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Utilising Availability and Vulnerability to operationalise spirituality

Melanie Rogers

Introduction

In this chapter I will introduce the concepts of ‘Availability and Vulnerability’ (A&V) and offer a rationale for adapting these concepts and using them as a framework for operationalising spirituality in practice. I will reflect on the concepts of A&V, describe how they have come to have personal significance for me, provide findings from a recent research study, and suggest how they are helpful for integrating spirituality in nursing, social and psychological care.

The Northumbria Community is a dispersed Celtic Christian monastic community with a ‘mother house’ based in Northumberland, UK. (Readers who are unfamiliar with the language of ‘monasteries’, ‘monastic communities’, and ‘monastic “Rules”’ may find it useful to read Chapter 9, in which Laura Béres gives a background to these ideas prior to describing the concept of ‘Hospitality’ in the *Rule of St. Benedict* and implications for practice.) I became a companion, or member, of this community seventeen years ago and have chosen to integrate their ‘Rule of Life’ and embrace the concepts of ‘Availability and Vulnerability’ into my own life and work as an Advanced Nurse Practitioner in Primary Care. Similar to other monastic communities, the Northumbria Community has a ‘Rule of Life’, which is like a structure of suggestions companions attempt to follow and which often incorporate vows. The two vows taken by companions of the Northumbria Community are in regards ‘Availability’ (to God and others) and intentional, deliberate ‘Vulnerability’ (before God and others).

My journey

My interest in spirituality stemmed from an early age, although at that time I would not have labelled it as such. I grew up in a family affected by severe depression which had a significant impact on my childhood. I learnt at an early age that my inner journey held a way to understanding some of the inconsistency and challenges that faced me in my outer journey. Although there was no Christian influence in my family, I became involved in my local church through the Girl Guide movement where I was an active participant. I am not sure I thought a great deal about 'God' or even listened that much at the church services but something about the liturgy gave me solace and opened up many of the ontological and existential questions of life.

Throughout my teens I spent much of my time seeking meaning and purpose in my life through achievements. I became a young leader for the Guides; I worked as a shop assistant and waitress from the age of 14; attained my Duke of Edinburgh Awards; was selected to represent Yorkshire on Sail Training expeditions; and also represented my school on an expedition to the Himalayas. As a teen I was sociable and keen to find out about others' lives through the experiences and adventures I had. I always had a nurturing, caring, and compassionate personality, and naturally followed my vocation as a nurse to St. Bartholomew's Hospital in London. On completing my nursing studies I went on to work in Africa for a charity on a hospital ship before commencing my nursing career in London, followed by time in Canada and finally back to Leeds in the UK.

These teenage experiences, and varied work experiences, led me to see the world in a different light; I saw poverty, affliction, and struggle as well as the human determination to face trials and live in a way that cultivates the human spirit. I developed a vision to care for others and walk alongside them in their suffering. This vision later became a source of deep

reflection as I started my nurse training and worked with many patients and their loved ones facing illness, adversity, and death.

Throughout my formative years significant people mentored and inspired me to consider my inner journey. They helped me see the way my life, work, and developing spirituality could make a difference to those around me. These people radiated an altruistic view of the world. They lived their spirituality by their caring, compassionate understanding of struggle in humanity and the pain associated with being human. They helped to nurture me in a way that cultivated my deepest compassion for others and led me to fulfil my vocation as a nurse which has been the focus of my working life for over twenty five years.

These formative relationships, my childhood experiences, and the expeditions to differing cultures, contributed to my considerations regarding 'the meaning of life.' This led to my exploration of Christianity and I made a commitment to become a Christian at nineteen years of age. In many ways my faith journey created more questions than answers. The belief I had when I was younger was that 'God' and 'spirituality' were synonymous. This has been challenged and refined to a completely different stance now in my forties where I see that for some faith and spirituality are synonymous but for many spirituality comes from other avenues, for example from relationships, work, hobbies, their pets, or nature. As a young woman I found a level of safety in what seemed to be the 'black and white' Christian values that were taught to me through different courses and groups I attended. As life in my early years had seemed inconsistent and at times chaotic I clung to the structure of this 'Christian box' in which I kept myself safe. The values of Christianity then as now deeply influence my view on life and my care for others. However, I have moved to a way of living which could be described as having a deeper spirituality rather than a religious way of living in that my faith is very much an inner journey rather than expressed through outer aspects of church

attendance and following doctrine. The 'black and white' values I held onto are now very much 'grey' which has created many more challenges in my life but has led to much more richness.

