Vancouver Coastal Health | Spiritual Care and Multifaith Services
Spirited Leadership – Humanizing Encounters
Compassion | Curiosity | Collaboration

Orienting Spiritual Care Practice in the Between

An Exploration of Relational Encounter

We may lament this human condition that we share
this mortal coil
yet it is this mortal coil
this very same condition
that makes sharing mortal moments
possible!

Understanding the Importance of Orientation

This essay may be of interest to seasoned spiritual care professionals, but it has been written most specifically for spiritual care interns who have just embarked upon their professional education. When I began my CPE journey, the ethos of some educational centres was still represented by supervisors saying things like, *"we will take you apart and see if you can put yourself back together."* Apart from the rather brutal imagery of the first half of the sentence, the second phrase, "*see if you can put yourself back together*", indicates how much was left to the student to figure out on their own. While this approach avoided reducing spiritual care practice to just a bag of pragmatic techniques to be applied with a mechanistic attitude towards care, it still left much to be desired.

Although one does learn something important from groping in the dark, the student gets enough of that in IPR without having to endure the withholding of practical explanation on points of practice. There are many things that need to be explored in the moment rather than analyzed, but exploration is not everything. In an action reflection model of education like CPE, one also expects reflection upon the experience, either soon after, or down the road. In addition, students also benefit from some explanation of how things work and why they work in a certain way. Spiritual Care may indeed lead one into many mysteries, but its practice should not be treated as if it were a secret sauce to be jealously guarded.

Spiritual Care may indeed lead one into many mysteries, but its practice should not be treated as if it were a secret sauce to be jealously guarded.

It is well known that every profession has a scope of practice that provides the parameters for their profession. In other words, professionals need to stay within the boundaries of their competency. Less frequently do we hear professionals discussing the orientation they have to their practice. Yet every profession has an *orientation*, or a particular *approach* to care, specific to their discipline. It is how a profession maintains the focus of their discipline, not just in terms of content but in terms of process. It is, in a sense, the *angle* by which we look at things. In some professions like medicine, differences in specialization can mean significant variances of orientation even within one profession.

To further clarify, the term "scope of practice" refers to the range of activities that a professional is deemed competent to perform. Those activities exist as a cluster within what is sometimes referred to as a field of practice. A professional field of practice may be defined on a simple level as an area of professional care in which people are trained. So, activities need to relate to a field of practice so they can be performed legitimately. But a field of practice and related activities alone do not provide enough guidance for a practitioner to know *how to approach* their work. Practitioners need to have the correct angle by which to approach the use of their skills, to be effective. In other words, they need to learn the correct stance or orientation from which their profession operates within their field.

Orientation stems from such things as philosophy of care and principles of care. It also stems from understanding the nature of where your field is situated in the broader landscape of the physical, psychological, social, or spiritual dimensions of human experience. This latter matter is obvious for some specializations like surgery, but even surgeons have times when they need to consider the psychological state of their patient prior to surgery or post operative. For other professions, the overlap between the dimensions is constant and very significant. Not only is orientation or perspective essential for a professional in having the right approach when working in their field of practice, but it is also that which keeps a practitioner focussed on what is most important to their purpose.

One's proper focus depends upon one's purpose and one cannot fulfill one's purpose if one is not oriented properly to the field

All these terms and their relationship to one another can be a little much to grasp when starting out. Therefore, let's make things a tad more understandable by considering the term "field" in a most concrete way. Imagine the literal field that North American football is played upon. The focus of some players is necessarily on the ball because they need to catch it, while for others their focus is on the bodies of the opposing players because their purpose is to block or to tackle their opponents. One's proper focus depends upon one's purpose and one cannot fulfill one's purpose if one is not oriented properly to the field. The angle by which the offence looks at the field is actually the opposite direction to the defence. Even players on the same side have very different vantage points from which to focus their attention according to where they line up. A quarterback looks at the field from a vastly different angle than that of an offensive guard

and so on. So it is that in the field of healthcare each profession has a distinct purpose and therefore its own focus and orientation to care. This also means that to get the best understanding of a case and how the patient is doing, all professions should be considered as having important information that others might miss from their angle of care. In fact, this multiple angled approach to utilizing the insights of the healthcare team has become standard practice in the west. It's not just that 6 pairs of eyes are better than one but that each pair sees the patient from its own distinct perspective.

