Advancing care of the soul

Contribution of professional ethics and codes of ethics to quality care of the soul

Evelyn Peeters – Faculty of Theology and Religious Studies (KULeuven)
OVERVIEW OF THE PRESENTATION

I. PRESENTATION OF RESEARCH PROJECT
   • Presenting research project
   • Sharing preliminary research findings

II. CONTRIBUTION OF PROFESSIONAL ETHICS AND CODES OF ETHICS TO QUALITY CARE OF THE SOUL
   • Professional ethics and codes of ethics for spiritual care in the care sector: reflections
   • Codes of ethics as framework for reflective practice: case study

Evelyn Peeters – Faculty of Theology and Religious Studies (KULeuven)
I. PRESENTATION OF RESEARCH PROJECT

1. Presenting research project
2. Sharing preliminary research findings
1. PRESENTING RESEARCH PROJECT

- **Title:** “A systematic comparative and evaluative research of the codes of ethics with a view on improving the quality of professional ethics for spiritual caregivers in the care sector”
- **Overview:**
  1.1. Research Topic
  1.2. Research Question
  1.3. Research Trajectory
  1.4. Research Outcome
1.1. Research Topic

Professional ethics and codes of ethics for spiritual caregivers in the care sector

<table>
<thead>
<tr>
<th>Professional ethics</th>
<th>Spiritual caregivers: Chaplains/carers and counselors</th>
<th>Care sector:</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus: codes of ethics</td>
<td></td>
<td>- General hospitals</td>
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<tr>
<td></td>
<td></td>
<td>- Psychiatric services</td>
</tr>
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<td></td>
<td>- Facilities for persons with disabilities</td>
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<td>- Homes for the elderly</td>
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</table>

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1.2. Research Question

General Objective:

<table>
<thead>
<tr>
<th>Improve professional ethics...</th>
<th>for spiritual caregivers...</th>
<th>in the care sector</th>
</tr>
</thead>
<tbody>
<tr>
<td>Focus: codes of ethics</td>
<td>... Improve quality of spiritual care</td>
<td></td>
</tr>
<tr>
<td>Means: guidelines and recommendations</td>
<td></td>
<td>... Improve quality of integral care</td>
</tr>
</tbody>
</table>

Research Question:

“How can we – through the development of guidelines for the codes of ethics – improve the professional ethics for spiritual caregivers in the care sector, as a contribution to the enhancement of the quality of spiritual care and therefore of integral care?”

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1.3. Research Trajectory

**Six Phases:**

1. Select codes of ethics, studies on codes of ethics and scientific studies on professional ethics for spiritual caregivers in the care sector
2. Select topics in codes of ethics
3. Analytical comparison of topics in codes
4. Develop an ethical framework of professional ethics
5. Develop comprehensive and synthesis guidelines and recommendations
6. Revise guidelines and recommendations
1.4. Research Outcome

• **Outcome:** guidelines and recommendations → resource for spiritual care organizations in the care sector in the formulation/revision of a code of ethics
  - Communication of guidelines
  - Process of implementation and provision of guidance
  - Feedback!

• **Motivation** for the development of ethical code:
  - Important tool to increase ethical conduct
  - Well-developed in the Anglo-saxon countries but under-developed in continental Europe \ Exception: Netherlands

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2. SHARING PRELIMINARY RESEARCH FINDINGS

• **Overview:**
  2.1. Selection of codes of ethics
  2.2. Selection of topics

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2.1. Selection of codes of ethics

A. Methodological tools for the selection of codes of ethics: **demarcation and quality criteria**

   ▫ **Demarcation criteria:**
     - Field of professional ethics: code of ethics
     - Target group of caregivers: spiritual caregivers
     - Envisioned professional context: care context

   ▫ **Quality criteria:**
     - Professional organization: representativeness
     - Code of ethics: formulation and/or revision
     - Options in code: explanation and/or justification