My journey through faith to what I now describe as spirituality has been the hardest 'adventure' of my life. It has challenged my core beliefs, values and moral compass. I have seen how within church settings people can become disillusioned. Some individuals within a church setting seem to feel they need to put on a mask of 'Christian living' whilst they struggle with the challenges we all face which make us human: love, fear, pain, selfishness, jealousy, lust, betrayal, loss, sexuality, and morality for example. Often, I witnessed those involved in a church setting feel as though they couldn't be real for fear others might think they did not have enough faith. Some of my work in church settings involved supporting and counselling those who attended a course I ran about relationships, sexuality, and trauma. Through this I helped to foster a place where people could be vulnerable and real in safety. I found many people had felt trapped by their belief that they had to be a certain way which seemed to stem from church politics. I became passionate about being authentic in my life and faith which led me to explore how this was expressed in my own day to day living.

Part of this journey led me out of 'church' and towards other faith communities who were struggling with what it means to have a faith and live authentically. This journey has been a rollercoaster with times of major activity within church settings, and other times of disillusionment and frustration about the chasm that often existed between people's day to day life, and their appearance and attitudes on Sunday at church. I had been seeking something external to bring me to a place of authenticity in my faith, rather than considering my inner journey.

The Northumbria Community

I came across the Northumbria Community through a chance conversation with an acquaintance. Having just finished facilitating a year-long course on the deeper issues of life, and feeling burnt out, I went to the community for a week long retreat not knowing what to expect. I was surprised to find a diverse group of people who were all struggling with organised church and were seeking companions with whom to be authentic in their questioning of organised religion. What I found there was an embracement of others irrespective of their life journey. During the first ten years of being a companion of the community I was never asked about my occupation, people were interested in me for me; a revelation as nursing formed part of my sense of self. Part of the values of the Northumbria Community is ‘the conviction that who a person is counts far more than what a person does’ (Miller, 2003, p. 34). I also found an acceptance for my faith journey which was reinforced on my first visit by one of the house team members who said ‘you are where you are on your journey and that’s okay.’ What struck me was that this community of people were wrestling with how to live authentically as Christians. When I first attended it was embryonic; there was little written guidance for the people who visited or became companions. Individuals focussed on reflecting on their own journeys, experiences, and challenges, following a rhythm each day which included time to read, pray, work, reflect, eat, and live together.

The Northumbria Community’s ‘mother house’ was initially a house deep within the beautiful countryside of the Cheviots straddling the England/Scotland border where people could go to retreat. There is a rhythm of the day based on monastic practices of prayer, work, rest and community with specific influences of a rich Northumbrian Celtic Christian heritage in order to integrate faith into daily life. These influences come from the heart of Celtic Christianity including living simply, and following Jesus and the journey of life in its

everyday ordinariness. Miller (2016) suggests that reflecting on the deep heritage of Celtic Christianity and the journeys of Celtic Saints like Cuthbert, Bede, Aidan, and Hilde for example, reminds us of their simple lives, service and care of others and faithful witness. Many stories of these saints are reflected in the daily readings of the community and continue to encourage and inspire companions of the community (Northumbria Community, 2002). The Celtic tradition was monastic in nature, committed to God and others, with hospitality at its heart, reflecting the community call to availability and vulnerability.

As the community grew it formed a dispersed community of people with a similar vision and ethos, with most companions living across the country and only a few based at the mother house which was a place for companions to come together to meet, to retreat and to take time out of their busy lives for contemplation. (The Iona Community, based on Iona in the Scottish Hebrides, and The Community of Aidan and Hilda, on Holy Island off the north east coast of England are two other dispersed Celtic Christian communities.) I often would go for retreat to the Northumbria Community to give myself time to reflect on my own life and explore questions I had about my spirituality with people who would listen and could relate to some of my questioning. What often struck me were the advantages of living as a dispersed community (part of their vision for a ‘church without walls’) where relationship, rather than denomination or place, was the priority.

The Northumbria Community has steadily grown from when I joined when there were approximately 50 companions into a larger community with 375 companions worldwide, 1700 friends and around 1000 visitors (Askew, 2014). Many people visit the community’s new ‘mother house’ which is now in Felton, Northumberland, where retreats are held, giving time to study specific areas, including spiritual formation, living authentically, and being available and vulnerable. Individual retreats are offered weekly where companions, friends

and visitors can come for a time to seek God and find space for reflection and inner refreshment. When I joined the community it was 'organic': there was a freedom to explore the community's ideas with no set guidance. There is now a formal process involved in becoming a companion where a number of core modules are followed with a mentor to discern the vocation as a companion and understand the ethos and vision of the Northumbria Community. Additionally, a number of texts have been published, the most well-known being 'Celtic Daily Prayer', to guide readers through the rhythm of daily life (Northumbria Community, 2002). I think this is inevitable when a community grows but the community tries to ensure that the guidelines offer individuals creativity and flexibility in following the modules and that they are treated just as a 'guide' rather than as regulations.

