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> 'Why me?' asks the patient newly diagnosed with advanced cancer.
> 'What did they die for?' asks the mother of a soldier killed in the Afghan campaign, interviewed on the radio.
> 'How can I look after her at home without any support?' asks the husband of a woman being discharged from hospital with end-stage heart failure.
> 'How can I carry on?' asks the patient with severe depression.

Most of us will have heard questions like these in our daily work and sometimes from our friends and family. Where does the cancer patient find the *meaning* in what is happening to them?

How can bereaved people resolve their grief?

How can families cope when faced with the practical and emotional pressures of caring for their dying loved ones?

The answers are personal and they depend on many factors. Cancer sufferers may find strength from the compassion of those who care for them and even find personal meaning in facing suffering and death. The mother of the soldier, whilst sad that Afghanistan is still not stable and the Western intervention did not achieve all that it aimed for, nevertheless may have found some consolation in the fact that her son died for a purpose and for values that he and she both embraced. The husband of the woman with end-stage heart failure may find strength to cope from the kindness and practical help of friends, family and the community nursing/support team. The person with severe depression may initially need medication and even inpatient care if actively suicidal. In the recovery phase they may need to find hope and meaning through psychotherapy and connecting with other people. How people respond to such crises depends on their own starting points, their life circumstances and the support they receive from family, friends

and professionals. This book is about how health and social care professionals can play their part in supporting patients and their relatives and carers as they face the challenge and distress of life-changing, sometimes life-threatening, illness.

The issues of *meaning*, *purpose*, *hope*, *connectedness* and *values* are at the core of our understanding of spirituality. Victor Frankl, an Austrian Jewish psychiatrist who survived three years in Nazi concentration camps, stressed the importance of the search for meaning in life (1). His pre-war work included successful initiatives in suicide prevention but he refined his ideas through observing how he and others dealt with the immense suffering in the concentration camps. According to Frankl, meaning could be found in three ways: through love, through dedication to a life's work, and through how one coped with unavoidable suffering. He developed a form of existential therapy which he called logotherapy (1). For him, existential issues were related to God and spirituality (2).

Spiritual Care Competencies

Van Leeuwen and Cusveller (3) reviewed the nursing literature to produce a list of spiritual care competencies for undergraduate education of nurses. This in-depth review defined six competencies in three domains. The competencies were backed up by illustrative vignettes and descriptions of key behaviours. In Box 1.1 we have adapted these competencies to apply to all health and social care practitioners and clustered them in the three domains (again adapted) identified by the original authors. We believe these can be a basis for identifying shared competencies needed by all practitioners.

Providing good spiritual care is part of whole-person, or holistic, care. Useful though spiritual competencies are in defining educational objectives, they are not enough. Holistic, or whole-person, care addresses physical, mental, emotional and spiritual needs and involves more than just 'possessing' competencies. It is not just about the competencies but *whether* and *how* we apply them in practice. This, in turn, is influenced by the work environment which can facilitate or obstruct practitioners in providing quality care. Holistic care demands a person-centred approach. We need to see the person using the service as a whole person with a life story, a sense of meaning and purpose, emotions and thoughts embedded

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Box 1.1 Spiritual Care Competencies*

Spiritual self-awareness and use of self
1. Spiritual self-awareness and sensitivity to the needs of patients with different beliefs and values, and cultural and religious background.
2. Spiritual issues addressed with patients in a caring and culturally sensitive manner.

Spirituality in practice
3. Collection of information about spirituality and identification of spiritual needs.
4. Discussion with people using the service and relevant team about how spiritual care provision, planning and reporting are carried out.
5. Provision and evaluation of spiritual care with people using the service and team members.

Quality assurance and improvement
6. Contribution to quality assurance and improvement of spiritual care within the organization.

*Adapted from van Leeuwen R, Cusveller B. *Journal of Advanced Nursing.* 2004; 48 (3): 234–246.

in a matrix of relationships and shared beliefs. They are not just a problem to be fixed. Too often the focus on technical and economic issues (including restrictions on available time) makes it exceedingly difficult for practitioners to deliver care which supports the person in all aspects of their need. This is to the detriment not only of the service user but also can result in a demoralized, dispirited 'burnt out' workforce.

