

PREPARATION FOR PROVIDING SPIRITUAL CARE

Ewan Kelly

Abstract: Spiritual care has become recognised as part of the holistic care offered collaboratively by health care professionals (HCPs), family and friends in hospitals and in the community to patients and their significant others. This article seeks to explore, from the perspective of a hospital chaplain working in an acute hospital setting, several issues which need to be considered by HCPs prior to offering spiritual care to others. These include HCPs having a degree of insight into their own personal story as well as questions about what they understand the nature of spirituality, spiritual need and the assessment of spiritual need to be. This article is based on the premise that in offering spiritual care to others we have to develop an ongoing awareness of who we are and what our needs are, as well as the needs of the other.

Key words : awareness, moment, story, spirituality, spiritual need, assessment

The Spiritual Carer's Story

Those who offer spiritual care, be they a chaplain, nurse, physiotherapist or doctor, potentially will enter into relationships where highly personal information and feelings may be shared. There is potential for much good and much harm to come to both patient and carer. In order that during an encounter with a patient we as carers can separate out what are our own feelings or issues from those of the other, we have to be very aware of our own personal story. Issues arising for the carer, if noted and owned, can be shelved during the encounter and dealt with at another time. Unless we are aware that our own feelings and worldview may be touched or challenged by involvement in spiritual care then an encounter may well end up being more about our issues than the patients.

What are the significant elements - experiences, prejudices, wounds, losses, bereavements, skills obtained through training and individual needs – in the carer's story? What are the wider narratives which have touched us and have helped to shape our beliefs, values and worldview – our family, circle of friends and our religious and cultural background? What is it the healthcare professional (HCP) brings to an encounter at any particular moment? How aware are we of our own spirituality? What gives our lives meaning and purpose? What is our theological stance and /or philosophical outlook on life, death, suffering, the existence of God and the possi-

bility of life after death? What are buttons in our lives, at the present time, that when pressed may lead to distress and an inability to function as a carer?

How as a HCP am I feeling right at the moment of being with a patient or family? Up all night with a young child at home and desperately needing sleep tonight, had a bad day with administrative work and now developed a throbbing headache – is it appropriate that this chaplain goes to be with a family on the neonatal unit whose baby is critically ill? Can someone else go?

Spiritual care in the acute hospital setting is about responding to needs in the present moment - the patient's needs and us as carers, acknowledging our needs too. It is often also about disengaging from one moment with one patient, letting go of that moment and then preparing ourselves for the next moment with the next patient. Importantly, it is also about us as HCPs revisiting particular moments later, at a suitable time, to reflect by ourselves, with colleagues, a supervisor to unpack what that moment was about for the patient, for me as a human being (not just as a HCP) and how I felt we related to each other.

What is Spirituality?

The word spirit has its roots in the Latin word 'spiritus' and is associated with a force that gives animation or breathe to life. Heyse-Moore (1996, p300) considers the spirit to be the 'essence of life'. As well as something very deep within the human makeup, traditionally the word spiritual has also been associated with the transcendent, the sacred or the 'otherness' in life – different faith groups and cultures having varied perspectives and understandings of its complex nature. However in more recent times it has come to have a much broader meaning – life experience out with that which is considered religious is now thought to have the possibility of being spiritual. Grasping the meaning and concept of things spiritual in our modern pluralistic world is not easy and Bellamy (1998, p185) makes an important point when she says –

'The term spiritual, however, needs to remain elusive if it is not to betray its very identity; inherent to it is the concept of searching rather than finding.'

To be spiritual is to be human i.e. every human being has a spiritual dimension to his or her life (though individuals may not name it as such). In this post-modern world the majority of people are not affiliated to any particular religious tradition or faith group Equating things spiritual with things religious is to narrow and constrain the former.

