

TEACHING SPIRITUAL CARE TO NURSES

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Abstract: This paper explores the reason why spiritual care is recommended for nurses by discussing two main pieces of nursing research on spiritual care. This is related to Judaeo-Christian teaching and related issues of gender and the body/mind/spirit split in western culture and the effect of this on bodily care in nursing. If there is a case for teaching spiritual care separate from bodily care the difficult questions are who should teach it and what should be taught which is separate from cultural care as already addressed.

Key words: *Nursing, spiritual, body, gender, poverty, health*

Why spiritual care in nursing?

Nurses care for people suffering with bodily illness, whether this is perceived as physical or mental: "Illness is never simply an attack on a biochemical organism [the body] but rather a subjectively profound and symbolical variation in our embodiment." (Turner, 1997:17). The complexity of human experience of illness, involving a person's cultural and/or religious background, is reflected in multi-ethnic education in nursing which focuses on modesty and dietary needs and rituals surrounding birth, dying and death (McGee, 1992; Schott & Henley, 1996; Neuberger, 1996). More recently, however, it is argued that, in addition to bodily and socio-cultural education, nurses need to be educated to meet a person's spiritual needs, whether religious or not (Ross, 1995; Narayanasamy, 1999; Burnard, 1992, UKCC, 1992).

Although various attempts are made to define spiritual, "One of the biggest obstacles for nursing research and practice is the lack of conceptual clarity of the term 'spirituality'" (Martsolf & Mickley, 1998b:294) Most writers argue for a clarification of the concept of 'spirituality' in order to teach it and include it in practice for nurses (Oldnall, 1995; Ross, 1992; Reed, 1992) but no agreement is reached beyond that it is an individual's inner core self, which attempts to find meaning, purpose and fulfilment in life (Burnard, 1988; Ross, 1992). There seems to be a tension between self as material, bodily stuff, and self as something more elusive, as mind or spirit: "It [the body] is all we have but we

seemingly cannot grasp it" (Coakley, 1997:2) This body/mind, nature/culture duality has dominated Western society since Descartes argued that the mind was above and in charge of the natural world, including the human body. "...the 'feminine' has been associated with the body, while the 'masculine' with the mind" (Shaw, 1996:58). This is described as a pathological splitting of the mind or soul from the body ...rooted in Greek and Christian androcentric dualistic ideology...everything that men have considered morally inferior or profane has been associated with 'woman' and the private world that she has been forced to inhabit. Embodiment (that is the nexus of nature, the material, emotion, feelings, sexuality, fertility, giving birth and suffering) has been symbolised as 'the flesh', the inferior world of the female which is to be transcended by the heroism of the spiritual - or rational, or existential, or scientific - male (Rosemary Radford Ruether, cited in Hampson, 1996:73)

Across cultures there is a tendency to associate woman with bodily care, which is seen as natural, and man with the mind, or spirit, and transcendence: woman below the line and man above it. This separation of spiritual from bodily needs may be related to nursing developing into a traditional profession, with more emphasis on the detached, objective, rational activities of the mind than bodily needs (Davies 1995). It may also be due to the changes in nurse education since (UKCC 1991) which places more emphasis on the academic tradition of objec-

tive rationality, rather than the practical care of people's bodies: nurses are educated to distance themselves, even from their own experience of suffering, as in essay-writing, where the self as 'I' is sacrificed to the detached, academic approach

Nursing Research and literature

Ross

In 1992 Linda Waugh (now Ross) completed a PhD in *'Nurses Perceptions of Spiritual Care'* at Queen Margaret College, Edinburgh. As a student nurse she had noticed a Bible on a patient's locker and when she offered to read it to her was amazed at how the lady sat up and took an interest when she had previously been moribund. After qualifying she did her research and in brief found that personal characteristics such as maturity, life experiences and religious affiliation made registered nurses more likely to identify spiritual aspects of patient care. Other factors were the environment such as nurses work-load, privacy and working with clergy. Clergy were seen by nurses as the main spiritual care givers. (Ross,1992) Ross argued that nurses need to have educational preparation for meeting spiritual needs and suggested the nursing process as a way of doing this. The nursing process was imported from the USA and has been in use in nursing since the 1970s. It was intended to individualise care and involve the patient as a partner rather than a passive recipient of care. Ross gives a theoretical sample of how spiritual care might be taught and practised using the nursing process of assessment, planning, intervention and evaluation. She devised a conceptual framework to help nurses meet spiritual need (Ross,1992)