Spiritually Competent Practice

It is not easy to provide a good definition of spirituality. Later in this chapter we provide two examples, one brief and one meticulous in its detail. We could have provided many others from a variety of sources; however, we have found, as we have looked into this area, that it is much easier to *describe spiritually competent practice* than to define spirituality. This is the latest iteration of how we would describe it:

> 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 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.

This is based on a previously published description (4), in turn based on a description developed from observational research in occupational therapy by one of our colleagues and co-author of two chapters in this work, Janice Jones (Chapters 3 and 7). We originally modified the description to make it generally applicable to all health care disciplines. Later modifications include adding the adjective *compassionate* to emphasise the central role of compassion in spiritually competent practice.

We want to make an important distinction between *competencies* as the building blocks of what can be taught to students and assessed and *competent practice* which requires the presence of other factors to be fully realised. We can express this in the equation:

$$\text{Spiritually competent practice} = \text{Spiritual competencies} + (\text{Compassionate motivation \& commitment}) + \text{Opportunity}$$

Competencies have been discussed, and an idea of how these can be framed is given in Box 1.1. However, compassionate motivation and commitment in the practitioner is essential to apply these. This in turn can be supported or obstructed by the organisation, depending on how it treats its staff and whether it promotes systems of care that provide time for compassionate, committed, spiritually competent care.

Chapter 3 in this book takes a closer look at spiritually competent practice. Chapter 4 looks at how two practitioners conceptualise these issues and how spiritually competent practice relates to other concepts in health and social care.

Definitions of Spirituality and Religion and Their Limitations

Spirituality

Spirituality seems to be a 'tricky' or nebulous concept to define (5–7) and that is why we have chosen to focus instead on the more easily described area of spiritually competent practice. However, we do not want to duck the issue of defining spirituality completely. We first address it by looking at our own research into how health care educators define it. When, as part of a small study (8), a group of health care educators were asked to provide their own personal definitions of spirituality, several themes emerged:

- That self, person (or personhood) and being were central to understanding spirituality, both in the context of teaching and in the delivery of care.
- That spirituality gave a sense of direction, meaning and purpose to life.
- That spirituality (far from being 'other-worldly') was practical, affecting how people lived and acted towards other people and the outside world.

Spirituality was regarded as something that could not be seen or touched but nevertheless could be experienced. This led to a need to use different methods to teach about spirituality focused on experiential learning rather than traditional methods (8). This is discussed further in Chapter 5.

How do the issues our health care educators identified compare with conventional definitions, and how does spirituality in this context differ from religion? Hill and Pargament (9), having commented that religion and spirituality are related rather than independent concepts, characterise spirituality as the 'search for the sacred' but go on to assert that religion is also characterised by the same search. This reflects the North American tendency to see spirituality as less distinct from religion than is the case in the UK where Cook (10), after a careful examination of existing work, developed a definition which embraced both the secular and the sacred positions:

> 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 (10).

This definition embraces personhood and relationship, sense of direction, meaning and purpose. To some extent, the emphasis on the fundamental nature of spirituality also accords with our respondents identifying it as being of practical importance and affecting how people live and act towards others. However, it is not necessarily a definition that can be easily operationalized or 'measured' for research purposes. In the end we return to the conclusion that it easier to accept, at the practice level, that spirituality is intensely individual. For that reason, it is preferable as already stated, to concentrate on spiritually competent practice in practical and educational terms.

Religion

What is religion? The Oxford Dictionaries online (11) gives the primary definition of religion as 'belief in … a superhuman controlling power, especially a personal God or gods'. Wattis and Curran (12), writing in a health care context, suggested that religion can be seen as a means of relating to God and our fellow human beings, connected with the beliefs and rituals found in many faiths and often associated with power structures; briefly, 'the politics of spirituality'. Some definitions would not necessarily refer to God and would implicitly include a number of systems ('isms') that we don't normally think of as religions (e.g. capitalism, socialism, communism, materialism, economism and even secularism). These may for some people function as a religion; see for example the critique of economism as a 'religion' by Richard Norgaard (13).