B. Outcome of methodological procedure of selection: **delineation of clusters**

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<table>
<thead>
<tr>
<th>REGIONS</th>
<th>SPIRITUAL CARE ORGANIZATIONS FOR CHAPLAINS</th>
<th>SPIRITUAL CARE ORGANIZATIONS FOR COUNSELORS</th>
</tr>
</thead>
<tbody>
<tr>
<td>International</td>
<td>IACC International Association of Christian Chaplains</td>
<td>/</td>
</tr>
<tr>
<td>Africa</td>
<td>/</td>
<td>SAAP Southern African Association for Pastoral Work</td>
</tr>
</tbody>
</table>
| America | SCC Spiritual Care Collaborative  
APC Association of Professional Chaplains  
AHKHCCM Association of Hong Kong Hospital Christian Chaplaincy Ministry Ltd  
AAPC American Association of Pastoral Counselors  
NACC National Association Christian Chaplains  
CASC Canadian Association for Spiritual Care  
AIISSQ Association des Intervenants et Intervenantes en Soins Spirituels du Québec | AACC American Association Christian Counselors  
NACC National Association Christian Counselors Malaysia |
| Asia | ISCN Israel Spiritual Care Network | ACCSA Association Christian Counselors South Asia |
| Europe | UKBHC United Kingdom Board of Health Care Chaplaincy  
AHPCCHC Association of Hospice and Palliative Care Chaplains  
CHCC College of Health Care Chaplains and SACH Scottish Association of Chaplains in Health care  
SCA Spiritual Care Australia | ACCUK Association Christian Counselors United Kingdom/PCUK Pastoral Care UK  
ACC Association Christian Counselors Germany  
ACC Association des Conseillers Chrétiens Suisse Romande  
IACC Irish Association of Christian Counselors |
| Oceania | NZHCA New Zealand Healthcare Chaplains Association  
Evelyn Peeters – Faculty of Theology and Religious Studies (KULeuven) | CCAA Christian Counselors Association of Australia |
|         |                           |                                           |
2.2. Selection of topics in codes

A. Methodological tools for the selection of topics: substantive and quantitative criteria
   - Substantive criteria:
     - Substantive compliance of the topics with research topic
     - Substantive character of the topics for the practice of spiritual care
   - Quantitative criteria:
     - Attention to recurrent topics
     - Attention to blind spots

B. Outcome of methodological procedure of selection: delineation of clusters
<table>
<thead>
<tr>
<th>Power imbalance &amp; vulnerability</th>
<th>Boundaries</th>
<th>Informed consent</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Promotion of client’s best interest</td>
<td>Promotion of client’s responsibility</td>
</tr>
<tr>
<td><strong>Related to personal-official-professional identity</strong></td>
<td>Limits regarding personal energy, availability, etc.</td>
<td>In case of intra- or interdisciplinary referrals due to limits regarding personal-official-professional identity</td>
</tr>
<tr>
<td></td>
<td>Limits regarding faith based spiritual care</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limits regarding professional competencies</td>
<td>In case of limits of confidentiality, use of touch, use of dual relationship</td>
</tr>
<tr>
<td><strong>Related to diversified professional relationships</strong></td>
<td>Limits of confidentiality, limits in use of touch, limits in/no dual relationship</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Abuse (physical, sexual, psychological, spiritual, verbal, financial, etc.)</td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>High standards of professional competence</th>
<th>Care of self</th>
<th>Multicultural/religious competence</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>External: correct representation of competence</strong></td>
<td>Fitness to practice</td>
<td>Respect for cultural and religious values of clients, colleagues, other care professionals, care institution – no imposition of values and beliefs</td>
</tr>
<tr>
<td><strong>Internal: advancing professional competence</strong></td>
<td></td>
<td><strong>Influence of Christian faith related views and practices in the spiritual care process</strong></td>
</tr>
<tr>
<td>(continuous) education/training, supervision, active participation in spiritual care organization, adopting regulations and requirement of healthcare institution, following developments in faith community and society.</td>
<td></td>
<td><strong>Presentation of spiritual caregiver</strong></td>
</tr>
</tbody>
</table>