Based upon the above, what follows could be just a description of where the spiritual care practitioner is to locate themselves clinically and where they must focus their attention. On another level it is more complex. I say this because although the focus of attention is clinical in nature, in another sense it is spiritual. It is the nature of spiritual care to be constantly both clinical and spiritual, because it is a hybrid profession that was birthed from the synergistic merger of clinical understandings and practices with spiritual interpretations that included a distinct way of being with the other. Being a hybrid makes it even more important to understand the orientation of Spiritual Care because it is less straightforward than *non-hybrids*.

Orientation to Care as both Sacred and Practical

Corresponding to the spiritual and the clinical sides of the profession are sacred and practical aspects of care. I hope to convey in this brief essay something of the sacredness of the practitioner-patient encounter. There is no doubt that without a sense of the sacred, one cannot really share the between with anyone at a meaningful depth. Yet this essay is also very practical in its focus. Students need a description of how transformative encounters can be engendered. In practical terms, the purpose of developing a better understanding of our orientation to Spiritual Care practice is to increase our competency. In turn, the purpose of increasing our competency is to make us more effective in facilitating encounters with patients that are effective in lowering spiritual distress and building spiritual resilience. Transformative encounters do not happen by accident, so there is a practical side to facilitating sacred encounters.

There is no doubt that without a sense of the sacred, one cannot really share the between with anyone at a meaningful depth.

There are both direct and indirect factors that make transformative encounters more likely. Direct factors are essentially practical things like listening skills or means of guiding a conversation in a particular direction. Indirect factors are essentially things that the student has learned concerning the human condition, in terms of how people think and feel about illness and death. Although such learning is not as direct as studying how to phrase exploratory questions for example, or how to use silence, the student can still see the relevance of the content. What can be harder for students to comprehend is the relevance of indirect factors relating to their own self-awareness. The student comes to CPE thinking they will be studying how to provide care to patients and instead they are informed that most of their basic learning

is about themselves. What could seem more indirect than approaching patient care through studying oneself?!

In CPE we speak of learning to read living human "documents" (think story). The thing is, that you cannot read anyone else's document or understand their story very well, if you have not read and understood your own. It is only through self-awareness that a student can gain a personal sense of existential aspects of the human condition (especially mortality), and being in touch with one's own felt sense of mortality is essential to Spiritual Care.

The more truth one can admit to oneself, about oneself, the deeper one can enter authentic moments with another.

Students are often surprised that to become more effective at patient care they need to know themselves better. Shakespeare knew something of this when he said, "*This above all: to thine own self be true, and it must follow as the night the day, thou canst not then be false to any man*" (Hamlet Act 1 Scene 3). The result of such an approach in spiritual care is that the likelihood of successful encounters occurring with a patient, increases as the student gains greater understanding of themselves. The more truth one can admit to oneself, about oneself, the deeper one can enter authentic moments with another. Although we should never assume that we know just what someone is going through, it is true that human beings are more alike than they are different. So, learning about yourself always pays dividends with respect to understanding others.

But even more important than understanding this felt sense of what is common to human experience, is how self-awareness makes it possible for the student to enter the moment of the between. Without the self-awareness that permits the student to sit with their own uncomfortable emotions and deep uncertainties, the student may be too anxious to stay with a patient's troubled feelings. This may result in the student simply not pursuing the matter further with the patient, or being so insensitive, as to change the subject. Such avoidance behaviors frequently show up in student verbatim presentations. So it is that self-awareness, although only indirectly related to patient care, is essential. A comparison might be how essential it is for a surgeon to have indirectly studied anatomy in textbooks before operating on a live patient or even exploring a cadaver.