The spiritual element in our lives is something, which can be described, in relational terms –
'...a capacity for self-transcendence that is expressed by expanding personal boundaries intrapersonally, interpersonally and transpersonally – inward, outward and upward. Transcendence can be found within or beyond self, depending upon one's religious or philosophical beliefs.' Reed (1998, p43)

Throughout our lives there is an ongoing deep-seated desire to understand ourselves, the world and those around us more fully, as well as what may be beyond the physical makeup of our environment. This driving force may become more immediate at certain times in our lives.

For example, in an acute hospital setting, many individuals become concerned with deep questions about their lives, suffering, death and the possibility of the existence of a greater being.

'Crisis situations, whether they be loss, illness or hospitalisation, bring one face to face with the ultimate issues of life – the limitations of one's humanness, the loss of personal and environmental control, and the meaning of pain and suffering in the overall purpose of life. The questions of why and when events occur raise the issue of a God who does or does not exist and is or is not involved with one's life.'

Stoll (1979, p1575)

However our spirituality is not just something, which comes into play as we seek to find meaning and purpose at significant or special times in our lives – good or bad.

'...if one reflects upon daily living it is often the mundane rituals such as going to work, doing the washing or walking the dog that bring meaning and purpose to everyday life.' McSherry (2000, p28).

Each of us weaves for ourselves a tapestry in life - made up of many different threads. These threads are the different aspects of our lives, which give meaning, shape and purpose to our existence - everything from enjoying a bath to watching rugby, special relationships we have, our beliefs and values to our membership of the church or a miner's welfare club. Each thread has its place and may seem insignificant or taken for granted in daily life but on admission to an acute hospital and being faced with issues which Stoll describes above may create a tear – large or small - in the person's tapestry, and the patient or relative has to begin to deal with threads that have been severed and may never be able to be repaired again.

A desire to make sense of life and significant events in life is a universal, shared experience and yet our own spirituality, whatever we understand it to be and its role in our lives, is a highly subjective thing. Simon Bailey (1996, p61), an Anglican priest, put it this way -

'What is spirituality? It is something to do with attempting to explore...taking the risk, setting out. Something to do with the capacity in us to make that beginning – the need the desire, the unrefusable urge....In the words of RS Thomas:

Enough we have been given wings

*and a needle in the mind
to respond to his bleak north.*

*There are times even at the Pole
When he, too, pauses in his withdrawal
So that it is light there all night long."*

This need, this desire, this "needle in the mind" is right at the very heart of us, deep at my mysterious centre and yet it's a very common, shared thing too.'

It is a risk to consider wrestling with spiritual issues, to be open to the "needle in the mind" and yet in acute hospitals many patients, relatives and staff are forced to do so by circumstance and their involvement with people they are caring for.

Woodward (1997), in his definition of the spiritual underlines the importance of this element in our human makeup. It is -

'..the essentially human, personal and interpersonal dimension which integrates and transcends the cultural, religious, psychological, social and emotional aspects of the person.'

The spiritual dimension in all of us holds together and is greater than all the other components of our makeup, including our sexuality (which Woodward omits). It is that element in us and beyond us that makes each one of us truly unique and gives us, at times, the ability to see beyond what is happening in the present moment.

What are Spiritual Needs?

Several chaplains – Speck (1988), Stoter (1995), Woodward (1997) and Cobb (1998), as well as writers from the nursing profession including – Stoll (1979), Highfield and Cason (1983), Bunard (1987), Narayanasamy (1991), Ross (1997) and McSherry (2000) have described various aspects of spiritual need and distress.

Most succinctly Bunard (1987, p377) describes spiritual distress as ...

'..the result of total inability to invest life with meaning. It can be demotivating, painful and cause anguish to the sufferer.'

Narayanasamy (1991, p7-8) on the other hand gives a more comprehensive list of spiritual needs -

*the need for meaning and purpose
the need for love and harmonious relationships
the need for forgiveness
the need for a source of hope and strength
the need for trust
the need for expression of personal beliefs and values
the need for spiritual practices, expressions of concept of God or Deity
the need for creativity*

Central to all descriptions of spiritual need is a search to find meaning, reason and purpose in the individual's current circumstances. In the immediacy of acute hospitals – in the accident and emergency department, in intensive care, labour ward or in any acute ward, circumstances can change in a moment. As a working definition for use when considering the spiritual needs of a patient or their significant others I would propose the following –

Spiritual need is that aspect of an individual's personhood which seeks to make sense of and find meaning in, the present moment. Any such exploration is done in light of an individual's previous life experience and aspirations for the future and involves, potentially, consideration of any significant element of their unique life story.