The Northumbria Community describes itself as an ecumenical 'new monastic' community: 'new monastic' in terms of a fresh expression and authentic living out of the Christian faith within a community setting and also in the sense of drawing from the traditional monastic lifestyle of living within a 'Rule of Life' (Northumbria Community, n.d.). As indicated earlier, a traditional 'Rule' is discussed in chapter 9, where Béres describes the sixth century *Rule of St. Benedict* which provided guidelines for Benedictine monasteries. The Northumbria Community's 'Rule of Life' was developed for companions to follow, integrating the concepts of 'Availability and Vulnerability' into their daily lives wherever they lived (Northumbria Community, n.d.). The 'Rule' was, and still is, the fundamental backbone of the Northumbria Community which companions choose to embrace within their own lives. I felt drawn to this as it is not set to be prescriptive but rather provocative: a challenge as to how to live one's day-to-day life with the flexibility and adaptability needed for individuals' varied journeys. The Northumbria Community suggests the 'Rule' 'serves as a framework for freedom - not as a set of rules that restrict or deny life' (Northumbria Community, 2004, p. 5).

For me, the simplicity of the 'Rule of Life' is a framework for a way of living authentically which resonates with many of my personal inner struggles. To be part of a community that welcomes questions and indeed encourages them is freeing. A community where all are valued and status is not sought, where a real spirituality is reflected in daily life and where the value of being authentic is nurtured enabled me to reach a place where the dissonance between my faith and my way of living was no longer so great. Spirituality for companions of the community is grounded in the 'Rule' and comes out of each individual's difficult and challenging life journey; it comes out of deep questioning including, 'How do I live with myself? How do I live with others? How do I relate to the world around me? How do I find time and space for God?' (Northumbria Community, 2004, p. 10). This naturally affects my professional life as well.

Availability and Vulnerability

Trevor Miller, one of the founders of the community, suggested that A&V are the keys to authentic living (Miller, 2014). Being available is defined as being accessible, at the disposal of another, and serving others (Northumbria Community, 2004). Miller takes this further, embracing hospitality as an outworking of 'availability' in the Christian context. His descriptions of 'availability' resonate for me as they call companions to be hospitable by welcoming others: in doing so he suggests we welcome Jesus into our own lives. This concept of 'Hospitality', and its resulting implications for practice, is described fully in Chapter 9. 'Hospitality', as described by St. Benedict in the sixth century, was also about welcoming the stranger as if we were welcoming Jesus, but, in addition, included the need to discern whether it was safe to welcome the stranger, ensuring that the way of life of the monastery could continue to be protected. 'Availability' is extended into care and concern for others through action, prayer, and intercession, being hospitable to others and following Jesus

in our own 'vocation' (Miller 2014). This definition of 'availability', if taken literally, has far reaching consequences for one's life and work. Companions are encouraged to work this out in their own way within the context of their own lives.

Choosing 'availability' as a bedrock for their approach to others evoked a significant question for the community, which continues to be a place of exploration for companions. The question that follows from the principle of availability is 'How then shall we live?' It is all very well choosing 'availability' but if one is to be authentic this decrees 'vulnerability' and not just an embracing, but a living out of these vows. This is something I continue to reflect upon as I have values and beliefs that are fundamental to my life and I want to live authentically by these. What I often struggle with though is my own selfishness that means sometimes I do not want to be available and vulnerable. However, the 'Rule' recognises that we are 'human' and that this is a journey, not a destination. This gives me hope that as I continue to mature and reflect my ethos can be evolving. Additionally it would not be possible to live in a way that is consistently available and vulnerable all the time. Perhaps this acknowledges some of what is described in Chapter 9 about the need for balance, including boundaries, as described in the *Rule of St. Benedict*.

The marrying of A&V significantly brings with it a desire and willingness to fully connect with others and God. Vulnerability for many is seen as weakness and a place of potentially being hurt (Herrick and Mann, 1998). On the other hand, the community suggests a position of choosing to be '*intentionally* vulnerable', thus exposing oneself to, or being willing to risk being harmed and wounded. Counter-intuitive though this may seem the community asserts that embracing 'vulnerability' in this way can lead to extraordinary freedom and connection with others. Herrick and Mann (1998) suggest that it takes courage to risk being vulnerable but by doing so we engender hope in others. Rolheiser (2004) talks

about not becoming a 'doormat' by becoming vulnerable and going to the extreme of letting every aspect of our lives 'hang out'. He suggests true vulnerability is held within the strength of being able to be present oneself to another without the 'false props' we often use to bolster our egos. Vanier (1982) talks about how our choice of vulnerability over ego can transform those in our care by creating the safety for them to feel loved and accepted: able to lift their masks and risk being vulnerable themselves. These viewpoints speak significantly to me and have helped me to understand more about vulnerability and the power of embracing this attitude and stance in my own life. Many times, through illness and difficulties, patients who are already vulnerable come to see me; it is part of my job to acknowledge this and create a context of safety for them to feel 'held'.