Psychologists have developed different ways of understanding religion. Allport (14) made a distinction between mature and immature religion, later conceptualised as intrinsic and extrinsic religion (15). Intrinsic religion is essentially religion that is 'of the heart', also described as 'religion as an end in itself'. Extrinsic religion is seen as 'skin deep', self-serving and essentially a means to an end. Intrinsic religion seems intuitively closer to what we mean by spirituality. Batson et al (16) added a third category to intrinsic and extrinsic religion: 'religion as quest'. This, too, overlaps with ideas about spirituality.

Secular Society, Religion and Spirituality

Most Western societies can be characterised as secular, in the sense that they lack consistent religious practice, belief or interest but generally tolerate diverse religious and cultural groups as part of the society. According to Stammers and Bullivant (17) these societies generate 'secular spiritualities' which make no reference to religion or ideas about God.

Secular*ism* is the term used to refer to philosophical and political doctrines that are reflected in the structures and procedures of institutions. One kind of secularism effectively excludes religion from the public arena and confines it to the private lives of individuals and groups. The other form of secularism, sometimes called 'ecumenical', advocates mutual tolerance between religious groupings and those of no particular religion (17). Nevertheless, there are boundaries that are often difficult to define but which can be crossed. This happened in the case of Caroline Petrie, a National Health Service (NHS) nurse who was suspended (but later reinstated) for offering to pray with a patient (18). It can be argued that the boundaries are not absolute but can be flexed by the mature practitioner sensitive to the patient's own spiritual position. It is interesting it was not Petrie's patient but another member of staff who complained when they heard about the offer. Boundaries also vary between cultures, with practitioners in North America generally being more willing to accept the idea of praying with patients.

The proportion of the population that are 'religious' (across a whole variety of different religions; predominantly Christian, Muslim, Hindu, Jewish and Buddhist in the UK and United States) is higher than many would imagine. It is around 79% in the UK and 84% in the United States (19). The number of fully observant members of their faith groups is much lower. Religion is not the same as spirituality or spiritual well-being, though for many people religion will be an expression of their spirituality and may help them

achieve spiritual well-being. We have tried to illustrate the relationship between religion and spirituality in Figure 1.1. In its original meaning (see below) spirituality was considered as wholly contained within religion (Figure 1.1 a). In the post-modern era it seems possible to express spirituality and achieve spiritual well-being without adherence to a formal religion and to be an adherent to formal religion (at least in its 'extrinsic' form) without experiencing spirituality or spiritual well-being. This overlapping relationship between spirituality and religion is expressed in Figure 1.1b.

The term *spirituality* comes from the Latin *spiritus*, literally meaning 'breath'. The derivatives of the Latin root include words like *inspire* and *expire* (both used in literal and metaphorical senses) *respire* and, of course, *spirit* and *spirituality*. According to McGrath (20), the origins of the modern term *spirituality* in the English language can be traced to 17th century French. It originally denoted direct knowledge of the divine or supernatural. This would make spirituality almost synonymous with mysticism and place spirituality, in its original English sense, firmly within the bounds of religion (Figure 1.1a). However, over time, the concept has migrated so that spirituality can also denote an 'inner' life without any reference to religion, God or the supernatural (Figure 1.1b).

Harold Koenig and colleagues (21, pp.47–48) argue that in clinical practice it is often best to use the term spirituality rather than religion, precisely because it is so broad and all-encompassing. Swinton and Pattison (22), in the title of their paper, argue for a 'thin, vague and useful understanding of spirituality'. This approach enables the practitioner to start with broad enquiry and follow where the patient leads. However, for research purposes this vagueness and broadness makes it hard to distinguish spirituality and spiritual well-being from existential issues and psychological well-being. This issue is addressed in detail by Koenig et al in Chapter 2 of the *Handbook of Religion and Health* (21).