Nothing is truly sacred if it is not authentic.

This indirect learning that comes through self-awareness is not only essential but sacred, because it is that which provides authenticity, and it is authenticity that is the key to entering into the between. To not be "false to any man" (ibid) is the beginning of being able to share truth with another person. Nothing is truly sacred if it is not authentic. Indeed, just as the indirect impact of self-awareness is truly an earmark of spiritual care as a profession, so is authenticity. The two go together. Dialogical skills have a more direct application but are of little effect when used by a student lacking in self-awareness. The reason for this, if not already apparent, will become clearer as we consider the meaning of working

relationally at a spiritual level, which is to say the level of truth. For it is the truth of the human condition shared in the moment without reservation, that lowers our degree of death anxiety, that lessens our fear of the future, and that helps us to embrace uncertainty in the moment.

As the student grows in self-awareness and as their knowledge of the art of practice grows simultaneously, encounters that meet the needs of patients at critical moments become increasingly frequent. So it is that the sacred and practical meet.

Comparatively Distinct Features of our Orientation and Focus

Spiritual Health Practitioners (SHPs) share many things with other helping professionals including clergy persons, counsellors, psychologists, and social workers. They also overlap in obvious ways with three of the four dimensions of modern healthcare, the bio, the psycho and the social, and impact the physical dimension more than meets the eye. Yet despite all the overlaps, SHPs are fundamentally different from all other health care professionals in their core orientation to care. Understanding something of this difference from the beginning of CPE, can assist a SC student to orient themselves to a process that can easily seem confusing due to its aforementioned, hybrid identity. That having been said, the more one learns about spirituality and about spiritual care the more mystery one discovers.

When the student is in an Individual Supervision session or IPR group, their focus is on themselves as they are seeking self-awareness. The knowledge of themselves that they gain in IPR and IS will become essential to the success of their process of engaging with patients. Conversely when they are reading clinical notes made about the patient by other professionals their focus is on the patient. Being able to read clinical notes and to focus on the patient in this way is also important to success, when they later meet with the patient. The question that remains is of course what their focus should be when meeting with the patient?

When the SHP or intern first meets a patient although their *concern* is for the patient, their *focus* is not really on the patient or on themselves. Their focus should normally be on the *relational encounter* itself, which is different than having one's focus on oneself or on the patient alone. Things look differently from this angle on the field. At VCH we refer to this relational encounter as "the between." Another way to phrase this is to say that our focus of attention is **on** the between and our orientation to care is **in** the between. The between is both the vantage point from which we focus our work and it is where we do our work with patients.

The between is both the vantage point from which we focus our work and it is where we do our work with patients.

If the above sounds very different from what you might have imagined, you are not alone. It may help to go back to the football imagery. Often when the quarterback has the ball in their hands and is deciding where to throw, they are looking at the space between them and their receivers. Certainly, they are not looking at the ball even though their hands must be placed just right on it. Frequently the quarterback is not looking at the receiver either, because the

receiver is in motion. In other words, the quarterback is negotiating space and looking where the ball needs to be in a few seconds of time from when they release it. In spiritual care we are negotiating relational space.

It may seem odd or daunting to think of what you are learning to do as so relationally dynamic as to be negotiating space, but you are. Know that many students before you have felt likewise unsteady, but this will improve as you, like the quarterback, develop the correct *stance*. If the quarterback's stance or orientation to the field is not right, the ball is much less likely to go where it is intended. Similarly, if your stance as an SHP or intern is not correct, your purpose is much less likely to be achieved. To learn the correct stance is a matter of experience. You cannot learn it from a book. Most often when students have expressed anxiety over the nature of such experiential learning, they have been told to just *trust the process.* This is good advice but in accordance with our belief that adults respond well to explanation, we will try to unpack this more.

