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Wattis, John, Rogers, Melanie, Ali, Gulnar and Curran, Stephen

Bringing Spirituality and Wisdom into Practice

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JOHN WATTIS, MELANIE ROGERS,
GULNAR ALI AND STEPHEN CURRAN

14. BRINGING SPIRITUALITY AND WISDOM INTO PRACTICE

This chapter considers the way in which the split between “objective” reductionist approaches and a more “subjective” understanding of the human condition arose in the 17th century with spirituality associated with the subjective approach. The consequent difference between the biomedical and the broader biopsychosocial approaches to medicine is explored. The relationship between spirituality, religion, secularism and wisdom is explored. The concepts of a shared journey and of spiritually competent practice are used to explore how spirituality and wisdom can be integrated into truly holistic person-centred practice. Obstacles and facilitators to this kind of practice are considered including approaches to educating clinicians.

PROBLEMS WITH MODERN PRACTICE

There is much that is good in modern medical practice. Scientific and technical advances over the last couple of hundred years have been extraordinary. Yet, there is discontent about the “industrialisation” and depersonalisation of health and social care. One general practitioner (GP) recently asked how they could possibly “know” their patients when their group practice had over 11,000 patients.

Similarly, in acute hospital care, patients may be moved from one setting to another as specialists address different problems at a technical level often without attention to personal relationships. Each move brings new nursing and care staff. Throughput and pressure of work mean that nurses feel they never get to “know” their patients. In mental health, fragmentation of services with different teams looking after service users in different settings leads to a lack of continuity and a situation where the personal knowledge of the patient, that used to be an important aspect of care, is dissipated. We have produced a situation where technical abilities are advanced; but models of care are industrialised, losing the personal touch. Financial pressures in healthcare and the push for ever-greater efficiency exacerbates the situation. A target-driven system of management encourages “gaming” the statistics and does not promote good management. Parts of health and social care provision are not joined up and there is increasing likelihood of people falling through gaps in what can scarcely be described as a “system” of care.

Here, we will briefly survey some of the causes of these developments and propose some remedies. We will consider how spirituality and wisdom can be applied, contrasting materialistic (biomedical) and holistic (biopsychosocial) approaches. We will explore some aspects of evolutionary theory and consider the relationship between wisdom, spirituality, culture, religion, humanism and

secularism. We will conclude by reviewing the work our group at the University of Huddersfield has done on spiritually competent practice and relating this to wisdom and journeys of transformation.

BIOMEDICAL, BIOPSYCHOSOCIAL AND HOLISTIC MODELS IN MEDICINE

We share experience of practice, teaching and research in a variety of healthcare contexts. Between us, we also have experience as managers, service users and carers of people with long-term illnesses. We do not subscribe to a narrow biomedical model of practice but embrace the wider biopsychosocial model (Engel, 1977). The biomedical model (sometimes characterised as *the* medical model) is based on a reductionist view of human nature and does not allow for the interaction of social and psychological factors in the causation and treatment of disease. The biopsychosocial model was originally proposed as a new model for psychiatry. Advantages over the biomedical model seem self-evident as there are clearly psychological and social influences which impact on mental health.

Engel (1980) described a patient with a heart attack illustrating how psychological and social factors also impacted on physical health. He characterised the biomedical approach as factor-analytic, solving problems by breaking them down into their constituent parts and contrasted this with the biopsychosocial model which recognises a hierarchy of interactive systems in medicine from the sub-cellular to the social. He asserted that medical intervention begins at the personal level and maintained that it was equally scientific to explore the psychological and social factors as it was to look at e.g. myocardial damage at the cellular level. Twelve years later, Engel (1992) was still asking “How much longer must medicine’s science be bound by a seventeenth century world view?”