Bradshaw

The second major piece of research on spiritual issues in nursing I want to consider is by Anne Bradshaw, who, after several years' nursing experience, took a career break for her family. On her return she found there had been a big change in nursing: theories or models of nursing dominated the scene with the intention of achieving holistic care. Nurses might, for example, be described as:

Shining Strangers who help patients gain harmony with body and mind and spirit and to find meaning in their existence and experiences by installation of faith-hope and allowance for an existential - phe-

nomenological- spiritual focus (Watson cited in Martsof and Mickley,1998a:300).

Of the forty or so models of nursing available only eight were devised in the UK the rest coming from the USA or Canada (McKenna,1990). Many models need a high degree of sophisticated theory to try to understand and implement and each reflects the values and beliefs of its originator. Some models do not include spirituality, some explicitly include spiritual care. For example, Nightingale (1857) saw nursing as a means of doing God's work. Nurse theorist Virginia Henderson (1966) identifies patients' needs to worship according to beliefs. Another American nurse theorist, Neuman (1982) devised a Systems model, where the patient as a person is a holistic, dynamic composite of inter relationships between physiological, socio-cultural, developmental and spiritual factors (Cawley 1997)

Bradshaw argued, however, that holistic care had always been integral to nursing. What was different now, she said, was how it was to be achieved: spiritual care was to be included in its own right, separated from bodily care. Her thesis, published as *Lighting the Lamp: the spiritual dimension of nursing care*, in 1994, is that nursing *itself* is a spiritual services based on a Judeo-Christian ethic She talks about the development of care for the sick and incurable from religious motivation and how this fell away following the European Enlightenment to become more a contract of care rather than compassionate service. On this religious model, Bradshaw argues, adding spiritual aspects is unnecessary and gives Jesus' teaching recorded in Matthew 25 as highly relevant to the spirituality of nursing:

I was hungry and you fed me, I was thirsty and you gave me drink, I was a stranger and you welcomed me, I was naked and you clothed me, I was sick and you visited me, I was in prison and you came to me. As you did it to these the least of my brethren you did it to me.

Bradshaw argues this is or was the very heart of nursing which she said embodied these values and which were caught rather than taught :

the spiritual dimension of care is inextricably tied to the ethic of nursing. The spiritual dimension is not a separate aspect of care but it is the root from which 'care' springs. Hence I would argue that the spiritual care given by the nurse is different to that given by

the religious minister. Spiritual care for the nurse is not so much talked about but lived out (Bradshaw, 1997:51)

She said she had learnt the art of compassion and care by watching the nuns in St Christopher's hospice. Interestingly, a German divinity student visiting the Royal Infirmary of Edinburgh said she learnt more about love from watching the nurses than from reading the Bible! (McGregor, 1994)

On the Judeo-Christian ethic, Bradshaw argues, nursing practice can be seen as a doing of the word rather than a discussion of the word, the fruit of the spirit rather than the letter of it perhaps. As George MacLeod, former leader of the Iona Community put it, "the physical is the only arena for the display of holiness ... God is life, not church life, but the whole life we now live in the flesh... the religious moment flowers from the practical" (MacLeod, 1990)

Practical care of the sick, then, has been the traditional role of the nurse in hospital and community but since Project 2000 came into being in 1992 nurse education is in a college/ university building, physically and ideologically separated from hospitals, emphasising the higher education of the nursing student and the health role of the nurse. With this has come a lessening of the traditions of the hospital, in this context that of chaplaincy, summed up in a chaplain's letter to me in 1997:

I remain concerned about the apparent lack of general input on religious and spiritual needs offered in the current course. Judging by my conversations with those who have qualified and come here to work and with others who are still students, there seems to be very little input on these themes and little or no awareness of health care chaplaincy provision

Ross and Bradshaw's research then seems to identify a lack of something which could be called 'soul' or 'spirit' or even 'heart' but each argues different ways of including spiritual care in nursing: Ross for specific teaching about meeting spiritual need in addition to bodily care; Bradshaw that it is not necessary to separate it from nursing care as it is integral to nursing practice.