The between is similar to what older models of chaplaincy referred to as presence, but presence has the drawback of sounding one sided. So, the first reason for the term "the between" being chosen is that it has the advantage of implying something being shared in the moment which is more accurate. The second reason is that it describes something of the felt sense one has when one encounters another person at their depths in the moment. Third, it reminds us that just as a surgeon needs to enter the operating theatre to do their work, we need to enter a certain spiritual space with the patient to do our work. This space begins with a mutually shared attitude of mind or *mutual mindfulness* between the patient and the SHP which is yet another way to describe what our profession means by its orientation to practice. There is a "natural spirituality" that arises from the extraordinary experience of a patient who is processing a critical illness in the moment with a self-aware SHP who has the courage and skill to open the door to the between.

There is a "natural spirituality" that arises from the extraordinary experience of a patient who is processing a critical illness in the moment with a self-aware SHP

The SHP opens the door, but the patient must enter of their own accord.

The SHP opens the door, but the patient must enter of their own accord. As such, our orientation to practice is in a very real sense a form of partnering with the patient. The SHP and the patient have different roles and levels of vulnerability, but unlike a surgeon operating on an organ, we need participation in the moment by the patient to bring about a reduction in spiritual distress. Indeed, the very act of joining or join-up has a healing power of its own that is immediate. For an example of this phenomenon, the student may want to read *Horse Sense for People,* written by the most famous of all horse whisperers, Monty Roberts. Although Monty's book is not about spiritual care he knows a great deal about the power of join-up. He learned what he knows experientially, first from horses, and later from

applying the essential principles of his process to people. Sometimes one can learn more things relevant to one's own profession, from someone outside of it, than one could ever have imagined. Monty is one of those people who surprises the imagination. The student may want to think of the human–horse encounter as primarily one of apprehending one another more than comprehending one another. This may make it a little easier to understand how a cross-species approach could be so informative for human-to-human encounters. The difference between comprehending and apprehending is central to the Agazarian approach used by VCH supervisors for IPR. The meeting of the patient with the SHP is also primarily about apprehending one another in the between, so you can see the relevance of the comparison. Thus the title, Horse Sense for People. Elsewhere I have written of this experience of the between as a form of horizontal spiritual experience. These are all relevant ways of looking at relational encounters.

Compare the Spiritual Care approach just described above, with for example, the approach of a psychoanalyst whose own self-awareness is critical to their practice but whose focus during therapy is solely the client. The analyst does not want an interactive relationship with the client to develop between them, any more than a surgeon wants this with the patient on their operating table. A relationship is counterproductive to the process of heightened transference that is at the heart of the highly honed therapeutic process of an analyst. A non-interactive distanced approach makes sense for the analyst because this form of focus leads to the analyst's goal of having the patient develop greater insight into their own inner processes. That form of therapy is based upon the interior reflections of the patient leading to insight, so the patient is not only the analyst's concern, but also their focus. Such an approach would be disastrous for Spiritual Care but is very effective for the analyst. This is an example of how one's purpose must match one's orientation to practice.

The extreme focus on the interiority of the patient that we see with psychoanalysis is less with some forms of therapy, and counselling. Some may intentionally be very interactive. But for virtually all therapists, the focus is primarily on the development of insight. For most therapists, insight is considered the transformative element, albeit different kinds of insights for different forms of therapy. Even for those counselors whose orientation to practice does not include much emphasis on analytical understanding, such as emotionally focussed therapists or gestalt therapists, the focus is typically on the inner experience of the patient and not upon the therapist developing a relationship with the client. Rogerian therapists are something of an exception to this, which is why CPE has always felt an affinity with Carl Rogers. Some existentialist oriented therapies might also see themselves as closer to our approach.