The community is attentive to how embracing A&V can impact companions positively and adversely. They encourage accountability through connection with 'soul friends'. O'Donohue (1997) suggests soul friends walk alongside one another, sharing intimately about their journey with God and life. In this relationship companions can be authentic, accountable, and share the ups and downs of the journey with someone who sees, accepts, and supports them for the beauty of who they really are. The Northumbria Community describes a soul friend as 'someone you choose to be there for you on that inner journey; to be there for you in the good and bad times. The soul friend sees the best and the worst in you and is committed to supporting you' (Northumbria Community, 2005, p. 10).

Choosing a life of embracing A&V is risky, and yet I have also found it profoundly helpful to be able to talk through the implications and experiences of living this way and to be seen as who I am. Reflection and discussion with a soul friend has often helped me to discern how to live out the values of the community in a healthy way at home and at work. Herrick and Mann (1998) caution that it is not possible to be vulnerable with every person in

every situation and that discernment must come into play to be able to be vulnerable in a healthy life-giving way. Within this, boundaries need to be established not to prevent relationships developing but to actually give them more freedom within the limits individually set. An example for me has been in my support offered to friends struggling with addiction. I have supported friends through alcoholism, sex addiction, and eating disorders, and have been there with, and for, them over long periods of time. It would not have been helpful for me at every point of need to drop everything and come to their physical aid. There was a need to establish some boundaries in order to attempt to empower them to address their issues; however, consistently affirming acceptance and care was profoundly helpful for them in their journey. The boundaries laid, and the discernment of when to be there physically and when to support from afar, was what enabled me to truly offer care and support within the context of A&V, without becoming bitter or burnt out. Nouwen (1998) suggests that without boundaries the needs of others can become overwhelming; in order to remain in a place of mutuality people must hold onto their own identity, and not try to be everything to everyone. A&V involve a measure of control in order to relate in a healthy way (Herrick and Mann, 1998). The intention of holding to A&V as one's ethos and then working to put that ethos into practice is actually strengthened through healthy boundaries, rather than diminished by them.

For the community, being 'vulnerable' also includes being willing to be teachable, being willing to learn, and willing to change. This often comes about through listening to God in the context of prayer and the study of scriptures, but also through dialogue with others and by being willing to reflect upon and challenge one's values, attitudes and behaviours. Faith in God is seen as an absolute, however, understanding other people and being accepting and open to differences encourages companions to allow their convictions to be challenged and sometimes changed. Life as a companion to the community includes being open to

change whilst remaining in the context of the stability of relationship with God. Being open and willing to be teachable, and also willing to consider changing or refining my views has been important in my own journey, which, as mentioned above, began in the ‘black and white’ context of an evangelical church. The move to uncertainty in many aspects of my life, whilst holding onto the certainty of my faith in God, has been freeing and has enabled me to continually reflect upon and review my own experiences and conceptions of life.

Vulnerability and willingness to learn and adapt stem from companions being asked to embrace the ‘Heretical Imperative’ for self and others (Northumbria Community, 2002). This is practiced through ‘challenging the assumed truth, being receptive to criticism, affirming that relationship matters more than reputation’ (Miller 2014). Accepting to live in this way, making a choice to challenge rather than just accept the status quo at times, can be a very vulnerable position to take.

Context for using Availability and Vulnerability as a way of operationalising spirituality

I have chosen to work in a way which is available and vulnerable in my professional practice and I have seen how this has impacted my connection with patients and how it has enabled me to integrate spirituality into my practice. My view of spirituality is that it is a way of finding hope, meaning, and purpose: it is innately human. This is foundational to my practice where I daily work with patients who are struggling to find hope, meaning, and purpose in their own lives. As I relate to them ‘human to human’ I can support them in these struggles.