Epstein (2014) reviewed how the biopsychosocial model had fared nearly 40 years after it was first proposed. He believed that trainees and clinicians had not developed the capacity for resilience, self-awareness and self-monitoring needed to implement the biopsychosocial model and needed to learn how to connect with patients at the personal level by becoming more self-aware, resilient, and actively compassionate. He advocated a *humanist* approach alongside the factor-analytic model of modern science. Davies and Roache (2017) presented a discussion on the biopsychosocial model in psychiatry, pointing out that it was compatible with recent philosophy of mind which embraces a monist and non-reductionist approach. They argued that this liberated the (mental) health professional from choosing between a reductionist model and the Cartesian dichotomy between mind and body.

THE GREAT DIVORCE

How has the tension between a reductionist biomedical science and the subjective aspects of medicine arisen? The middle of the 17th century was a time of flux in religious and philosophical understanding. A worldview was developing which was materialist and reductionist in its approach. This came to be the dominant scientific worldview which achieved amazing advances in objective knowledge of the material

world but resulted in a split with subjective understanding of the human condition. During this period of philosophical turmoil, the term *spirituality* came into the English language (McGrath, 2011, pp. 108-109), denoting direct knowledge of the divine or supernatural, roughly equivalent to what we might today term “mystical” experience. Not surprisingly spirituality (and religion) tended to be found on the subjective side of the split.

Worldviews can be considered as the cultural “spectacles” through which we view our experiences. Unless we stop and think we simply accept them as representing how things are. There are many different worldviews and variants within them though one worldview may be dominant in a particular culture. We have discussed this in more detail elsewhere (Wattis, Curran, & Rogers, 2017, pp. 7-8). For present purposes we will focus on two: the *materialist* and the *systems* worldviews. The materialist worldview understands knowledge purely in material terms addressing it by a reductionist approach, breaking everything into its component parts. This has proved invaluable in understanding organisms, cells and molecules and has made a major contribution to medical science. Engel sees its weakness as not allowing for the understanding of systems where, for example the patient with the heart attack may, at a personal level, not just experience sensations resulting from myocardial damage but also where psychological and social factors from higher order systems may influence the experience, the degree of myocardial damage and the eventual outcome. This might well be called a systems worldview (Laszlo, 1996) and corresponds to the biopsychosocial model.

INCREASING COMPLEXITY

Evolution is usually viewed as a process of increasing complexity. In the early 20th century the atheist scientist Vernadsky and the Jesuit palaeontologist, philosopher and theologian, Teilhard de Chardin (1959) developed the idea of stages of complexity, the *geosphere* of the inanimate planet leading to the *biosphere*, the sum of all living things on earth and this giving rise to the *noosphere*, the sphere of human thought. The term *noosphere* is derived from the Greek *nous*, νοῦς, meaning that which enables human beings to think rationally. The biosphere represented a step change in complexity from the geosphere and the noosphere represented a step change from the biosphere. The systems all interacted with each other and Teilhard de Chardin believed that this would all end in an Omega point which he seems to have seen as an expression of the Divine. This idea ties in nicely with Engel’s biopsychosocial approach of cosmogenesis and was explored in a short science fiction story, *The Last Question* (Asimov, 1956).

The *noosphere* relates to the idea of transcendence. Mind does not just exist within the individual organism but also in the *noosphere*. The term *transcendence* has specific meaning in theology and Kantian philosophy. The wider understanding of transcendence and the concept of the *noosphere* allows those who believe in God and those who don’t a point of contact above the purely organismic level.

SPIRITUALITY, RELIGION AND SECULARISM

Like transcendence, spirituality is hard to define from the perspective of conventional biomedical research. We have found spiritually competent practice to be a more useful concept for research, teaching and learning purposes (Wattis et al., 2017). The difficulties in defining spirituality can lead to misunderstanding. For now, we will use Cook's comprehensive definition:

Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective experience of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately 'inner', immanent and personal within the self and others, and/or as a relationship with that which is wholly 'other', transcendent and beyond the self. *It is experienced as being of fundamental or ultimate importance and is thus concerned with meaning and purpose in life, truth and values* [emphasis added]. (Cook, 2004, pp. 548-549)

At the subjective level the last sentence of this definition is vital. Here again, secular and religious understandings of spirituality can find common ground.