Thus spiritual need is something dynamic – it can change from moment to moment as external circumstances and internal perceptions, thoughts and feelings, change – and is ongoing, especially during or after a crisis. As well as being multi-faceted, involving an individual reflecting on potentially any part of their own story, spiritual need is also multi-layered – the depth of the patient's need and their ability or motivation to explore such need can change very quickly in an acute hospital context. At what level individuals want to explore any spiritual need, at any moment in time, will depend on various factors –

- how they interpret their present circumstances
- the privacy of their surroundings
- how they relate to the HCP present with them at that moment i.e. how they interpret the HCP's story as revealed by their profession, their appearance, their manner, their spirituality etc.
- their physical and psychological state

- their personality and ability to articulate thoughts and feelings

Therefore in responding to these needs HCPs need to be sensitive to the cues that they are given by the individual, at that moment, in order to let that person begin their exploration at a depth they feel safe and comfortable with. The level of the patient's self disclosure may alter during the encounter or at a later time. For example, prior to visiting time a patient may mention to a HCP that they are getting a visit from a member of their family and talk about where the person lives and what they do for a living. However following the visit the same individual may want to explore some very personal issues relating to family relationships, prompted by the time spent with their visitor.

Spiritual need involves questioning and searching. Hence often it is difficult for a person to articulate precisely their spiritual needs to another in the present moment of a traumatic event. Their values and beliefs may be called into question or may provide a source of comfort and strength. In a moment of particular spiritual need an individual may well be reflecting on the past or contemplating the future in light of what is happening to them or their loved one in the present.

Assessment of Spiritual Need

Traditionally a patient's spiritual, or rather religious, needs were assessed on admission to hospital – the patient was asked their religious affiliation, if they wished their minister, priest or religious leader to be notified and if they wished the hospital chaplain to visit them – and by doing so assumed to be responded to adequately.

However as has been discussed, an individual's spiritual needs can change very quickly in an acute hospital environment, for example as a patient gains more information about their condition or the bad news they have been given begins to sink in. Therefore assessment of those needs has to be ongoing. For patients, articulating spiritual needs and asking for support can be difficult as this may mean discussing very intimate issues in an often far from private environment. Also, patients may be wrestling for the first time, in stressful circumstances, with issues which are hard, for anyone, to articulate.

Therefore Cobb's point (1998, p110) that spiritual needs are most effectively assessed in '*a relationship of trust, respect and usually out of their (the client's) life story,*' is paramount.

Some hospitals and hospices have devised tools to aid assessment of spiritual needs. Whilst this ensures that this aspect of care is not forgotten and may aid some patients to verbalise their needs, there is a danger that a 'tick the box and move on' approach to spiritual needs and care develops. In an already dehumanising environment it is important that assessment of an individual's spiritual needs is done sensitively and at a pace which enables the individual concerned to feel safe enough to share with the HCP involved at least part of their life story.

Assessment may or may not involve the use of an assessment tool but will certainly require good observational and communication skills as the cues given by patients regarding their spiritual needs are both verbal and nonverbal.

As with photography, where the quality, depth and feeling of a photograph depends on the skill and experience of a photographer as well as the quality of the camera, so assessing spiritual need depends on the professional and personal attributes of the HCP as well as the assessment tool used. Assessing an individual's spiritual needs at one moment may give great insight into their needs at that time but it is only a snapshot relevant at that moment and set of circumstances. When assessing spiritual needs we as HCPs need to be aware of the colour of lens we are looking through as we take the snapshot, as we assess the patient's spiritual needs. Spiritual assessment, as with spiritual care, begins with self-awareness. Our own story – our own worldview, beliefs, values and life experience influence greatly the way we view the world and other people and thus any assessment of the spiritual needs of others.