Personal reflection, observation of clinical practice, empirical research, and study of the spirituality literature has highlighted the difficulty many practitioners have operationalising spirituality. Holistic practice is well recognised and includes spirituality, yet many clinicians struggle to know what spiritual care actually means and often feel

unequipped to address these issues in practice (Coyle, 2002; Agrimson and Toft 2008; Cook 2011). A research project I conducted offered Advanced Nurse Practitioners an opportunity to reflect on A&V and whether these concepts could be used as a framework to integrate spirituality into their work. Eight participants were interviewed face to face during two in-depth interviews spaced 18 months apart. The dialogue that occurred between myself and the participants allowed for the development of a thick description of the phenomenon of spirituality in their practice.

Although participants indicated having struggled with how to conceptualise and integrate spirituality into their practice, having introduced the concepts of A&V to them, and after thorough exploration, they recognised and identified that A&V were concepts which could be a useful lens for integrating spirituality in ANP consultations. This framework can be transported to settings where faith, religion, and the spiritual beliefs of those concerned cannot be assumed, offering structure and direction in practice. There is a precedent for this in the example of how mindfulness has been adapted from Buddhism and integrated into healthcare as a recognised treatment option (Williams and Penman, 2011). Lisa McCorquodale discusses mindfulness and its use in occupational therapy in Chapter 8.

Translating A&V into life and work means giving not just time to patients and those in our personal lives but also being truly present through listening, care and compassion (Helming, 2009; Carron and Crumbie, 2011). It involves being intentional in our work and life relationships to try to be present, to understand, to give of ourselves unconditionally within the boundaries of context. It necessitates standing up when we have seen injustice and standing alongside others as they struggle to be heard. It leads to saying ‘yes’ to being ‘human’ especially in the context of our work, allowing our patients to see us as people and not just clinicians. This requires at times appropriate sharing of self within the boundaries of

our regulatory bodies. For example, I was meeting with a patient who I thought had bowel cancer who had been referred for investigations. I saw him regularly and spent time talking through his feelings and concerns about the diagnosis, treatment, and his prognosis; I shared with him that my dad had been through a similar situation and I understood some of how he may be feeling. This helped this particular patient to feel 'held' and cared for by someone who could empathise rather than merely sympathise. What was important for me in my sharing was that my emotional distress about my dad was not present; he had had bowel cancer 10 years previously. It would not be appropriate to share something which could lead to the consultation becoming about my distress; the aim in my sharing was to be supportive and to empathise appropriately. Other times I have tried to offer patients hope when going through significant illness by sharing learning from other patients' experiences (anonymously) which I have witnessed and what helped others in similar situations.

Occasionally my sharing may be something seemingly small and incidental like talking about a recent trip to somewhere they too may have been, or a connection with a hobby they may also have. The times I share something of myself are often spontaneous though within me there is a strong sense of boundaries and the need to not confuse the professional relationship. This means that the aspects shared are often incidents from the past where the emotions for me have been worked through and I feel contained in my sharing, or they may involve something which is not at a depth where it would have an adverse impact on me. It would not benefit my patients if I became distressed about aspects of my life whilst trying to support them or if the consultation lost focus from them. However, the sharing of myself and my experiences has repeatedly shown me that patients appreciate this and feel more understood and able to trust me when they recognise my 'humanity' within my professional role.

In these choices and ways of practicing with my patients I have chosen A&V to integrate spirituality into practice.

In this next section I integrate my own experiences with my research findings to propose a framework for practice.

Availability and Vulnerability: a framework for operationalising spirituality

Availability

Availability to 'ourselves'

In order to integrate 'availability' into practice, awareness of our inner life and the places from which our values and beliefs emanate is important. This is certainly consistent with critical reflection of practice and the findings of Jan Fook's work presented in Chapter 2. Many of the participants in my study viewed their work as vocational and consistently gave of themselves, sometimes unfortunately to the point of 'burn-out'. Burn-out is not uncommon amongst health professionals who often put their 'heart' into caring (Wright, 2005). Being conscious of our 'inner journey' personally and professionally enables us to be able to practice holistically whilst also being aware of our own needs. Self-reflection, self-acceptance, self-care, and supervision are vital for healthy relationships that are needed in the helping professions. Self-acceptance is important before we can truly accept others as they are (Vanier, 2004). Being comfortable with self, being at home in one's skin, is a foundational starting point for authentically working with patients. Vanier states that 'People reach maturity as they find the freedom to be themselves, and to claim, accept and love their own personal story, with all its brokenness and beauty' (Vanier, 2004, p. 23). By consistently reflecting on our journey the authentic self becomes an agent for increased compassion and honest relationships through true self-acceptance.

The first aspect of availability, therefore, involves being available to ourselves in our inner lives, continuing as clinicians to be self-reflective and self-accepting, embracing spirituality (broadly defined as understanding of one's meaning, purpose and direction in life) as key to our inner journey.