Spirituality as a term in English language was born out of Christianity, but it is no longer confined to religion. Some have asserted that the terms are entirely distinct. We prefer to see them as overlapping. Some people express their spirituality through their religion; but it is possible to have a secular spirituality and some expressions of religion may be merely outward forms without any underlying spiritual engagement (Allport, 1950). We have discussed these issues more fully elsewhere (Wattis et al., 2017, pp. 5-7).

We live in a secular society. In the United Kingdom (UK), the National Secular Society (2018) sees the separation of religion and state as the foundation of secularism. Some forms of secularism exclude religion from the public arena and confine it to the private domain. Others stress the need for mutual tolerance between those who adhere to different religions and those without a specific religious affiliation. Stammers and Bullivant (2012) discuss of the issues around secularism and spirituality more fully.

WISDOM AND KNOWLEDGE

Wisdom is a (personal) quality based on experience, knowledge and good judgement. Knowledge, particularly in the "objective" materialist sense used by much post enlightenment science presents some interesting contrasts with wisdom (see Table 14.1). To be fair to knowledge we need to rehabilitate a wider understanding of the term. Swinton (2012), writing in the context of healthcare spirituality, distinguished *nomothetic* and *idiographic* forms of knowledge.

Table 14.1. *Wisdom versus knowledge.*

Wisdom	Knowledge
A thinking tool (and more)	A substrate of thinking
Value-based, makes judgements	Value-free
Divergent thinking and convergent thinking	Mainly convergent thinking
Broadens the options	Narrows the options
Considers the whole person	Considers the parts
Considers context (social, political, economic)	Focuses only on presenting problems
Seeks balanced “solutions”	Seeks a solution to the presenting problem
Views compassion as central	Does not of itself acknowledge centrality of compassion

NOMOTHETIC AND IDIOGRAPHIC KNOWLEDGE

Swinton (2012) described the wonder of experiencing a beautiful waterfall and the mundane experience of looking at a bucket of water taken from the waterfall. He asserted they both contain “truth”; both are made up of water (H₂O). H₂O is the nomothetic perspective. Then he asked whether the subjective sense of wonder accompanying perception of the waterfall (the idiographic perspective) is merely an artefact or something more? He asserted that healthcare practices tend to “focus on buckets rather than waterfalls”, on the parts rather than the whole person in context and suggested that spirituality was needed to bridge and fill the gaps between these different ways of knowing the water and the waterfall (Swinton, 2012, p. 99).

Nomothetic (from the Greek term for lawgiving) knowledge tests hypotheses to produce general “laws”. It approximates to the knowledge gained by traditional medical science utilising experiments and randomised controlled trials. Knowledge of this kind is generally based on hypothesis testing and must fulfil three criteria. It must be falsifiable, replicable and generalisable. To be falsifiable means that it must be logically possible to disprove the hypothesis. For example, a drug trial will often be set up on the basis of a null hypothesis (that there is no difference between the active drug and placebo). The research design, including the statistical analysis ensures that any difference between active drug and placebo is unlikely to have arisen by chance and any trial, conducted according to the same design with similar subjects, would be expected to produce similar results. Finally, the results can be generalised to patients with the same characteristics and (disease) condition. This kind of knowledge is generally the main basis for evidence-based medical practice.

Application of quantitative scientific methods can be used to study the effects of religious *observance* on various aspects of health and generally there is a positive relationship between the two (Koenig, 2000). However, because spirituality involves subjective (idiographic) experience it is much harder to study. Attempts have been made to produce scales to measure spirituality in the healthcare context. A

systematic review by Monod et al. (2011) identified 35 instruments. The two most commonly used in clinical research contained subscales related to religious and existential dimensions. For example, the Spiritual Well-Being Scale (SWBS) (Ellison, 1983) has two separate scales for religious well-being (RWB) and existential well-being (EWB). When summated these give the overall SWBS score. Items which score in a positive direction in both subscales have face validity. However, the use of a RWB component assumes that all spiritual well-being must involve religious belief in God or a higher power and the EWB scale seems to correspond closely with what the positive psychology movement refer to as sustained well-being. Thus, one of the most commonly used scales to quantify “spiritual” well-being might be said to be really measuring a combination of religious and psychological/existential well-being.