Our profession was very heavily influenced by the psychoanalytic movement when it came to understanding ourselves. However, the processes we use to gain self-awareness, like IPR, are often very different from analysis and come from a variety of sources including the pastoral tradition from which the "P" in CPE originated, prior to changes made in Canada by the Canadian Association for Spiritual Care. Those pastoral and other approaches will not be explored in this essay, but it is important to acknowledge their existence.

Not only do students of CPE gain self-awareness through different means than analysts, but our actual practice with clients is very far from analysis. So it is that when it comes to insight into our psyche, our debt to psychoanalytic thought is enormous but when it comes to our way of providing actual care, we owe much more to Carl Rogers. This is because Rogers' approach was a good fit with the Pastoral Tradition from which we first emerged. Neither Rogers nor the CPE tradition, belittles the importance of insight. Indeed, we want to achieve perspective shifts with patients when needed and such perspective shifts often require insight as a preliminary step. It is rather that we are most often looking for something different from insight or an emotional shift as important as both are. That "something different" or something more, is firstly, our connection with the patient in the between. Secondly, when needed, it is a shift in perspective that relates to their understanding of that which they hold as holy or transcendent.

As paradoxical as it may sound, in a sense Spiritual Health Practioners are looking for something both less and more than our psychotherapist colleagues, are seeking for their patients. The truth is that for our purpose, we do not need the patient to have the depth of insight achieved with an analyst into the passions of their mind, nor do we need to facilitate the degree of emotional expression brought about by emotionally focussed therapists. Ours is a profession that explores places where emotions and thoughts come together to form existential feelings like despair and hope, angst and peace, desperation and acceptance, hate and love, fear and trust and so on. Such words are often used in dialogue about transcendence because they describe the intersection between the human and the divine.

our focus, which is also to say the orientation of our care, lies in the between

So, SHPs do value insight and emotional expression, but our focus, which is also to say the orientation of our care, lies in the between. We are speaking of the between as relational moments with the patient, but we can also speak of the between in terms of that place where thought and emotion meet to form feelings like those just mentioned above that have an existential taste to them. So, as we enter the relational between, we do so mindful that our language is somewhat different from that of counsellors or therapists. To some degree our language of the heart is closer at times to the words of the poets. Also, because most of our work occurs in healthcare contexts involving a crisis of illness, we are less focussed on insight leading to a change in behaviour than on insight leading to a change in perspective. Those SHPs working in prisons have quite a different context that leads them to work with a heavier emphasis on both insight and emotional release. This is because the source of their client's problem is not centred in an illness but in the behaviours that landed their client in prison.

Focus Relates to Purpose

In order to understand something of the mystery of the between as our place of focus, it may be helpful to reflect upon how at least one spiritual path speaks to this space. One can find similar parallels in other faith traditions and the reader is encouraged to do so. I am simply sharing

from the one I know best. In the spiritual tradition to which I belong, Christianity, there is a verse in the New Testament book of Matthew that reads as follows: *"wherever 2 or more of you are gathered in my name, there am I in the midst of you."* Although traditionally considered to apply to the meeting of 2 or more Christians experiencing the Holy Spirit's presence amongst them, this scripture can also be extrapolated to parallel any 2 persons made in the image of G-d experiencing the between. This occurs when persons allow themselves to apprehend one another in the moment. As one imago Dei meets the other, it is like 2 mirrors facing each other. The result is a transcendent refection of each that is far more than the sum of their parts. As mentioned before this is a transcendental form of horizontal spiritual encounter in which the experience of the whole is greater than sum of the parts. It is transcendent because it is an encounter with something greater than the sum. It is spiritual because it is about a connection of being. Such encounters of apprehending, are the soil from which meaning and purpose grow, which is the side of spirituality that has more to do with comprehending. So, apprehending the other, creates the condition for comprehending, or what we refer to as shifts in perspective. So, when the SHP meets a patient, their focus is on the connection found in the between, because it is through this connection that the goals of spiritual care are dependent. *The work of the SHP is driven by this purpose of connection because it is the connection that is catalytic to the reduction of spiritual distress.*

