Report of meeting on 8th November 2001 at the Royal College of Psychiatrists

'THE HEALING POWER OF LOVE'

Research Findings on Patients' and Nurses' Perceptions and Views on Spiritual Care in Mental Health Practice

and

Overcoming Barriers to the Provision of Spiritual Care: the place of compassion in clinical practice.

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Reported by Dr. Gillian Broster

Mary Nathan trained in general nursing, midwifery and in mental health. She has nursed in Nigeria and served as a General Nursing Council examiner. Currently she holds the post of Research and Practice Development Nurse in the Ealing, Hammersmith and Fulham Mental Health Trust. The study described here forms part of what is to be a larger multi-centred study. Mary has a deep concern with spiritual care in mental health practice.

Mary began by explaining that the study had two objectives. The first was to explore patients' and nurses' perceptions and views on spiritual care. The second was to elicit whether or not mental health nurses feel sufficiently competent to assess and provide spiritual care to their clients. This was a descriptive study, which took place on an acute mental health unit. Eighty-eight qualified mental health nurses participated, coming from a range of ethnic origins, including Afro-Caribbean, Black African, Caucasian, Asian and others. Their religious backgrounds were diverse.

The nurses were asked a wide range of questions. They were also asked if they had any training or qualification in spiritual care.

Data Analysis was by SPSS, the Statistical Package for Social Sciences. Findings from the nurses' questionnaires showed that:

- There was a lack of clarity with the concept of spirituality.
- Spiritual care was strictly defined as meeting the patients' religious needs.
- Spirituality is not clearly featured in the curriculum or taught during, or after, training.
- There was no clear view as to who should be held responsible for this area of care.
- Additional comments were made that training should be provided and that there should be a working definition and guidelines for practice.

Nurses were asked to give their own definitions of what was meant by spiritual care. The following are some examples of answers given:

- Attending to patients' religious needs.
- Form of care directed exclusively towards the soul and its function as a link between the mind and body.
- The care that promotes a sense of belonging and offers alternative coping skills.

- The care that provides peace, hope and faith in God.
- Helping patients to identify their own spiritual needs.
- The care that is concerned with the esteem needs of the individual.
- Provision of meaning and hope to lean on, to help with moving on.
- Allowing patients to talk about death and dying.
- Looking after the thing that keeps a person going.
- The provision of that which, in addition to the necessities of life, provides a framework for the person's life.

The majority of nurses thought that spiritual care was to do with religion in some way.

In the patient sample, which numbered thirteen, 54% were male and 46% female. They came from a range of religious backgrounds. Diagnoses included paranoid schizophrenia, bi-polar disorder, alcohol dependence and schizoaffective disorder. Some had attempted suicide. The duration of illness was from 1 year to 25 years and the age range was from 20 – 55 years.

Examples of questions that were asked were:

- What does spiritual care mean to you?
- Should it be provided in the hospital?
- During a stay in hospital were you provided with some form of spiritual care?
- Would you have benefited if it had been offered?
- Who should provide spiritual care?
- Do you think spiritual care is as important as other forms of care?

As with the nurses, all patients equated spiritual care in some way with religion. Here, the emphasis seemed to be on harmonious communication - the patients wanted help to understand their illness. Mary gave examples of patients' definitions of spiritual care:

- Spiritual care is talking with patients about God.
- Spiritual care is in loving your neighbour as yourself.
- Spiritual care is assisting those who are weak and need help.
- Spiritual care is 'like the Good Samaritan stuff'.
- A longer definition given was, 'Spiritual care is when you are weak someone gives you strength, when dirty someone cleans you up, when hungry someone gives you food, when thirsty someone gives you drink, when confused someone stays by your side, when wanting to end your life someone gives you hope, when frightened someone calms your fear, when no-one cares about you someone holds your hand and gives you a smile."

Mary then discussed the story of the Good Samaritan (Luke 10: 30-37). The priest did not stop, neither did the Levite, but it was the Samaritan, who was of a lower class, a person looked down upon, who actually helped. In the parable, it was the one who belonged to no particular religious group who was the person to do everything for the man who had been attacked and had fallen by the wayside. This was what patients meant by spiritual care.

Mary went on to say that the main source of the world's ills was lack of love. There are two basic qualities, which define us as human beings, sharpness of mind and kindness of the heart. She mentioned Mother Teresa in this respect who has said that the biggest disease of today is not TB or leprosy but a lack of being cared for and loved.

Mary contrasted the patients' definition of spiritual care with that of the nurses'. Nurses related spiritual care to religious care, whereas patients related spiritual care more to qualities of life and recovery. Points highlighted were helping patients find meaning in their experiences by listening to them when they express their concerns, and supporting them to talk through their problems. Patients wanted to feel accepted, that they belonged and were safe, were valued and loved. Practitioners should treat patients with the respect and dignity as individuals and fellow human beings that they themselves would like to be shown. What is important is recognising and respecting patients' values and religious beliefs and providing the necessary resources for these needs.

Both patients and nurses had made additional comments. Patients thought it was important to dispel the myth that any forceful religious expression is a sign of madness and emphasised that everyone needs spiritual care. They wanted the opportunities and resources to express feelings appropriately and to make contribution to the society through structured work or leisure. More staff and activities were needed.

Nurses commented that training in spiritual care should be arranged as part of continuing education and that spiritual care should be included in the care plan of patients. However, they thought that spiritual care should be provided by the priest. Some were unsure of what spiritual care was and even thought spiritual care could increase patients' delusions. Another comment made was that 'this is an acute admission ward, not a church' and that if clients needed spiritual care they could request to see the priest of their faith.

In summary, Mary pointed out that patients' perceptions of spiritual care differed significantly from that of the nurses. While the patients associated spiritual care with religion, all the patients regarded spiritual care as more encompassing than mere religious practice. Patients described spiritual care holistically and related it strongly to their quality of life and recovery. By contrast, nurses described spiritual care as referring to the religious needs of the patients and were unclear who should be responsible. Nurses demonstrated a lack of confidence and expertise regarding spiritual care but did express an interest in undertaking training when provided.

Research implications were that this study needed replicating in other mental health care settings. There was the question of whether specialist practitioners in spiritual care should be trained and if so, how to commence training and how to provide prophylactic and therapeutic spiritual care.

Discussion: It was thought important to tease out what is meant by spirituality and what is meant by religion. It was pointed out that the General Medical Council states that it is appropriate for doctors to share their religious beliefs with patients *so long as it does not put pressure on the patient*. One way of looking at spirituality is that it is not encapsulated but underpins all we do. Care and compassion should be at the basis of all our work. Did we need to define spirituality if we are going to be able to investigate it? The chair reminded the meeting that in setting up the Spirituality in Psychiatry Group, it had been decided that spirituality should not be tightly defined. Some people believe that 'spirit' is primary and we are spiritual beings in physical bodies (hence survival after physical death) while others hold that spirituality carries no such implication. Mary warned against being so restrictive in our definition of spirituality that we become like the priest or Levi in the Good Samaritan and pass by on the other side of the road! The discussion closed with the comment from the chair that both perspectives were important. Sometimes the big existential questions of life and death have to be faced. Other times the need was simply for compassionate care, when a person might be feeling lost and alone.