Idiographic (from the Greek term for oneself, one's own) knowledge derives from unique, non-replicable experiences. It is subjective lived experience. It is no less valid than nomothetic knowledge; but it cannot be proved or disproved in the same way. Nor can it be replicated or generalised like conclusions derived from well-designed quantitative studies. It is amenable to rigorous research using qualitative methods and these can sometimes generate hypotheses that can be tested using nomothetic methods (Wattis et al., 2017, p. 12).

WISDOM IN RELIGION, PHILOSOPHY, HUMANISM AND SPIRITUALITY

The main religious traditions all emphasise the importance of wisdom. In the Hebrew Bible a variety of books, including Job, Proverbs and Ecclesiastes are classified as wisdom literature. There are many references to wisdom in the Christian New Testament including a passage in the letter of James which reads:

Who is wise and understanding among you? Let them show it by their good life, by deeds done in the humility that comes from wisdom ... [but] the wisdom that comes from heaven is first of all pure; then peace-loving, considerate, submissive, full of mercy and good fruit, impartial and sincere. Peacemakers who sow in peace reap a harvest of righteousness. (James 3:13, 17-18 NIV)

Islam also associates understanding and thought with spiritual growth and wisdom (Walker et al., 2016). Like early Christian thinking Islam incorporates ideas from Greek (Aristotelian and Neoplatonic) philosophy (El-Bizri, 2006). Various intellectual traditions of Islam emphasise ideas of personal search and wisdom through truth-seeking and self-awareness as ways of addressing spiritual aspects of religious life (Esmail, 1998; Madelung & Mayer, 2015). In Islam, wisdom and spirituality are inextricably intertwined.

Buddhism focuses on wisdom and in Mahayana Buddhism this is coupled with compassion (which not only empathises with the feelings of others but also acts to relieve suffering). Buddhism shares with early Christianity an emphasis on non-violence and loving peace. Ancient Greek philosophy recognised wisdom as one of the cardinal virtues (alongside courage, moderation and justice). Wisdom appears

BRINGING WISDOM AND SPIRITUALITY INTO PRACTICE

high in the list of virtues recognised in the modern *Values in Action Classification of Strengths* (VIA Institute on Character, 2018) which is broadly humanistic in orientation.

SPIRITUALITY AND WISDOM IN PRACTICE

How do spirituality and wisdom work together? Wisdom surely dictates that we take a biopsychosocial approach to practice embracing the spiritual dimension. As noted earlier, spirituality is “*experienced as being of fundamental or ultimate importance and is thus concerned with meaning and purpose in life, truth and values*” (Cook, 2004 p.549). Spirituality should be addressed in terms of the experience of the person with whom we are working. How can we effectively bring spirituality into practice and healthcare education?

A SHARED JOURNEY

The concept of a shared journey is useful here. This was one of the findings of Jones (2016) in her ethnographic study of how occupational therapists embody spirituality in practice. This concept of the shared journey resonates with the *Kawa* (Japanese: *River*; Iwama, 2006) model of occupational therapy, in which the patient’s life is seen as a flowing river with the therapist sharing part of the journey. This puts the clinician on more even terms with the person than the more traditional expert-patient relationship. There is a need for expertise; but clinicians need to recognise the limits of their expertise and importance of patients’ expertise about their own lives. Recognising one’s limitations is itself a characteristic of wisdom. Emanuel and Emanuel (1992) described four models of the physician-patient relationship: *paternalistic, informative, interpretive* and *deliberative*. The paternalistic model is the traditional model. The informative model is aligned with the idea of health as a *consumer* commodity and an emphasis on patient autonomy. The interpretive and deliberative models represent a co-operative/co-productive or partnership approach (Coulter, 1999). Wisdom and spiritually competent care both demand this approach. The clinician functions as a *limited* expert and partners with the patient in making decisions based on their own experience of illness, social circumstances, attitudes to risk, beliefs, values, preferences and spirituality.

