SPIRITUAL CARE IN HEALTH CARE

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Abstract: Effective spiritual care must truly interact with its recipients in order to discern need and to engage in a mutual process of exploration. Spiritual carers should be a resource in the individual's search for meaning and purpose, and a support through the sometimes painful re-examination of beliefs in the face of some life crisis. To be effective the carer must have personally engaged with the existential issues which arise. Support for spiritual caregivers is essential in order to increase self knowledge, address sources of anxiety, and work through the difficult feelings which engagement with another person at this level will arouse.

Keywords : chaplaincy; spiritual care; support; narrative theory; spirituality.

Introduction

It is difficult to envisage an effective chaplaincy, or spiritual care, service that does not strive to be truly interactive with the recipients of that care. To provide spiritual care that is relevant, meaningful and supportive to the patient necessitates a process of discernment of what the person's needs might be, exploration of the options appropriate to meeting those needs and then engaging together in the relevant ritual or activity.

The sensitive nature of this interaction becomes even more important when one considers the wide variety of ways in which people will try to make sense of critical events in their lives. Within the context of any life crisis people will usually revert to previous patterns of understanding. They will also have developed some strategies for helping them come through a crisis. If these are of use in the current event, then all well and good. However, if they do not provide what the person needs then they may well seek new or alternative approaches. Within the person's inner life a similar re-examination may be taking place in terms of trying to understand why this event should have happened, does it have any purpose for them and their family and what resources can they draw upon for support and guidance. The impact of the disease and the treatment offered may also add to this experience so that it can feel as if the person's very identity is being threatened or changed. The inner dialogue that can take place within many patients is a very private and personal affair but the concept of narrative can be useful in understanding this process.

Constructing meaning through narrative

Narrative theory focuses on the valuations that a person identifies as being the key units of meaning in his or her life and which provide ways for people to make sense of themselves through stories. These stories often run in the individual's own mind as they identify what is important in the process of thinking about his or her life situation. Hermans (1992) expounds a theoretical understanding of this process when he describes the '*dialogical self*' that is multiple and embedded in dialogue. We tend to take for granted that the self is singular and that, to some extent, I create *my* life story. While my life story may have many characters it is a single I who creates them. According to Hermans instead of an individual, rational self, the person is endowed with multiple storytelling selves, each in dialogue with the others (Hermans, Kempen, & vanLoon.1992).

Within the context of a new life experience the individual will review that experience from the perspective of their various storytelling selves as they seek to make sense of what is happening to them and to incorporate this new experience into their on-going life story. The different areas of importance for the person, within this life event, will be re-evaluated

and have great significance for their ability to retain a sense of identity in the presence of an illness which has the potential to threaten their very (eternal) existence.

If pastoral or spiritual care is to be of benefit and support it must engage at some point with that ongoing inner dialogue. For this connectivity to happen there has to be established a relationship of trust that allows for sharing and exploration. There can be many inhibitions about sharing this inner dialogue and it may take time before people feel safe enough to do so. However, not knowing and understanding where the person is in relation to the effect the illness and treatment is having upon them can lead to assumptions being made and care being offered in an inappropriate way. For a chaplain / minister of religion to rush to the bedside of a dying patient and administer a religious ritual without foreknowledge of the patient or the benefit of exploring what may be relevant can often alarm more than comfort all who are present. The search for existential meaning is frequently within and our role may be as safe companions and resources for the patient, irrespective of our professional or family role.

Chaplaincy and the search for Meaning

In our present time it is frequently claimed that religion is declining and people do not need or wish for religious ministry. In the USA there has been much valuable research to demonstrate the importance of religion in health care outcomes (e.g. Koenig 1994, 1997. Pargament 1997, 2000) However, the different cultural norms within the UK mean that the findings from these studies do not translate easily into our health care setting and culture. Current research in the UK is beginning to show that, while some people may not be overtly religious and attend places of worship, nevertheless they still participate in an existential and spiritual search for meaning and purpose in their lives (Coleman, Mills, McKiernan, Speck 2002). The role of health care chaplaincy has changed a great deal from being the sole providers of traditional religious ritual to one of being a resource to people undertaking this much wider search for meaning within the illness or dying process. In 1993 The Dept. of Health and the main chaplaincy bodies produced an ‘Occupational Standard’ for chaplaincy which defined the ‘key purpose’ as being to:

Enable individuals and groups in a health care setting to respond to spiritual and emotional need, and to the experiences of life and death, illness and injury, in the context of a faith or belief system. (NHSTD 1993)

The individuals and groups referred to in this aim could be patients, families or health care staff. Historically, pastoral care has always been concerned with listening attentively to the other person and enabling them to grow and develop in their relationship with God, self and others. But there has also been at times a less comfortable prophetic voice in which chaplains and others have reflected back to the organisation or society some of the issues people have shared with them in pastoral encounters. In this way those not empowered to speak for themselves, may have their needs voiced in a different way. Because chaplains are in, but not totally of, the organisation they *can* offer an overview that can challenge any de-personalising tendencies at various levels of interaction between those cared for, the carers and the organisation (Speck 1994). In 2002 many chaplaincy departments, or spiritual care providers, would additionally see their primary aim in fairly broad terms embracing the religious *and/or* wider spiritual, existential, needs of patients, families and staff. The differentiation of spiritual from religious has been well described even though the exact nature of the non-religiously spiritual still requires further clarification (Speck 1998, 1998b). This does not mean that chaplaincy is in the process of abandoning its original religious role in order to ‘capture’ the wider spiritual territory. Rather what is happening is a much clearer recognition of the fact that healthy religious behaviour and practice is the outward expression of an underlying spiritual development. Recent UK research papers, in End of Life care, have indicated the relevance of faith / belief when determining the psycho-social needs of cancer patients (McIllmurray et al 2003), the capacity to cope with breast cancer (Feher and Maly 1999), the ability of spirituality to reduce death distress in dying patients (Chibnall et al 2002) and the importance of the spiritual needs of people dying of lung cancer and heart failure (Murray et al 2004).