Professional Guidelines

The professional guidelines also specify spiritual aspects of care as distinct from the usual mental physical and social aspects:

Clause 6 of The UKCC Code of Conduct (1991) says we should: "Take account of the customs, values and spiritual beliefs of patients/clients

The Patient's Charter (1991) makes it clear that staff should "acknowledge their (patients') spiritual needs and aspirations" (p.5)

The Scottish Office NHS Management Executive (1994) makes it clear that "people can expect NHS staff to acknowledge their spiritual needs" (p.1)

Other documents include spirituality as part of health eg:

The World Health Organisation (WHO, 1998): "Health is a *dynamic* state of complete physical, mental, *spiritual* and social well-being and not merely the absence of disease"

The International Society of Nurses in Cancer Care (ISNCC) suggest that educational programmes should have a core module on spiritual care.

Theory into practice?

I shall now discuss my own experience of trying to implement some of the research and professional guidelines. From 1992 to 1997 I developed a theory elective in Cultural and Religious aspects of nursing. The twenty or thirty students electing to take the course visited various cultural centres and places of worship: such as the mosque, the chapel in RIE and the Tibetan centre at Eskdalemuir or had visitors from different faith communities. Many people actually found it hard to identify and speak about spiritual issues separate from their cultural / religious practices such as diet, hygiene, prayers and so forth. These learning opportunities were highly evaluated by all participants.! Students also enjoyed themselves.

Changes and chances

Since 1997 curriculum changes saw the demise of Theory Electives but spiritual aspects of care have been included in the module on Pain and Loss when there are 4 hours' teaching. Like all change there are some good and some bad aspects to the new way of teaching it. Including spiritual issues as part of a regular module with all students taking it rather than

an Elective course for those with a special interest gives it 'respectability'.

On the other hand there are now a minimum of 186 students twice a year instead of a maximum of thirty so visits are impracticable: Should you try and explore spirituality in a large impersonal lecture theatre? Despite these difficulties the students seem to evaluate the sessions positively and even enjoy the assessment essay of 2000 words which is a literature review of spiritual aspects

As with the Elective, students on the whole prefer meeting people and hearing about faiths other than Christianity. However when we included a Chaplain in a session on assessing spiritual need rather than as a representative of Christianity the feedback was excellent! "The best lecturer yet" many students said!

Approximately four hours is given Spiritual/religious aspects in philosophical approaches to health care in some modules in BScNursing/ Health Care where it is more consciousness-raising, plus an overview handouts and reading. Aspects of it are included in the assessment. Most of the students on BSc. courses are experienced nurses trained under the pre-1992 scheme who find it relatively hard to adjust to theories of ethics and spiritual aspects of care. Most have excellent experiences to share about religion and chaplains! eg 'he's great...very helpful' to 'he never talks to the patients, only to us...' A different kind of teacher- challenge!

I am trying to raise with the chair of the Curriculum Committee the importance of having a planned course throughout the whole programme but despite the growing amount of literature and research it is difficult to overcome the emphasis of the medical model in teaching programmes. A rare exception to the more piecemeal approach to spiritual care in nursing is the Honours option in spiritual care in the Department of Nursing Studies in Edinburgh University (Tilley,2000)

Teachers?

Another difficulty, is who teaches and marks written assessments. Should any individual with a personal interest be able to teach this subject or should teachers be properly educated to do so? In my experience most teachers who volunteer to teach spiritual care

do not have educational qualification in any area of religious studies. What does this teach the students and staff? If you need a degree in biological sciences to teach life sciences teachers of cultural/ religious/ spiritual aspects of care should similarly have at least a relevant first degree. Would we expect to be taught engineering by people who love walking across bridges but who are not qualified engineers?

What should be the content and who decides?

Nurses should be informed about appropriate resources for nursing individuals be they Pagan or Protestant. Should they have to take on something as apparently esoteric as spiritual care as well? It seems to me that the challenge about spiritual care is both social and professional. The social challenge is partly due to the secularisation of society: people may not have a formally expressed faith connection which can help them in their time of trouble but does this circumstance make it more or less important that nurses should include spiritual issues in their professional care?