As one imago Dei meets the other, it is like 2 mirrors facing each other

The primary need of patients in spiritual distress is to reduce their feelings of being alone in their suffering. If as a new intern you are feeling overwhelmed at not being able to remove a patient's suffering, know that you can reduce the feeling of being alone in that suffering. This is accomplished when the patient can connect their personal experience in the moment with the SHP in the between. The patient thereby connects also with their place in the human condition that they share with the SHP. This is not only the patient sharing *about* their suffering but instead it is letting someone *into* their suffering through mutual vulnerability. Although this requires the SHP having empathy, it is not empathy alone. It is more of an empathic connection or as mentioned earlier, a mutual mindfulness that can lead to a deep compassion. As a result, the patient feels not only understood, but undergirded. The SHP cannot have an authentic encounter with a patient without in some way being touched, or even changed themselves by their time spent in the between. However, as they turn their empathy into compassion, being touched spiritually and emotionally by the patient does not need to be overwhelming. It is necessary to feel something of the patient's suffering, but it is not helpful to anyone if the SHP feels overwhelmed. The more self-awareness the SHP has, the less the chance of them becoming so.

The SHP cannot have an authentic encounter with a patient without in some way being touched, or even changed themselves by their time spent in the between.

Lest the student think that every encounter with a patient needs to be at the greatest of depths, be assured that one's presence with a patient can be at lesser depths and still involve a meeting in the between. A true connection in the between is always authentic but meetings occur at various depths. A surgeon removing a tumor in the leg is not as deep inside their patient as one performing open heart surgery, yet both are surgeries. So, it is with Spiritual Care. Sometimes we need to be metaphorically holding someone's heart in our hands, while on other occasions we are just holding their hand. The patient's level of need, the openness of the patient, and experience of the SHP are all determining factors. Often depth develops over a series of sessions but on occasion the need is so great that the patient opens up immediately. For this the SHP needs to be prepared.

The Relationship of Orientation to Results

Vancouver Coastal Health has the 3 core values of Caring for Everyone, Always Learning, and Striving for Better Results. I think all 3 are evidenced in what has been said up to this point about our orientation to care but because our profession is less concrete than others, we need to pay special attention to the 3rd value and demonstrate results. If we say our work is too sacred to speak of in these terms, we do so at great risk. It is risky because if we do not demonstrate results, our work remains unmeasured and that which is not measured is of uncertain value. We can legitimately maintain that many benefits accruing to patients from entering the between with an SHP are hard to quantify. Nevertheless, the results of an SHP meeting in the between with a patient, can be described in plain language and at one level they can even be measured or at least objectively observed.

If we say our work is too sacred to speak of in these terms, we do so at great risk.

The following are results related to a pt spending time with an SHP in the between, some parts of which might be mentioned in a clinical note. However, as they appear below, they are not written as notes specific to a patient. Each indicates a form of measuring change.

1. The patient discovers that the strength they gain from their experience of someone being truly with them in their depths of the moment, translates into them being subsequently better able to face the *emotional* challenges of their illness with greater power.
2. The patient is better able to process challenging existential *thoughts* on their own after sharing them with someone who considered those thoughts as relevant questions for them too, due to their shared human condition.
3. The patient finds greater *courage* in connecting with the divine mystery due to experiencing the connection in the between with the SHP, which itself is a manifestation of the spiritual world.

The patient finds greater courage in connecting with the divine mystery due to experiencing the connection in the between with the SHP, which itself is a manifestation of the spiritual world.

But these results need to be shared in a language common enough to be appreciated by others on the interprofessional team. Here then are sample clinical notes corresponding to the above 3 results. They are written as if they were reflecting actual sessions in which each of the above results were manifested. The reader will note that as mentioned earlier, clinical notes should focus on the patient. Although, at times the relationship of the SHP with the pt may be mentioned, the point of the note is to describe the spiritual state of the pt and not to describe the process engaged in by the SHP with the pt, any more than the point of a surgeon's note is to describe their surgical technique.