Availability to others through welcome

How we welcome our patients often impacts the whole interaction. Simply introducing ourselves to patients and offering them time to talk about their presentation and anxieties is akin to offering hospitality and welcome. Hospitality here can be defined as simply providing a friendly and open reception (Thompson, 1995) (See also chapter 9 for a full discussion of the complexity of, and limits to, hospitality). By consciously welcoming each patient and by being open and willing to be available to them and to truly listening to them the ground is laid for a mutual exchange based on equality and acceptance. There is no need to justify attendance when one feels welcomed, heard and accepted. The key to welcoming a patient is to truly listen. Nouwen (1996) links listening to welcoming and acceptance. He suggests that true listening is not about just letting someone speak, but rather is about paying full attention to what they are saying, what they are not saying and who they are. Expanding upon this, he says ‘the beauty of listening is that those who are listened to start feeling accepted, start taking their words more seriously and discovering their true selves. Listening is a form of spiritual hospitality’ (Nouwen, 1996, p. 85).

The second aspect of ‘availability’ involves being welcoming to patients: offering time, acceptance, and understanding whilst being truly present and listening attentively.

Availability to others through caring

Care and concern are the primary focus of our work. To care for another is to commit to give of self, and in doing so welcome a patient’s story, creating a safe place where patients, free to be themselves, can ‘tell it like it is.’ This is, in Nouwen’s words, ‘the highest form of hospitality’ (Nouwen, 1973, p. 95). To be able to do this we need to have an understanding of our own inner journey and also our areas of experience and expertise. Many beginning clinicians seeing patients may rigidly hold on to taught models of practice which may include specific questions and approaches. As clinicians mature they are often aware of how

interactions become more meaningful for patients when they simply feel listened to (Balint, 1964) and they no longer rely so rigidly on the taught practice models. In order for this to happen clinicians need to open themselves up to letting the patient lead the interactions and give time to hear the patient's story.

The third aspect of availability involves offering care and concern for patients through active participation, creating a safe place for patients to tell their story as it is.

Availability in response to the needs of patients and the community:

For many clinicians our work is dynamic and aims to respond to the needs of those in our care. Over time many of us may have developed specialist areas of practice where we see the needs of patients beyond what is normally offered in our practice. By responding to the needs of our patients and by being aware of ongoing needs within the community in which we practice we can develop and be flexible in our work. (For example, in chapters 11 and 12, Rumbold and Béres respectively both comment on the need to develop compassionate cities and communities that will better respond to the needs of people within in community.)

Therefore, the final aspect of 'availability' is being available and willing to develop practice in response to the needs of communities, and to the needs of patients in communities.

Vulnerability

Vulnerability may need further exploration and a change of emphasis to be understood as a helpful way to operationalise spirituality. It necessitates moving away from seeing it as 'weakness' or as 'defencelessness' and towards seeing it as intentional. Several aspects of vulnerability will resonate for many, especially the idea of embracing vulnerability by being teachable. The wide varieties of interactions we face each day constantly challenge us to ensure we are kept up to date about the issues impacting our practice. Additionally, being willing to learn from our patients and seeing working with them as a privilege often reframes our practice. Being willing to learn from our relationships, our interactions and the

responses of our patients can be incredibly powerful. Duvall and Béres (2011) discuss the vulnerability and tentativeness of language in their chapter regarding ‘Circulation of Language.’ They also describe vulnerability as incorporating tentativeness that suggests moving away from rigidity and towards greater flexibility and openness to new learning.

Embracing Vulnerability by being teachable

Being teachable includes being willing to learn, to adapt and, to gain new knowledge. None of us will ever have ‘arrived’ in terms of knowing all that could ever be needed for our work. Using our knowledge, experience, skills, and discernment aids practice. Equally, choosing to work collaboratively with our patients develops trust and may be key to recovery or working together to solve problems and anxieties. Within the many complex and challenging situations we face we will not have all of the necessary knowledge; referring to other colleagues for support and advice may be needed at times and can be considered through supervision and reflection, helping us to recognise our learning needs. In order to do this we must be willing to accept our on-going need for education, training, supervision, and reflection in order to provide a service where patients feel safe, supported, and able to know they will be listened to and treated with understanding and respect.

The first aspect of vulnerability therefore involves developing an openness to be teachable; accepting the vulnerability of our clinical role and the reality that within our work we will never ‘know all’.

