

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

Mary Nathan MSc.

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 put forward the following list of possible barriers for discussion.

- Inadequate educational preparation and lack of competence in spiritual care.
- Emphasis may be placed only on biopsychosocial issues
- Spiritual care has been described as lacking a scientific base, compounded by the associated problems of time constraints and shortage of human resources
- Lack of clarity of the concept.
- Religion is taken to be synonymous with spirituality.
- There are conflicts in belief and value systems among mental health professionals,
- Spiritual care can be personally challenging to most mental health practitioners and the practice setting or institution may be a barrier.
- There is an absence of the right kind of relationship between the clients and the practitioners (it has been described as the 'it and thou mentality'), reflecting a rigid model of care.

As to overcoming possible barriers to spiritual care, Mary proposed the following:

- Promoting and utilising educational opportunities in spiritual care and empathising with the whole person.
- Recognising the limitations of science and prioritising limited resources.
- Working at what is known until the unknown is clarified.
- Recognising that religion and spirituality are not synonymous.
- Addressing the challenges spiritual care poses to health care practitioners and practising a holistic approach to care.
- Using positive attitudes towards self and others and implementing care interventions that address the whole person.

Mary described a 'compassion scale' that she has devised for her research. (This stimulated the group to think about the actions we take as psychiatrists and whether they are to alleviate pain or because it helps us feel better. Whose sense of safety and well being comes first? There is a need for honesty. Do our actions promote the quality of life for our patients or do they afford us a position of power and control over that person? We could try asking the question 'would I be happy to be treated in that way'?)

Mary then looked further at the question 'What is spiritual care? *It can be seen as providing the necessary resources to address and support people's values and beliefs, provided these values and beliefs place no individuals at risk.* It is based on treating each person with respect and dignity, promoting love, hope, faith, and

helping vulnerable people to find the strength to cope at times of life crises when overcome by despair, grief and confusion.

Discussion: What implicit attitudes are held by mental health professionals? Are psychiatrists more sceptical of spirituality than the population at large? Service users say how much their spiritual beliefs have helped them cope with illness but feel unable to discuss it with the psychiatrist. Yet if Jung's concept of the wounded healer is to be taken into account, the mental health professional is well qualified to support an attitude of spiritual enquiry when the patient shows signs of wanting to explore spiritual concerns.

Mary then proposed the following key aspects of spiritual care:

- Acceptance: accepting people as they are.
- Help: helping people to be what they can be.
- Affirming: affirming people when they feel weak
- Giving: giving strength to set people free.

The point was raised that people enter the vocational professions, including medicine, social work and teaching, because they are spiritual beings but seem to have the spirituality knocked out of them during training! It seems that neither the training, nor the work environment, are supportive of the spiritual task. As to psychiatry, the idea was mooted of establishing local networks, to find ways to prevent burnout and disillusionment. Mary, in summing up, made the point that in the final analysis, it is deeds not words that count, as illustrated so powerfully in the parable of the Good Samaritan.