SPIRITUALLY COMPETENT PRACTICE

Spiritually competent practice is a core concept for the Spirituality Special Interest Group at the University of Huddersfield.¹ Janice Jones’s work produced a description of spiritually competent practice in occupational therapy subsequently modified to apply to all healthcare practitioners:

Spiritually competent practice involves compassionate engagement with the whole person as a unique human being, in ways which will provide them with a sense of meaning and purpose, where appropriate connecting or reconnecting

WATTIS ET AL.

with a community where they experience a sense of wellbeing, addressing suffering and developing coping strategies to improve their quality of life. This includes the practitioner accepting a person's beliefs and values, whether they are religious in foundation or not, and practising with cultural competency. (Wattis et al., 2017, p. 3)

We have identified factors which obstruct or promote spiritually competent practice. They either obstruct or promote care informed by clinical wisdom.

FACTORS WHICH OBSTRUCT SPIRITUALLY COMPETENT PRACTICE

Several factors obstruct spiritually competent care:

- fragmented patterns of working
- time and caseload pressures
- bad management systems and cultures.

Patterns of working in healthcare are increasingly fragmented. In the UK, social work input has been cut back and may be managed separately from healthcare. People with mental health issues may be supported, at different times by people from different teams, with loss of continuity. In the UK this is partly to facilitate the commissioner-provider split and ideas about market competition in healthcare; but "industrial" mechanistic, depersonalising ways of working prevail in many places as part of a political culture based on a materialistic worldview.

Doing a job well, particularly adopting a partnership rather than a paternalistic or consumer ethical stance, takes time and professionals often do not have enough time to spend with the people they work with. The number of sessions of therapy intervention may be limited, regardless of real personal need. Workers may have excessive workloads and be expected to end therapeutic relationships prematurely. Secondary pressures arise from staff stress-related sickness and demoralisation and from difficulties and delays in recruiting replacements.

Treating workers like mindless machines is unhelpful. Top-down command and control management does not free professionals to work in partnership with patients. An authoritarian, bullying culture may develop where the attitude of people at the top is "do what you're told, deliver your targets and shut up". This does not encourage workers to engage in genuine co-production, though they will no doubt tick the appropriate "patient involvement" box if required to do so. Role cultures where clinicians are seen as interchangeable "cogs" do not facilitate good personal relationships, an important foundation for ethical care within the partnership framework.

In our research around spiritually competent care by occupational therapists, ANPs and mental health nurses (Jones, 2016; Rogers, 2016; Elliott, 2017) we discovered that healthcare workers seek ways to work round constraints imposed by healthcare systems. We suspect this is common; but practitioners should not have to work against the system; the system should be working to support them.

FACTORS WHICH PROMOTE SPIRITUALLY COMPETENT PRACTICE

Several factors promote spiritually competent practice:

- team working
- good leadership and supervision
- good management systems and cultures.

Good teams where people are mutually supportive and aware of each other's special competencies and capabilities facilitate partnership working with patients. Working together in an atmosphere of mutual respect encourages members to work with patients in an equally respectful way. Acknowledgement of different and complementary but limited expertise within the team encourages recognition of the expertise of the people using services in their own subjective experience.

Good distributed leadership within teams, which recognises that different people are best equipped to lead on different issues, encourages the humility of accepting one's own limitations. This extends to working in partnership with people using services and recognising and supporting the key contributions they can make to creating new meaning and purpose when thrown off balance by illness. Peer supervision can support team members in engaging with people's spiritual needs. Beyond the team, the organisation needs to provide support through appropriate supervision and by having realistic expectations about workload.

There are alternatives to top-down command and control management. NAViGO, a social care enterprise providing mental health services uses design principles in its services (Bond, 2017), based on Social Role Valorisation (SRV), originally developed in learning disability. They are as follows:

- People who use and work in services influence design and operation
- Design facilities on domestic scale and style
- Educate staff to understand their power and influence for good or bad
- Ensure organisational design focuses on people who use services
- Language is important "people" not patients; avoid clinical jargon
- Involve people who use services in all staff education and training
- Make clinical and security features unobtrusive in buildings
- Share common space
- Encourage public access and interaction
- Support people (staff and service users) to develop valued roles and creativity.