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<tr>
<th>Use of touch</th>
<th>Dual relationship</th>
<th>Confidentiality</th>
<th>Intra/interdisciplinary collaboration/communication</th>
<th>Public advocacy</th>
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<td><strong>Public advocacy</strong></td>
</tr>
<tr>
<td>Transference and countertransference</td>
<td>Records Self-disclosure</td>
<td>Referrals Continuity of care</td>
<td></td>
<td><strong>Integration of spiritual care in the care institution &amp; in faith community</strong></td>
</tr>
<tr>
<td>Evelyn Peeters – Faculty of Theology and Religious Studies (KULeuven)</td>
<td></td>
<td></td>
<td><strong>Attending to the voiceless</strong> in care institution, faith community, society</td>
<td></td>
</tr>
</tbody>
</table>
II. CONTRIBUTION OF PROFESSIONAL ETHICS AND CODES OF ETHICS TO QUALITY CARE OF THE SOUL

1. Professional ethics and codes of ethics for spiritual caregivers in the care sector: reflections

2. Codes of ethics as framework for reflective practice: case study

Evelyn Peeters – Faculty of Theology and Religious Studies (KULeuven)
1. PROFESSIONAL ETHICS AND CODES OF ETHICS FOR SPIRITUAL CAREGIVERS IN THE CARE SECTOR: Reflections

• Overview:
  1.1. Professional ethics for spiritual caregivers in the care sector
      • And the professional ethical model
      • In codes of ethics

  1.2. Codes of ethics for spiritual caregivers in the care sector
      • Purpose
      • Limits

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1.1. **Professional ethics** for spiritual care in the care sector ... & the professional ethical model:

- **Professional ethical model**
  
  profession → professional ethics → codes of ethics → **boundaries**

  *Power imbalance & vulnerability*

- **For spiritual caregivers**
  
  Theological framework: Vocation & Service
  
  Professional framework: Power imbalance and boundaries > individualistic ideology

  → **Points of attention:**

  → Principles of service, beneficence, non-maleficence & liberation, empowerment, justice
  
  → Interplay between power and vulnerability
  
  → Theology: body of Christ & originality of God’s love (PCUK, Guidelines for Good Practice in Pastoral Care)
  
  → Spirituality: non-individualistic (intra- and interpersonal, structural & environmental)

  (J. Mostyn, in Lebacqz & Driskill, 2000)

- **In the care sector**

  - Power and vulnerability
  
  - Boundaries

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Christian pastoral care is the activity which flows from the attitude and commitment to love one another because we ourselves, are first loved by God. 

Pastoral Carers are called to be burden bearers and burden sharers with and for others, whilst not creating dependency or denying the person their responsibilities and capabilities (Galatians 6:1–5). (PCUK, 2015)

Spiritual and religious care involves establishing relations and engaging in practices in situations where people are vulnerable and there is an imbalance of power. Pastoral relations can therefore go wrong and they have the potential to be damaging or harmful. You must therefore exercise your role with sensitivity, discernment and within ethical boundaries. (UKBHC, 2014)

The care that chaplains offer usually proceeds without any explicit agreement, it takes place wherever there is need and it is often unplanned. In a caring relationship there is also a possibility that attempting to do good may result in a degree of harm, and that in helping someone a chaplain may be fulfilling a personal need. (AHPCC, CHCC, SACH, 2005)

The posture of a spiritual caregiver towards a patient shall be characterized by respect for the patient, for his/her capabilities and incapacities and by recognition of both the responsibility of the patient and one’s own responsibility. (VGVZ, 2005)
1.1. **Professional ethics** for spiritual care in the care sector ... in codes of ethics:

<table>
<thead>
<tr>
<th>Spiritual Care</th>
<th>Chaplains</th>
<th>Counselors</th>
</tr>
</thead>
<tbody>
<tr>
<td>Professional Ethics</td>
<td></td>
<td>Theological-ethical framework</td>
</tr>
<tr>
<td>For Spiritual Caregivers</td>
<td>professional - official identity</td>
<td>Professional - official - personal identity</td>
</tr>
<tr>
<td>In Care sector</td>
<td>Diversified professional relationships</td>
<td></td>
</tr>
</tbody>
</table>

