

Candlelight Group II: brief comments about congregational rituals in dementia care for a multi faith community

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The experience of the Candlelight Group raises questions on how to adapt the activity of shared worship to multi-faith client populations, and its feasibility in terms of acceptance and administration.

Bringing in religion and rituals may cause a sense of uneasiness for participants, who may feel that their identity is threatened or undermined, or that the hospital staff are being intrusive. This may even provide material for persecutory ideation to breed in an already compromised brain! Also, individuals may find it difficult to accept that people of a different creed could share in worship, especially where in the group there is numerical predominance of one faith over another. Indeed major differences can arise if any members of the group hold particularly unyielding views about their faith and rituals.

How can an old age psychiatry service work around issues like religious assumptions that *'they and we **must** be different'*? People may have rather rigid views of each other's formal customs, ethics, practice and rituals. This is particularly likely to be the case in elderly people with cognitive dysfunction. It is conceivable that some may not accept priests or ministers from another denomination, and perhaps also feel offended by the offer of worship. Carers may themselves hold rigid ideas about religion and what their partners and parents should be engaged in. They may feel that for someone with dementia it is inappropriate - or even undignified - to take part in these groups, and therefore object to their participation.

The professional staff understanding of their patients' faith, cultural and ethical diversities may be insufficient. This would be particularly relevant for staff in a dementia unit, where one main aim of treatment is facilitating communication where the patient's loss language skills is already a major obstacle in decoding deeper meaningful needs and preferences. Staff will therefore require training in appreciating and focusing on nuances of ethical and religious diversity in individuals with cognitive impairment. For example one may be led to the assumption of *'same skin colour and same God'* by the appearance of individuals known to be from the same region of the world. This would not necessarily be right.

As an illustration of a difficult predicament involving the mistaken assumption of similar background and religion, it may be useful to quote the following real life anecdote. In 1998 Mrs M.M. (aged 78) was referred to a Community Mental Health Team because of moderate dementia for which she required further assessment and management. Mrs M.M. was born in India and was a Muslim. She lived with her son and daughter-in-law, who had full time jobs and were struggling to care for patient, who needed much assistance and supervision. Mrs M.M. could not speak English at all and as a result of this could not be sent to an English-speaking day centre. Here she would have been and felt totally isolated. The Team decided to find a place where Mrs M.M. could meet with someone able to speak her language. After a long search, a day centre was identified where another lady (aged 75) Mrs H.H. - also from India - attended. Mrs H.H. suffered from a dementing illness herself and was a Hindu.

On the very first day of attendance Mrs M.M. was introduced to Mrs H.H. Mrs M.M. realised that Mrs H.H. was a Hindu from the sound of her name and her attitude suddenly switched to disdain. She immediately rejected the other lady, and even refused

to sit next to her. The other patient perceived the rejection and soon both of them were arguing and shouting at each other, and this continued even outside the gates of the day centre. The staff patiently attempted to diffuse the situation but very little could they do for as long as the two ladies were in sight of each other, and they both spoke Urdu whilst no member of staff did! Mrs M.M. subsequently refused to attend the day centre.

In the Candlelight Group pilot study described in another paper, the nurse remained the organiser of the activity and the recipient of feedback following each session, whilst the group itself was conducted by a chaplain with much experience in pastoral care both in hospital and with people with dementia. Whilst bearing in mind that not all official pastoral advisors will agree that such a group can be helpful, their contribution may not always be available as their numbers are limited. In future members of staff may be required to act as 'spiritual group conductors' in health care settings, and this some may indeed find deeply at odds with their professional views.

Finally, providing for the spiritual and religious needs in a multi-faith patient population may arguably lead to 'dilution' of core elements of faith and rituals. If the membership of the group is of mixed religious denomination, pastoral advisors from denominations other than Christian should be called to advise on the desirable form and content of group worship from their religious perspective, and it may even be possible to encourage them to run these sessions. A compromise format would be commencing the prayer session with general – ecumenical - acts of worship and on a broad spiritual base, leading to a second part in the group where different religious denominations could be catered for, but this would not be devoid of operational difficulties.

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