These principles emphasise the common humanity of staff, managers and people who use the services and reduce stigma in the wider community. They do not speak to spirituality as an intellectual abstraction but do signify spiritually competent practice.

The Virginia Mason Production System (VMPS) (Kenney, 2010) sounds very "industrial" but is based on insights originally from the Toyota Production System (TPS). This in turn was based on an adaptation of American mass production (see Dennis, 2015, for an account of Toyota's "lean production") The key point of the

TPS for present purposes is that workers are not treated as automata but as valued partners in production who contribute to the design of production systems and to continuous quality improvement. This is SRV for the workers! The VMPS similarly engages and values people who use the service, front-line clinicians and managers in ongoing service and quality improvement. NAViGO and VMPS are both discussed as examples of innovation in the second edition of *Practical Management and Leadership for Doctors* (Wattis *et al.*, in press).

INSIGHTS FROM WORLD RELIGIONS

The Buddhist principles of mindfulness and compassion have been used to develop approaches to resilience and therapy. Mindfulness practice and mindfulness-based cognitive therapy (MBCT) are well established fusions of ancient Buddhist ideas and pragmatic modern science.ⁱⁱ MBCT is endorsed by the National Institute for Health and Care Excellence (NICE) for people who are currently well but have experienced three or more previous episodes of depression. Gilbert's (2010) *Compassion Focused Therapy* integrates techniques from cognitive behavioural therapy with insights from Buddhist psychology and neuroscience. Thus, therapies based on ancient Buddhist wisdom have proved clinical efficacy.

Other traditional wisdom has also been investigated, though at present research is at an earlier stage than for mindfulness and compassion-based therapy. One of the authors (Rogers, 2016) conducted research on applying the principles of availability and vulnerability from the Celtic Christian tradition to spiritually competent practice with advanced nurse practitioners (ANPs). The findings suggest that the application of these principles within a professional relationship could be transformative for patient care as well as for the clinician. The Northumbria Community is a Celtic Christian Monastic community in the North of England that follows a "Rule of Life" based on two vows: availability and vulnerability (Northumbria Community, 2018). These vows imply relationship with God and other people in a non-judgemental, authentic, caring and compassionate way.

The research suggested that true availability was more than just physical presence and included emotional, spiritual and vocational aspects. All the study participants went into clinical work with an altruistic motivation and desire for their work to be vocational. Over years the changes in healthcare and push towards target-driven care had challenged their initial motivations. As they explored patient interactions, they all spoke of times which had affected them deeply. This connected to seeing the patient as a fellow human being. They recognised that to be available they first needed to be available to themselves, reflecting on their own spiritual journey and whether their own values were congruent with their practice. They recognised that to do this they needed self-acceptance, self-care and clinical supervision. Reflecting in these ways enabled them to "give" of themselves without reaching a point of burnout.

Availability also included a choice to practise in a way where patients feel welcomed and accepted (hospitality). This was integral to spiritually competent practice and included being truly present and listening attentively so that patients felt

accepted, heard and cared for (Rogers & Béres, 2017). Concern for “being with” rather than “doing to” people was another key aspect of availability.

The concept of vulnerability carried negative connotations of risk of harm, whether to the patient or the clinician. However, authenticity and “giving of self” were seen as positive aspects of vulnerability involving connecting to a fellow human being. This involved genuineness, authenticity and congruence, which are well-accepted psychological approaches. One aspect of vulnerability the ANPs recognised was being open to their own limitations and being willing to be teachable. This included humility and willingness to learn from patients. ANPs viewed this as intentional vulnerability. Key was the willingness to be challenged as they gave relationships with their patients priority over professional status.

Relationships based on care, compassion and connection are the basis of holistic care and can be risky. Availability and vulnerability are deeply concerned with human connection. They are useful constructs to make spiritually competent care tangible. They necessitate a level of risk of hurt or misunderstanding but they can transform relationships with patients and make clinical practice more authentic.