**Explanation:** development of code of ethics...
- because of professional involvement in the care sector & need to indicate the distinct professional contribution
- modeling the counseling profession & need to indicate how it is distinctively Christian

**Conclusion:**
- attention to professional and religious nature of spiritual care
- attention to professional, official and personal identity (and spirituality) of spiritual caregivers
- specific attention to the professional care context

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1.2. **Codes of ethics for spiritual caregivers in the care sector**

- **Purpose:**
  - **External and internal** (G. Lynch, 2002, p. 67):
    - reference point for professionals, patients and public:
      - Guidance to spiritual care professionals
      - Protection of spiritual care recipients
      - Protection of public standing of profession
  - **Aspiration and limitation:**
    - VGVZ (2005): “The professional code is to some extent a code of aspiration, in which important aspired ideals are formulated. To another extent the code is a code of limitation: a system of specific rules of conduct, imposed by the profession, that provide a bottom limit that may not be transgressed by members of the profession”.

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1.2. **Code of ethics** for spiritual caregivers in care sector

  - **Aspiration**
    - Good intentions $\rightarrow$ good practice?
  - **Limitation**
    - Criterion for selection of unethical actions?
      - $\rightarrow$ public & media scrutiny
      - $\rightarrow$ patient’s well-being?
- **Framework for reflective practice**
  - Aspirational principles and unethical actions
    - $\rightarrow$ Aid or block to reflective practice? (S. Pattison, 1999)
2. CODES OF ETHICS AS FRAMEWORK FOR REFLECTIVE PRACTICE: Case Study

• Overview:
  ▫ Case study
  ▫ Reflection in three groups
    • One topic per group
      ▫ Dual relationships
      ▫ Confidentiality
      ▫ Intra- and interdisciplinary collaboration
  • Questions for reflection
  • Analysis and comparison of three codes
    ▫ VGVZ (Netherlands Association of Spiritual Caregivers in Care Institutions)
    ▫ UKBHC (United Kingdom Board of Healthcare Chaplaincy)
    ▫ PCUK (Pastoral Care United Kingdom)

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Case study

The psychiatric department of a general hospital. A patient (man) is restless and portrays self-destructive behavior. He refuses to collaborate with the psychologist (woman) of the healthcare team, and instead demands to see the spiritual caregiver (man), whom is an acquaintance of his.

The spiritual caregiver is not sure whether it would be ethical to engage in a spiritual care relationship with the patient and, upon discussion with a colleague spiritual caregiver (woman), decides to propose the patient to be referred to a colleague spiritual caregiver.

The patient insists that he only wants to speak with him because he is the only one he trusts in the hospital. The spiritual caregiver says he appreciates his trust, but explains that his colleague is an equally trustworthy person. The patient nevertheless insists, and in the end the spiritual caregiver takes on the responsibility of caring for the patient.

During their encounters, the patient discloses that he wants to commit suicide, but makes the spiritual caregiver swear not to discuss it with no one of the care team, because he does not trust them. By chance, the spiritual caregiver meets the patient’s sister on the market one month later. She says how she is worried for her brother, as he has been isolating himself over the last 6 months after his girlfriend left him.

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Questions for reflection

• **GROUP 1: Dual relationship:**
  ▫ “Is the dual relationship justifiable according to the spiritual caregiver’s professional ethics?”
  ▫ “Does the dual relationship benefit the (spiritual) health and well-being of the patient?”

• **GROUP 2: Limits of confidentiality:**
  ▫ “Should he disclose the information on the planned suicide to the patient’s sister or not?”
  ▫ “Should he disclose the content of the encounters with the patient – and specifically his planned suicide – to the healthcare team?”

• **GROUP 3: Intra- and interdisciplinary collaboration:**
  ▫ “Did the spiritual caregiver disrespect his colleague in eventually not referring the patient to her?”
  ▫ “Should the spiritual caregiver function as an intermediary person in (re-)establishing trust between the patient and the team – and in particular, with the psychologist?”

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