In addition to the concerns already discussed above it is well-known that nurses are under increasing pressures of work from high patient turn-over, staff shortages, increasing technology and bureaucratic paper-work

Concerns some nurses identify as spiritual can be met by improving the standard of nursing care eg better support, care and communication. Nurses who do not communicate adequately with patients who are suicidal or depressed are being unprofessional and adding spiritual assessment will not necessarily do anything to change them. Talseth et al, (1999) for example describe nursing behaviours which patients describe as comforting or lacking in comfort which are basically good nursing but with no mention of spiritual care. Similarly, many of the situations described by nurses theorists and writers as indicators of spiritual need seem to be social, political or religious in origin, eg loneliness, poverty-related: the effects of too much consumption or too little seem to be inter-related in health terms. (King, 1990)

When nurses are themselves dispirited the solution may be to take effective professional action eg about work-loads, family-friendly shift patterns and work-

ing conditions as well as the content of nursing education programmes.

A peoples' spirituality?

Since the Black report in 1980 on the widening gap between rich and poor, and the repeated evidence of the damage poverty has on the health of individuals and communities, I think our 'spiritual' responsibility lies in working to overcome social injustices which cause people to be ill physically, mentally, socially and perhaps spiritually. As Sorley MacLean puts it:

*My eye is not on Calvary
nor on Bethlehem the Blessed
but on a foul-smelling backland in Glasgow
where life rots as it grows;
and on a room in Edinburgh,
a room of poverty and pain,
where the diseased infant
writhes and wallows till death*

When the recent Joseph Rowntree Foundation reports that one in three children live in poverty compared with one in ten thirty years ago; when one in five from a workless household get good GCSEs compared to four in five in professional; when a third of Central Clydeside and Strathclyde's households are workless with the increased risk of sickness related to poverty such as heart disease and cancer; when 362,000 Scottish children and 119,000 Scottish pensioners live in damp housing ; when homelessness in Scotland has more than doubled in the last two decades - all with devastating effects on health and personal fulfilment - I marvel how we can spend so much time trying to define spirituality and teach it in *health care*. As Archbishop Desmond Tutu said ' I am puzzled about which Bible people are reading when they suggest politics and religion don't mix' (Christian Aid Poster).

The Hebrew prophets, on whom Jesus presumably based his spirituality, have good teaching on this I think:

*rather is this not the fast that I require;
rather to lose the fetters of injustice
...Is it not sharing your bread with the hungry
taking the homeless home to your house,
clothing the naked when you meet them.
and never evading your duty to your kinsfolk?
... Then will your light break forth like the dawn..
you will be like a well-watered garden*

*like a spring whose waters never fail
(Isaiah,58:2-3,5-8)*

And Amos,
*if you would make your way to me not to Bethel..
establish justice ..and righteousness like an ever-
flowing torrent.
(Amos,5:3-4, 4-11, 14-15,24)*

This 'Righteousness', or *tzedekah* in the Hebrew, was salvation for the whole community rather than the pious sense of individual 'souls' being saved. Salvation came from doing God's law which is the great Shema in Deut 6 - loving God and your neighbour as yourself, and involves caring for the poor and sick, service for others. This *tzedekah* salvation leads to *shalom*, peace and healing. If we want our patients and staff to have peace (as so many writers argue in their spiritual needs model) then I think we have a responsibility to address the pressing inequalities in our society and world which militate against peace. This seems to me to be at the heart of the Judeo-Christian ethic on which Western nursing is based. I would agree with Anne Bradshaw that there is no need to have an add -a- line of spiritual care infusion if nurses are caring for patients with care, compassion and competence. As George MacLeod, the former leader of the Iona Community puts it, "The kingdom of God" (presumably the ultimate spiritual experience?) "is not announced with handshakes or speeches that move the heart...it will be known in thorough healing work: painstaking attention to human bodies" (MacLeod,1990).

Conclusion

Nursing education has traditionally taught nurses to care for individuals based on a service ethic derived from Judaeo-Christian teaching. On this model there is no need for an added dimension of care known as 'spiritual' but many writers argue that nurses need to be educated to undertake spiritual care independent of bodily/mental care. If this is necessary then an academically acceptable curriculum needs to be devised, taught and assessed to the same standard as other subjects. But the effects of poverty on health and the growth of feminism are important factors, both of which, I argue, are integral to Judaeo-Christian teaching and can indeed be said to be 'spiritual'. Perhaps our salvation lies in feminist theology in its attempts to reclaim the mate-

rial body “ as the primary focus for the divine”(Stuart,1996:24).

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