide behind creeds and dogmas, busy nurses can protect themselves from patients' unanswerable questions by calling in the chaplain, and the new holistic practitioner can use listening skills to disengage from the pain of 'having no answer'. Whether spiritual care can be organized on a large scale, and still be worthy of the name, has yet to be demonstrated.

Walter's warning is worth noting, but even more worthy of note is his contention that spiritual care depends upon the quality of relationship offered rather than ways in which spiritual care may be organized.

Models of spiritual care

It is clear from the previous discussion that developing a model for spiritual care involves both articulating an understanding of spirituality and choosing a context for practice. It is also clear that it is unusual for a contemporary healthcare institution to embrace religious understandings of spirituality, except insofar as these are assimilated within cultural needs. For spirituality to be included within contemporary healthcare systems it must adopt a generic form, that is, one applicable to all. Lartey (see also Chapter 41) provides a useful example of this. He suggests that spirituality involves relationships:

- With places and things (spatial)
- With self (intra-personal)
- With others (inter-personal)
- Among people (corporate)
- With transcendence ('God', 'Something There').[19]

Obviously any model based on such a description will be both interdisciplinary and inter-paradigmatic, for the disciplines needed to understand and address all these aspects come from across the span of human enquiry. Further, the description provides not only a general guide for spiritual enquiry (which relationships matter, which have been disrupted, which might be renewed? ...), but it also identifies a framework into which relational content unique to each person can be mapped. The capacity to provide both a general framework and specific attention to individual needs, resources and possibilities is an essential feature in meeting the demands of a health service and respecting the uniqueness of an individual's spiritual path.

Most screening and assessment tools (see chapters 44–46) are derived from a description of spirituality, which is in turn frequently developed from enquiries into the views and patients and caregivers. Lartey's description too has been used as the basis for a Relational Web model of spiritual screening.[20]

Operational models of spiritual care

Spiritual care models predominantly need to address a health services context where care provision is organized according to a biopsychosocial model. Spirituality is introduced as a further dimension or domain of care alongside physical, psychological and social domains, and spiritual needs assessments are carried out alongside psychosocial assessments. Usually these spiritual assessments are adapted to the style of other assessments carried out in the psychosocial domains. That is, the assessment of spiritual needs and resources adopts a form readily recognisable to the host system with a view to acceptance, and ideally participation, by all healthcare staff.

Frequently, this spiritual domain of care is simply juxtaposed with other domains: little attention is given to the effects of expanding the system of care in this way or the compromises involved in adapting spiritual care to the host model. Some of these conceptual compromises have already been outlined in the 'spirituality in the biomedical and biopsychosocial models' discussion above. A further risk is one endemic to health systems: that spiritual care strategies

will become stereotyped and that workforce substitution will put initial spiritual screening in unskilled or unsympathetic hands.

The biopsychosocial-spiritual model, by including spiritual care within an integrated model, attempts to reduce these risks by addressing them directly. Sulmasy's comprehensive discussion that introduces the model[8] identifies such compromises and calls attention to conditions that are essential to maintaining spiritual care as spiritual, not pop-psychological, care.[18] These include an awareness of the richness and diversity of spirituality beyond the functional approach taken in healthcare settings, and the need for healthcare practitioners to be formed in spiritual care, not merely trained in using the assessment tools. This in turn has implications for the way spiritual care participates and cooperates in the whole enterprise of care. Further discussion of this can be found in Sulmasy's book[8] and in contemporary applications to spirituality in end of life care.[21,22] In practice the biopsychosocial-spiritual model finds natural allies in the patient centred care model and further developments of this approach.[23–26] These are models that cross between or combine conceptual paradigms with the aim of creating unity of practice. All are examples of the participatory enquiry paradigm[2,27] that integrates the insights of a range of conceptual frameworks through collaborative practice.

Sulmasy's own account identifies the importance of moving spirituality beyond health systems models. The spirituality of health systems remains individualistic and spiritual care professionalized. Broader spiritual concerns, such as social inclusion and justice, are not addressed. While health systems aim for, and struggle to achieve, some degree of equity in treating illness they cannot address equity in health. Health is created and maintained in places beyond the control of the health system, where people are born and brought up and live their lives.

Narrative development within and beyond healthcare

Spiritual journeys may well begin, or be revived, within the health system, but they should not end upon discharge from the system. Spiritual care models within healthcare must point to wider horizons. One description of a process by which this can take place is Bury's account of chronic illness narratives.[28] He identifies three categories or storylines. Each storyline incorporates, but transcends the previous one. They are not inevitably progressive, but are potentially so. They correlate with the storylines of the expanding horizons of health outlined at the beginning of this chapter.

The initial stories people tell are about the origins, onset, symptoms and effects of illness. Bury calls these contingent narratives, and they are located within a health services (biomedical) framework. People recount how they recognized the illness, how they presented for diagnosis and treatment, how their career as a patient is developing.

In the midst of these contingent narratives another storyline usually begins to appear. Bury calls this moral narratives, and these are stories that explore and evaluate altered relationships with body, self and society. People begin to reflect upon how their engagement with everyday life is changed as a consequence of their illness. These narratives are located in a social framework. While contingent stories are still told, they are told now within the wider horizon of social participation, which gives a meaning to illness experience beyond that provided by the diagnostic and prognostic interpretations of a health services perspective.

As contingent and moral narratives are developed further, another storyline begins to appear. These stories are about people's changes in identity and self-presentation. Bury calls them core narratives, and they represent a further expansion of the horizon to include reflection upon meaning and purpose in life. These narratives are located in a holistic model of care.

Bury thus sketches an illness journey that takes its participants through experiences that, to be assimilated into a person's life, require expanding the horizons of that person's understanding of health. Transitions between storylines are not always easy—Frank[29] names as chaos the first transition that occurs when biomedical perspectives no longer work and meaning must be found elsewhere—but the process outlined is that of a spiritual journey.

Conclusion

Current conversations between spirituality and healthcare are conducted largely on healthcare terms. Within the biomedical model interest is in whether providing spiritual services will serve its goals, decreasing the length of admissions, improving patient compliance, and increasing responsiveness to treatments. Within the social model interest is in whether spirituality will increase social cohesiveness and social support, and promote resilience.

From the viewpoint of those with spirituality as a primary interest, contemporary models of spiritual care must avoid assimilation to health service models even while accepting that a cost of incorporating spiritual care in healthcare is a degree of conceptual narrowing and functional application of spiritual insights. One safeguard is to ensure that there is a robust and expansive spiritual discussion beyond the boundaries of the health system so that healthcare spirituality models can never be seen as comprehending the richness and diversity of human spirituality. The wider discussion must move beyond the interiority of modern spirituality to engage with issues of human destiny and human possibility that currently confront us as the unsustainability of modern culture becomes increasingly apparent. It should also stand as a constant reminder that spiritual care takes place within genuine human encounters, and requires both skill and humility of its practitioners; it is not something that can be delivered simply as a professional service.

A further suggestion here is that encounters within health services can catalyse a spiritual journey. For many people in western societies it is a change in health status that provides the challenge to view life in a different way. For this challenge to invite a spiritual journey we need health practitioners that can respond to patient' experiences of disruption and health services that are open to them doing so. However, for the journey to continue, and for health practitioners to be resourced themselves, we need communities that nurture lively spiritual enquiry.

In the chapters that follow in this section many of these issues are worked out in accordance with differing disciplinary stances and contexts of practice.

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