1- *Patient describes herself as spiritual but not religious. She was able to gain some emotional and spiritual strength from our session today. She states that these visits help her to feel less lonely in her spiritual struggle to come to terms with all the uncertainties she is facing. Writer will continue to follow.*
2- *After struggling with many existential questions related to her illness, Ms. Lee is now describing herself as better able to accept that there are some things we cannot know this side of death. She is somewhat comforted as she reflects upon all those who have travelled this path before her. Writer is on vacation for 3 weeks but will have a colleague check in on her next week.*
3- *Patient is less anxious than yesterday at the prospect of needing major surgery. The anxiety has abated as a result of his willingness to admit and discuss his underlying fear that has more to do with not wanting to leave his wife as a widow, than with his own eternal destiny. Patient indicates that our sessions together help him to feel connected to his higher power and that this sense of connection is giving him courage. At the pt's request writer has agreed to be at her bedside for prayer one hour prior to her surgery.*

SHPs engage with patients in the between primarily because the connection itself lessens the suffering of the patient.

SHPs engage with patients in the between primarily because the connection itself lessens the suffering of the patient. Healthcare teams are fine with us establishing connections with patients that are of a spiritual nature, but they want to know the results in practical terms such as the impact on thoughts, emotions or even feelings like courage. They are not looking for a description of the depths of experience the patient had in the between. That is why the clinical notes above do not go into those details. Yet the content of each note is clearly spiritual, reflecting the orientation of our discipline.

As alluded to earlier in this essay, another important intent is the hope that, when needed, the patient will make a shift in perspective that will still further lessen their distress. When a solitary and often lonely journey of illness is transformed into a shared experience of mutual mindfulness such a perspective shift is much more likely to occur. An SHP who observes such a shift in perspective might make a note like the following:

This is my 5th visit with Mr. Smith. He reports feeling less lonely than before and closer to his higher power. Today, we once again explored deeply into his thoughts and feelings about how his injury has affected his identity. In previous sessions he described himself as "a cripple" but now refers to himself as a 'survivor." This shift in perspective seems to be rooted in his spirituality. He stated "God does not want me to give up. There is still much for me to do in this world." As a result, he says that he is now more hopeful about facing each day as a step in a new direction. I believe this bodes well for him cooperating with his physical and occupational therapy. Writer will continue to follow this patient as there may be further challenges of a spiritual nature on the long rehabilitation journey ahead of him.

Patients may be at one level of depth or another in their exploration of the between. The walls of the inner caverns they discover there are sacred and do not usually need to be expressed in clinical notes. What needs to be recorded, is only that which is relevant for the team to do their work. With the note immediately above, the relevance is very high, due to the shift in perspective. At other times it may be much less.

The Nature of the Experiential Encounter

Although the benefits described above as results, can be understood without great difficulty, the student may wonder if the *actual process* of entering the between is beyond normal description because it is a spiritual experience. While on one level there is some truth to this, on another level the process is quite describable. For example, the between involves connecting with the eyes which in common parlance are often referred to as the windows of the soul. It involves listening to words and speaking words in a dialogical exchange using a language of feelings known to most people, even if not frequently used by them. What transforms these normal activities and words into something very special and sacred, is not just verbal technique or conversational strategy, but the authentic presence of the SHP born of self-awareness and the courage to be vulnerable with the patient in the moment, as one who shares the human condition i.e. as a mortal who will one day die. The process of such an encounter is quite observable from the outside. One can often notice visible changes in the patient's face and body language. The process is simultaneously natural, yet extraordinary.