DEVELOPING PRACTITIONERS TO PROVIDE WISE, SPIRITUALLY COMPETENT CARE

Spiritually competent care is supported by various aspects of wisdom; but how do we prepare people to deliver this kind of care? Research carried out by one of the authors has focused on improving the preparation of undergraduate nurses to provide spiritual care. The work is reported in more detail in her PhD thesis (Ali, 2017). An initial literature review (Ali, Wattis, & Snowden, 2015) was followed by a multiple case study, based on review of documents, interviews with educators and focus groups with students. This identified major knowledge and practice gaps in nurse education conceptualised as follows:

- lack of ontological integration
- lack in phenomenological understanding
- lack of support combined with environmental constraints
- curriculum structure and unprepared faculty.

Lack of ontological integration refers to relative inattention to the transformative experience of becoming and being a nurse. A focus on competencies to be learned and even on models for teaching about spiritual care will not be effective without work on personal development. To bridge this gap, educators need to support students in becoming self-aware and reflective in their practice through coaching, mentorship and role modelling, properly conducted.

A lack of phenomenological understanding is typified by a focus on “objective” rather than “subjective” truth. Without neglecting evidence-based practice in its narrower (nomothetic) sense people also need to embrace the evidence that idiographic person-person encounter with patients supports healing. This can be recognised in Carl Rogers’ principles of *empathy*, *congruence* and *unconditional*

positive regard (Rogers, 1959), validated in education and clinical practice (Kirschenbaum & Jourdan, 2005) and discussed in Wattis et al. (2017, pp. 12-13).

Students sometimes felt ill-prepared and under-supported in addressing spiritual issues. In addition, fragmented “industrialised” patterns of working, time and caseload pressures and bad management systems and cultures mitigated against developing skills in managing subjective, interpersonal aspects of care.

Finally, educators themselves faced similar issues of lack of support and environmental pressures, compounded by a relative lack of emphasis in the curriculum on more subjective phenomenological aspects of care. Standard-setting bodies themselves need to be persuaded to adopt a wiser, more inclusive attitude to education. These findings are summarised in Ali and Snowden (2017).

Nurturing and transforming healing approaches can accelerate the development of increased self-awareness in patients by expanding their subjective consciousness, facilitating transcendence at an intuitive level. A reflective framework, SOPHIE (Self-exploration through Ontological, Phenomenological, Humanistic, Ideological, and Existential Expressions), was developed from this work (Ali, 2017). It proposes a pedagogical shift grounded in heutagogical learning approaches, SOPHIE recognises the underlying reflective needs of a learner that are essential to develop personal authenticity, a knowledge seeking attitude and behavioural transformation. The need for a transformative approach is also reflected in the experience and education of practitioners from other disciplines, especially in palliative care (e.g. Gardner, 2012)

CONCLUSION

In this chapter we have considered the “great divorce” between materialist reductionist science and more subjective person-centred approaches to practice characterised by the contrast between nomothetic and idiographic knowledge. We have argued that wisdom and spirituality are concepts that transcend this divide. We have considered the obstacles and facilitators to spiritually competent practice which we would suggest also apply to practice wisdom. We have looked at ways of putting spirituality and wisdom into practice and of developing practitioners who are competent and have the personal qualities necessary to do this.

NOTES

ⁱ <https://research.hud.ac.uk/institutes-centres/carh/ssig/>

ⁱⁱ More can be found on the website MBCT.co.uk including references to a variety of books.

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BRINGING WISDOM AND SPIRITUALITY INTO PRACTICE

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WATTIS ET AL.

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*John Wattis FRCPsych
School of Human and Health Sciences
The University of Huddersfield, UK*

*Melanie Rogers
School of Human and Health Sciences
The University of Huddersfield, UK*

Gulnar Ali-PhD, MSc, MA, RN

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*School of Human and Health Sciences
The University of Huddersfield, UK*

*Stephen Curran
School of Human and Health Sciences
The University of Huddersfield, UK*