Willingness to be accountable to others

Accountability is fundamental to practice as a clinician. The Nursing and Midwifery Code of Professional Conduct (2015) suggests this is a way of ensuring practice is safe and transparent. Patients need to feel safe and to trust us. In light of the reality of us not knowing everything, patients often value our honesty about our limitations. Statements of honesty can actually improve the clinician/patient relationship. For example, ‘I’m not sure what is going

on here but let's try this and see how things go', 'I'm going to ask a colleague to see you as I don't have much experience of . . . ', or 'What do you think is going on here?' can all add to the sense of honesty and transparency in the working relationship. These sorts of admissions make the clinician accountable to the patient and often engender healthy relationships. Additionally, admitting mistakes as a clinician helps us to recognise our own limitations and recognise the need for further training, education, and the support from other colleagues. Miller, paraphrasing the theologian Thomas Merton, reminds us that the only mistake is one you don't learn from (Miller, 2014).

The second aspect of vulnerability involves being willing to embrace accountability, engaging in supervision, reflection and admission of mistakes, and being receptive to constructive criticism. It requires being willing to share uncertainty with patients and act in a way that is open, honest, and transparent, working within our limitations.

Willingness to be Vulnerable by advocating for patients

Embracing the 'heretical imperative' as part of vulnerability may come to the fore in terms of us being willing to speak up for those who may not have a voice (to be an advocate); to speak the truth even if it means challenging colleagues or the systems within which we work. We strongly desire to meet our patients' needs and through advocacy patients can see that they are valued and listened to which can lead to a stronger sense of meaning. In order to advocate not only do we need to consider challenging colleagues but the wider systems, including the political arena and the culture of 'individualism'.

The third aspect of vulnerability involves being willing to be an advocate for patients. If necessary, it may require questioning authority, being honest and truthful with the best interests of the patient at heart.

Vulnerability and authenticity

Another aspect of vulnerability includes being willing to receive constructive criticism to develop personally and professionally, which necessitates maturity and resilience so as not to lose confidence. The goal with this aspect of vulnerability is to put building relationship with the patient before reputation. Though professionally, of course, reputation is of importance the goal here is not to put value as a professional above the relationship with the patient. Relationship based upon care for patients is another mainstay of all clinical practice.

The final aspects of vulnerability involve a willingness to be authentic in the approach to care of patients, and a willingness to be challenged and questioned without defensiveness.

Perspectives on implications for practice

Seeing A&V as a framework for operationalising spirituality could have a major impact on us and our patients and lead us towards fully integrating holistic care. A&V supports practice in a way which is freeing and adaptable, recognising the patients' and our own spirituality. It certainly promotes a tangible and pragmatic method for operationalising patient-centred care.

Aspects of being available and vulnerable have also been explored in a number of nursing, psychology and sociology texts (Rogers, 1959;1961;1962; Rogers, 1997; Schmidt, 2001; Van Deurzen and Arnold-Baker, 2005; Martinsen, 2006; Brown, 2010; 2012; Thorup et al, 2012; Alvsvåg, 2014; Lindström et al, 2014).

From a Christian perspective, Martinsen (2006) and Eriksson (2007), both Nordic nurse theorists, suggest that nursing is founded on giving of oneself to care for others and offering neighbourly love (agape) and charity (caritas) as reflected in Jesus's commandment. Within the concepts of agape and caritas, presencing (being available) is paramount (Lindström et al, 2014). Alvsvåg (2014) suggests that the agape love and caritas offered are coupled with discernment which is moral, practical, and professional. This enables healthy

relationships to occur whilst maintaining professional boundaries. Discernment necessitates balancing the emotional involvement with patients with the mutual vulnerability which must be present partly due to the caring role, but also because of shared humanity (Martinsen, 2006; Heaslip and Ryden, 2013).

Rogers (1997), writing about vulnerability in health care identified that all are vulnerable to differing extents and that this can have negative consequences leading to harm, hurt, and neglect. She recognises the mutual vulnerability of caring which can be positive or negative depending on the situation, because of the emotional investment needed to care for others. Like the Northumbria Community, Rogers (1997) also recognises that a truly therapeutic relationship requires commitment and emotional investment. She acknowledges that emotionally distancing from patients is unhelpful and suggests that feeling vulnerable may be a facet of good quality care (Rogers, 1997). Denying emotional engagement with patients to reduce personal vulnerability may unintentionally increase vulnerability in patients as it can limit therapeutic connection.