Spiritual needs may be recognised by HCPs but not always by patients and their families themselves. Sensitive exploration of issues elicited may enable help to be offered and 'hidden' needs to be met. However some people may refuse such support and HCPs have to respect the privacy and individuality of all we seek to care for. As Ross (1997, p38) puts it –

'We should not assume, therefore, that all patients will have spiritual needs which require constant attention. Some may choose to deal with them in their own way and in their own time. We should respect a patient's right to refuse spiritual care.'

Conclusion

Spiritual care does not begin with the patient nor does it begin with assessment of his or her spiritual needs. It begins with the HCP who seeks to offer such care.

At the heart of spiritual care is the personhood and the spirituality of the care-giver. It is essential that we as caregivers have begun to look at our own individual stories (where we have come from, where we are now and where we would like to be heading) and our own mortality, as well as realising we don't have all the answers about ourselves (and never will). Being aware of personal and professional limitations is important, as is the ability to seek help for ourselves and to refer patients and their loved ones to other HCPs when appropriate. Developing our active listening or counselling skills by attending appropriate training courses would also be of benefit and aid our self-awareness.

Offering spiritual care also involves taking risks. There is a need for an awareness of our own story, including any greater narratives that may shape our story, and the story of the context in which we are working. However more than that, there is also a need for openness to the possibility that during any encounter our story may be challenged, and indeed significantly changed, by what takes place. This may not just affect how we approach our work as HCPs and how we relate to our hospital context, but it may also profoundly alter our interpretation of our own personal story, as well as our interpretation of the wider narratives that inform it.

In responding to the ever changing spiritual needs of others in the present moment there is the challenge for us as spiritual care-givers to attend to our own dynamic spiritual journey and spiritual needs which also, as we are as much human as those we care for,

change through our experience and sharing of life with others.

References

- BAILEY S. 1996 *The Well Within: Parables for living and dying* DLT, London
- BELLAMY J. 1998 *Spiritual Values in a Secular Age* In COBB M., ROBSHAW V.(eds) *The Spiritual Challenge of Healthcare* Churchill Livingstone, Edinburgh
- BUNARD P. 1987 *Spiritual Distress and the nursing response*, *Journal of Advanced Nursing* 12, p377-82.
- COBB M. 1998 *Assessing Spiritual need: an examination of practice* In COBB, M. ROBSHAW, V. (eds) *The Spiritual Challenge of Healthcare* Churchill Livingstone, Edinburgh.
- HEYSE-MOORE L. H. 1996 *On Spiritual Pain in the dying* *Mortality* Vol. 1 No. 3, p297-315.
- HIGHFIELD M., CASON C. 1983 *Spiritual Needs of Patients: are they recognised?* *Cancer Nursing* 6(3): p187-92.
- MCSHERRY W. 2000 *Making Sense of Spirituality in Nursing Practice* Churchill Livingstone, Edinburgh
- NARAYASAMMY B. 1991 *Spiritual Care; a resource guide* Quay, Lancaster
- REED P. 1998 *The re-enchantment of health care: a paradigm of spirituality*. In COBB M. ROBSHAW V. (eds) *The Spiritual Challenge of Healthcare* Churchill Livingstone, Edinburgh
- ROSS L. 1997 *The nurse's role in assessing and responding to patients' spiritual needs* *International Journal of Palliative Care* Vol. 3, No. 1. p37-42.
- SPECK P. 1988 *Being There* SPCK, London
- STOLL R. 1979 *Guidelines for Spiritual Assessment* *American Journal of Nursing* Sept., p1574 – 1577.
- STOTER D. 1995 *Spiritual Aspects of Healthcare* Mosby, London
- WOODWARD J. 1997 *Some Straw for the Bricks? – Developing Standards for Spiritual, Religious and Cultural Care*, Middleton, Warwickshire (unpublished)

Ewan Kelly is chaplain at the Edinburgh royal Infirmary, Edinburgh.