Life crises and the examining of beliefs

Research is also beginning to show that many who are spiritual do not always choose to express that

spirituality in a religious way and may retain a broadly spiritual stance or a philosophical approach (King, Speck, Thomas 1999, 2001). Whatever the underlying belief may be it leads, at critical moments in their lives, to a re-examining of the content of that belief to see whether or not it can answer the existential questions arising for the patient and family. This can lead to a feeling of vulnerability while the belief is re-structured, re-affirmed, or dispensed with as inadequate. Preliminary studies indicate that offering support to people at such times may enhance the chances of a good outcome in terms of well-being and maintenance of identity (Clarke 2001 unpublished BSc thesis). To engage with this agenda requires the utilisation of inter-personal or counselling skills to foster the safe relationship which enables mutual exploration of very personal material.

Within chaplaincy there is much experiential evidence that people find it difficult to articulate the inner struggle that they may be experiencing. This is especially so if they have previously had a religious belief but no longer follow or practice that faith. If they are presented with a religious person with whom to explore these issues then what that person represents may create barriers to effective communication and sharing. Within health care chaplaincy this has been recognised and addressed within much of the literature and training on offer, and in the recruitment and use of lay (non-ordained) volunteers within a spiritual care team. Far fewer chaplains would now operate in a purely religious mode but would focus on establishing a rapport with a person who is seeking to come to terms with whatever is happening to them. An important part of the introduction of a chaplain to a patient either by staff or by the chaplain him/herself is explaining that chaplaincy is there for all, whether religious or not. It is also important to reassure people that chaplaincy is not about off-loading religion onto a captive audience, nor going for the religious 'hard sell'. Respect for the person is paramount and, in the case of some illnesses where communication can be difficult, flexibility in finding ways to affirm the humanity of the other may be paramount. (Stoter 1995, Wright 2002, Orchard 2001)

There can be different perceptions as to what it is or is not appropriate to explore with what is deemed to be a 'vulnerable' group of people. The extent to which people are willing to share personal material is often related to an understanding of possible benefits and a sense that the person is genuinely interested in hearing your 'story'. In the Schultz cartoon series "Peanuts" one of the characters, Lucy, says "When I grow up I want to be a famous psychiatrist". Charlie Brown asks "Is that because you are really interested in people?" "No", says Lucy "I'm just nosey!" Genuine care is, of course, not about being nosey. It is about helping the other to explore events, past and present, for a demonstrable reason that they can agree with.

Wrestling with the issues

Spiritual care, therefore will depend on the patient and caregiver being willing to enter together into the experience and explore without quite knowing where it will lead. The uncertainty which this embraces can be challenging for both, but especially so for the pastoral caregiver if he or she has not explored ultimate or existential issues in their own life story. One of the reasons why health care staff find this a difficult area to engage with is that it can quickly confront them with all the unresolved areas in their own lives. Working with dying people, for example, already has that power and leads to the development of a variety of defences to protect against the long term exposure to death (Speck 1994). To explore issues concerning ultimate meaning and purpose in another person's life is not a philosophical exercise but a potential encounter with another person at a very deep and personal level.

The health care chaplain is not the only person who can undertake this role with a patient or family (Walter 1997, 2002 and *Scottish Journal of Healthcare Chaplaincy* vol 6, 2003). There is a sense in which spiritual care (as distinct from religious care) can be everybody's concern. However, by its very nature, chaplaincy should be a vital resource to patients, families and staff and should contain people who have at least wrestled with the issues – even if they have not obtained all the answers. Chaplaincy, therefore, becomes a key resource for such spiritual / existential explorations by patients and staff, but the actual listening, reflecting and exploration can be undertaken by anyone with the time and commitment to follow where the patient leads. However, the ability and willingness does depend to a degree on the extent to which one has for oneself faced some of these issues. At a time when there is much being written about spiritual care, it is interesting to see that many health care staff still see this as a very

intrusive area to explore. Some of the problems are linguistic, when trying to be clear what we mean by some of the terms and concepts, but often it is the degree of personal challenge that such conversations have for the caregiver themselves.

Caring for the Carers

Ordination or appointment to a religious ministry does not automatically mean that the individual has 'it all worked out'. In fact there are many clergy who find visiting sick or dying people in hospital or at home almost impossible. Being in the presence of the sick and dying can present them with such a graphic reminder of mortality that they are unable to cope with it. Training can help, but often it is more a matter of helping the individual engage with the anxieties and fears being aroused within themselves. In a similar way those providing spiritual care need to have access to appropriate support. Support might be in the form of someone to whom they can take the difficult questions, or feelings, raised by the patient. This can either be in terms of how to respond and support the patient at the next meeting, or how to work through the feelings created within the caregiver following the encounter. The development of truly multi-professional working, and attendance to both our own personal agenda and the unconscious processes which are attendant upon any human interaction, might enable us to move forward towards a greater readiness to hear and respond to these wider needs of patients who enter a health care setting.

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