

Some Countercultural Caveats for Pastoral Healthcare

**- the fractious coexistence of packaged care
and therapeutic spirit**

David Zigmond

© 2014

Managers and conveyors of Pastoral Healthcare know we have a crisis of morale and practice. We respond with our usual pattern: wearying, prolix documents offering rejuvenated and revised management initiatives; then the frustrated, confused meetings called to consider these. Something important is perennially elusive: What is it? This is an (uncommissioned!) offering to one such meeting, about Mental Health.

'We can be knowledgeable with other men's knowledge, but we cannot be wise with other men's wisdom'

– Michel de Montaigne, French Essayist 1533-92

The success of bio-technology in much of physical medicine has led to this becoming the instructive model throughout healthcare. Likewise competitive commerce, quantifiable science and standardised, commodified, industrial manufacture – these are all now elevated to principles commanding current NHS services. All these have led to a complexly structured, factory-like culture that cannot– perversely – embrace *human* complexity. So, pastoral healthcare – which includes the bulk of Mental Health Services and General Practice – is now dominated, yet poorly served by, such models. For human complexity needs responses of sophisticated flexibility: this is a primal element of pastoral care. Attempts to short-circuit these essential complexities by 'standardising' and 'objective' management systems will always fail. The evidence for this is all around us. Yet our factory-culture now has massive momentum and is hard to influence. This collage is a small effort to do this.

*

This medley of caveats and aphorisms is offered to help fuel and guide a necessary counter-cultural response. The notions are interlocking, often overlapping and deliberately unsystematised. They are necessarily incomplete.

*

- There is an old German motto: *The more laws, the less justice*. We can create a simile for our Welfare Services: *The more official designations and procedures, the less humane imagination*.

*

- Healthcare encompasses the complete span of human dysfunction, from the evidently broken bone to the invisibly broken heart.

- We need an equivalently wide span of responses to attend to these. This is difficult and made even more complicated by the fact that patterns of distress sometimes mask or encode one another.
- Experience – unlike certain bodily states or processes – is never directly measurable. Scientific *attitude* (eg dispassionate, inferential imagination) has much to offer our navigation, amidst our multilayered and intertwined experiences; scientific *activity* (eg measurement) is much more problematic and limited.
- Another distinction needs attention here. Dis-ease and disease are often both close yet very different. These differences require from us equivalent differences of skills, understanding and interchange.
- For example, treatment of acute disease usually needs little understanding of personal meaning. This offers clear territory for our more straightforward procedures.
- By contrast, healing or quieting dis-ease or chronic disease usually needs much more understanding of personal meaning. Artful imagination here may be more valuable than procedure.
- Despite these differences, there are many situations when they can (and must) be blended.
- The kind of creative human receptivity required to do this itself needs certain kinds of milieu – those that encourage imagination, attachment, containment and affection (= personal, valued, feeling-suffused bonds).
- The human exchanges necessary for these types of personal work are always unique and bespoke. Each is like a delicate improvised dance we do with an other: they are very different from generic ‘treatments’.
- In these areas of pastoral care science may inform but it should rarely define or decide.

- Models and words are not, in themselves 'real': they are human devices of packaging that have protean relationships with 'reality'. This is true of our diagnoses, though their evanescence varies greatly.
- For example, physical diagnoses of structural disorders generally offer us clear, durable and robust usefulness.
- In contrast, non-physical diagnoses of functional complaints are generally much less reliable, durable or robust. They often offer only temporary, loose clusters that provide administrative illusions of order. Psychodiagnosis examples this well.
- Psychodiagnosis nevertheless has short-term conventional allure. Its limits are important to understand as it otherwise becomes easily overused.
- Overuse of psychodiagnosis-based systems is a kind of specious packaging which can then become more of a problem than what is being packaged. Such unwise human packaging can have a paralytic effect on the head, heart and imagination of both practitioner and patient.
- Because of these irreducible yet complex limits, psychodiagnosis must be seen as *protoscience*: it may sometimes be useful, but only partially, and then only when submitted to intelligent and imaginative views of personal context.
- Likewise psychometry (psychological tests): these are very interesting and complex exchanges, but what they document is far from 'objective'. They may sometimes tell us something, but what that 'something' is is often very uncertain. Such tests may enlighten, but alone they should never define or prescribe.

*

- Good pastoral healthcare needs skilful mixes of structure and flexibility, like tyre-technology.

- The medical model's dominance in healthcare is a mixed blessing. It secures much structure, but at the expense of flexibility. The result is like driving a vehicle on solid tyres (pneumatic tyres brought humanity much safety and relief in the 1890s).
- The skilful balancing of structure and flexibility is one definition of holism.
- An important inverse relationship: generally the larger and more complex an institution, the more rigid it is, and the less able it is to respond flexibly to human complexity and variation.
- So it is that excessive diagnosis, schematisation and specialisation obstruct wider and growing forms of understanding: our personally attuned yet holistic views and contacts.
- Holism must include meaning. This is not easy, for we humans are polymorphous, complex and paradoxical: much meaning is not explicitly expressed and can only be reached (or constructed) by imagination.
- Likewise with communication. Probably most communication is *metacommunication* (ie not explicit, or direct, or (even) aware).
- Our understanding of others must depend as much on what is not said, as what is said.
- We now talk much about 'talking therapies'. But even here much of the therapy lies behind, between and beyond our words. We need to understand these interstices as much as our words.
- Schematic psychology, and derivative therapies, can deal only partially with the explicit. For the (often more important) implicit we need to draw on much else.
- This 'much else' is now being driven out by the previously described overpackaging and overschematisation. These schemata may – at first – look tidy but, unchecked, destroy the head, heart and soul of pastoral care.

- Schematic medical sciences and treatment psychologies share aims of reducing uncertainty, doubt and ambiguity: this reduction is often essential to 'treatment'. We are here ushered quickly, often by a managed Care Pathway, to an Orderly Ness.
- Therapeutic psychologies of resonance and imagination, by contrast, take a less direct and prescribed route. Here we will often amplify and explore together Life's vicissitudes. 'Healing' often involves lingering and cohabiting in our Wilder Ness.
- Healthcare is a humanity guided by science. That humanity is an art and an ethos.

*

- *'The quest for certainty blocks the search for meaning. Uncertainty is the very condition to impel Man to unfold his powers.'*

Erich Fromm (1949) *Man for Himself*

Interested? Many articles exploring similar themes are available via David Zigmund's home page on www.marco-learningssystem.com