The psychotherapist and researcher Carl Rogers detailed and explored the well-recognised core conditions needed in therapeutic practice; empathy, congruence, and unconditional positive regard (Rogers, 1959). Schmidt (2001) and Van Deurzen and Arnold-Baker (2005) consider these core conditions as necessary to connect with another as human to recognise their uniqueness, their inherent worth, and to love and respond to them with understanding and solidarity. Schmid (2001) recognises Rogers' concepts of presencing, authenticity, and empathy as fundamental to building a relationship with another where the other can feel truly accepted. The unconditional positive regard Rogers describes must be free from 'buts' and 'ifs' in order to allow the other to experience acceptance in a way they may not have experienced before. Rogers reminds therapists that the offer of emotional warmth does not lead to 'emotional over-involvement', but to the other being able to 'actualise'

(1961, p. 4). Schimdt (2001), like the nursing theorists, values the individual as a fellow human being of inherent worth who deserves to be loved and accepted as they are. The fundamental acknowledgment of a shared humanity and a call to love, care, and accept others echoes A&V.

Pollard (2005) and Brown (2012a) suggest that authenticity is what makes meaningful relationships. Authenticity is the key to wholehearted living and is evident in A&V. It involves being willing to be seen, being available to others, and being real; it necessitates vulnerability. Schmid (2001) proposes that being authentic comes out of presencing and is the place where the other recognises congruence, unconditional positive regard and empathy; it is being fully human and fully open. In being authentic one learns to encounter the other as fully human. He suggests that a person is created to be authentic, to be open, to be transparent, in order to enter into dialogue with others and acknowledge their need (Schmid, 2001). Herrick and Mann (1998), Nouwen (1998) and Rolheiser (2004) recognise that boundaries are needed in order to maintain one's own identity and not to become overwhelmed and fully enmeshed in another's suffering.

Brown (2012a), from a sociological perspective, discovered the importance of vulnerability. This reflects the work previously cited of Carl Rogers and Martinsen. In her work on vulnerability Brown (2012a) asserts that humans are 'hard wired' for connection and stresses that empathy fuels connection, whilst sympathy drives disconnection. Her research identifies vulnerability as the precursor to wholehearted living. Human to human connection is present when we meet with all our vulnerabilities. Brown's (2010) extensive research on vulnerability suggests that those willing to be connected, authentic, available, and vulnerable live a more wholehearted and connected life than those who see vulnerability as a weakness. She suggests that blocking authenticity and vulnerability occurs by striving for perfection (not allowing others to see our weaknesses) and numbing emotions through alcohol, drugs,

over-eating or obsessive shopping, for example. In her research the participants who chose to be authentic about their own vulnerabilities and who connected with others with the willingness to not have any guarantees were more joyful, more hopeful, and more secure (Brown, 2010). Being willing to be authentic and courageous is from her perspective the most vulnerable but freeing and wholehearted way to live (Brown, 2012b). She suggests that true belonging only happens when presenting our authentic imperfect selves to the world; our sense of belonging can never be greater than our level of self-acceptance (Brown, 2010).

Van Deurzen and Arnold-Baker (2005) have written widely on existential therapy and, again, aspects of A&V can be seen which are fundamental to the therapist/client relationship. They suggest that the spiritual dimension is the most controversial of all human experiences yet it is the dimension which allows the fullness of individual uniqueness, values, and experiences to be explored with a therapist who listens fully, respects the individual, is authentic, and values humanness (Van Deurzen and Arnold-Baker, 2005).

Gilson (2014), offering a feminist critique, focuses on the ethics of vulnerability and reiterates that to be human is to be vulnerable. She states that this cannot be avoided; it is fundamental to being human and something we share. She also recognises the dangers of vulnerability in that it can be unpredictable and uncontrollable, leading to many actively avoiding it. However, she asserts that, depending upon the view point held about vulnerability, it can be an ethical imperative for human connection (Gilson, 2014). If the view of vulnerability is that it denotes weakness, powerlessness and harm, it will be actively avoided; if it is seen as part of the human condition, it will lead to ethical and moral action, and a shared humanity.

All of these perspectives suggest that A&V are paramount to building professional and therapeutic relationships. There are also important considerations if choosing to truly integrate spirituality within health and social care practice.

Conclusion

The aim of this chapter has been to offer a description and an understanding of my own spiritual journey through becoming and living as a companion of the Northumbria Community. I have also described the concepts of A&V within the Northumbria Community 'Rule of Life' and provided a declaration of my personal position and influences in order to ensure transparency.

Finally, I have proposed a framework of A&V for operationalising spirituality which can be simply used in clinical practice and offered examples of availability and vulnerability from nursing, sociological and psychological perspectives. Practitioners do not need to be spiritual or religious in order to integrate A&V into their practice. The aspects of the framework are not widely different from professional codes of conduct but they offer further ways in which we can understand how to authentically connect with others 'human to human' in direct practice. Additionally they are methods of supporting our own development both as individuals and practitioners. I suggest that spirituality is innately human but sometimes difficult to conceptualise and apply to practice. A&V is one simple way of practically operationalising spirituality.

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