As alluded to earlier, entering the between is more experiential than explanatory and more about apprehending the moment than about comprehending ideas. However, while always experiential, the between may involve the containing of feelings as much as it may involve deep exploration. The SHP holds the space of the between with the patient either way, and it is this holding that creates the opportunity for containment or exploration alike. So, although decidedly not explanatory in nature, the meeting of the SHP and the patient in the between may be one of containment or exploration. In this way one can see how although the content of conversations certainly matters, an orientation of working in the between as a place of

Being with the other in the between is the single greatest factor of healing in the Spiritual Care field of practice.

healing means that there is a belief that process needs to take precedence over content. This makes sense when one remembers that being with the other in the between, is the single greatest factor of healing in the Spiritual Care field of practice. Content is therefore always secondary. Current folk wisdom alludes to this truth a little when it says "*people may not remember what you said, but they will always remember how you made them feel*."

We may therefore say that, *just as existence precedes essence for existentialist philosophers, so for an SHP, process precedes content*. As such, the encounter of the SHP with the patient necessarily involves such common things as tone, timing and the choice of the most suitable common words. All choices of approach made by the SHP are guided by their belief that connecting in the between is necessary in making space for the type of realizations that are helpful to a patient facing the crisis of illness. Again, this makes sense when one considers that any change of perspective in this model of care is predicated upon the two participants being in connection with one another. *In a very real sense, an authentic relationship automatically changes* ***perception****, which in turn makes a change in* ***perspective*** *more achievable*.

When exploring perspectives, the encounter between the SHP and the patient may certainly involve the exploration of both ideas and feelings. However, as mentioned earlier, this form of dialogue is never about inner insight divorced from relationship. Existential thoughts are not discussed by the SHP with the patient as abstract considerations of a general nature. Instead, they are explored as poignantly relevant to the patient's personal condition and the human condition that is shared *between* the patient and the SHP. Indeed, in palliative care one might observe the SHP providing a sounding board for the deepest thoughts of the patient, while reflecting upon the wisdom of the ages. But at a different level, the SHP may very well be learning with the patient how to die. Similar parallels of mutuality may be found on many levels. In every instance the SHP is never the expert offering an objective opinion, as if the patient does not impact them. Instead, the SHP, or intern, is a co-sufferer whose suffering is simply at a different stage, allowing for them to provide care until it is inevitably their turn to be on the receiving end of compassionate support.

The SHP, or intern, is a co-sufferer whose suffering is simply at a different stage, allowing for them to provide care until it is inevitably their turn to be on the receiving end of compassionate support.

A Place of Responsibility

Working with patients in the between comes with a high degree of responsibility. Although it is a place of mutuality, the patient has a greater degree of vulnerability and need than the SHP. Due to this power imbalance, and the SHP being in a professional role, the spiritual intimacy is in some respects largely one sided. As a result, it is extremely important for the intern to understand the importance of boundaries within that relationship and the significance of their role as a place of power from which good or harm may arise. This does not mean that an SHP

should never be direct with a patient and offer some good advice. While it is not our preferred mode, at times, tired hearts and minds do need some direction, even from within the between.

Closing Words

The VCH spiritual care program provides many articles to students on a wide variety of topics on spiritual care and far more are available in journals and books. Orientation is just one part of a large field of information on Spiritual Care practice, but it is a particularly important topic to understand near the beginning of your professional education. Hopefully, this brief foray into what is at the heart of our profession, has helped you to gain some perspective on how things fit together. As a hybrid profession there is a complexity to Spiritual Care that can be hard to make sense of until one understands its orientation to care as centred in the between.

We need patients to be our teachers amidst the mystery, just as patients need us to be the ones leading them into the between.

We need patients to be our teachers amidst the mystery, just as patients need us to be the ones leading them into the between. May you be increasingly less confused by all the challenging scenarios you will face in this profession, and yet simultaneously remain constantly in awe of the mystery opened to you by all the privileged encounters you will have. May you be blessed with many mortal moments.