Despite the difficulties in measuring spirituality, there have been many attempts to do so. A systematic review by Monod et al (23) identified 35 instruments, classified into measures of general spirituality (N = 22), spiritual well-being (N = 5), spiritual coping (N = 4) and spiritual needs (N = 4). The instruments most frequently used in clinical research were the Functional Assessment of Chronic Illness Therapy — Spiritual Well-Being (FACIT-Sp) (24) and the Spiritual Well-Being Scale (SWBS; 25). Interestingly, both these scales contain subscales that relate to what might broadly be described as religious and existential dimensions. The SWBS specifically incorporates two separate scales for religious well-being (RWB) and
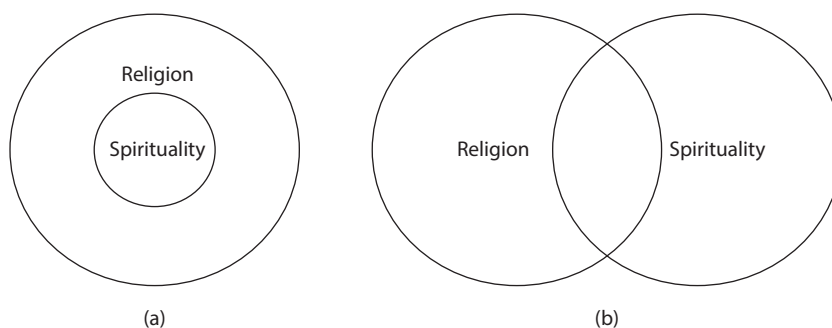

Figure 1.1 How religion and spirituality relate to each other. (a) Religion 'contains' spirituality. (b) Religion and spirituality overlap but are distinct.

existential well-being (EWB). When summated these give the overall SWBS score. The two components were designed to reflect 'two commonly recognised components of spirituality'. Items which score in a positive direction in both subscales certainly have face validity; for example, 'I believe that God loves me and cares about me' (RWB) and 'I feel that life is a positive experience' (EWB). The RWB scale (which relates to 'God' or 'a higher power' rather than a specific set of religious beliefs) tends to have a 'ceiling effect' in communities with strong religious beliefs.

There is also the complication that existential well-being appears to be closely related to what the positive psychology movement refers to as sustained or 'eudaimonic' well-being. This focuses on meaning and self-realization in contrast to hedonic well-being, which defines well-being in terms of short-term pleasure attainment and pain avoidance.

So, whilst the various scales may be good for specific research in specific groups, in the end we are thrown back on the realisation that spirituality is understood in different ways by different people. At the practical level, as Gordon et al (26) assert: 'The key to providing spiritual care is to understand what spirituality means to the person you are caring for' (p.5).

Spirituality and Different Worldviews

To fully comprehend the differences of understanding that exist, we need to take a look at different worldviews.

A worldview is a fundamental set of assumptions about the world in which we live, based on a 'controlling narrative' shared by people within a given culture. It acts as a lens through which we make sense of our experiences. Just as people are not conscious of the lenses in their eyeglasses as they read text, we are often not conscious of our worldview as we read the world around us. Nevertheless, our worldview alters our perceptions and can produce otherwise inexplicable conflicts between people of different worldviews. Radical theologian Walter Wink (27) asserted that there have only been a handful of religious/spiritual worldviews in history (see Figure 1.2). Wink described the 'Ancient' Worldview (Figure 1.2a). The narrative behind this worldview is that events on earth reflect events in the spiritual or heavenly realm. In this view, if two nations are fighting each other it reflects their spirits (or 'gods') fighting in heaven. The 'Spiritualist' Worldview (Figure 1.2b) is distinct from the modern-day spiritualist religion. The narrative here views the earthly, material realm as inferior to the heavenly spiritual realm. The material world is 'fallen' and true good can only be found on migration into the 'other-worldly' spiritual realm. The 'Materialist' Worldview (Figure 1.2c) became prominent at the time of the Enlightenment (mid-17th century) and is still powerful today. This view holds that there is no reality that cannot be reduced to purely material terms. The 'spiritual' simply does not exist, except perhaps as a psychological phenomenon explainable ultimately in terms of the physical world. The 'Theological' Worldview (Figure 1.2d) is a reaction to this, conceding the earthly, material realms to science and seeing the spiritual world as essentially separate or other worldly. This view is tartly criticised in the aphorism 'he is so heavenly-minded, he's no earthly use.' Finally, there is an 'Integral' Worldview, described by Wink as a 'new' worldview (though it, too, can be traced back to ancient times). This sees everything as having an inner (spiritual) and outward (material) aspect. We postulate that the integral worldview can be expanded into two variants, in one of
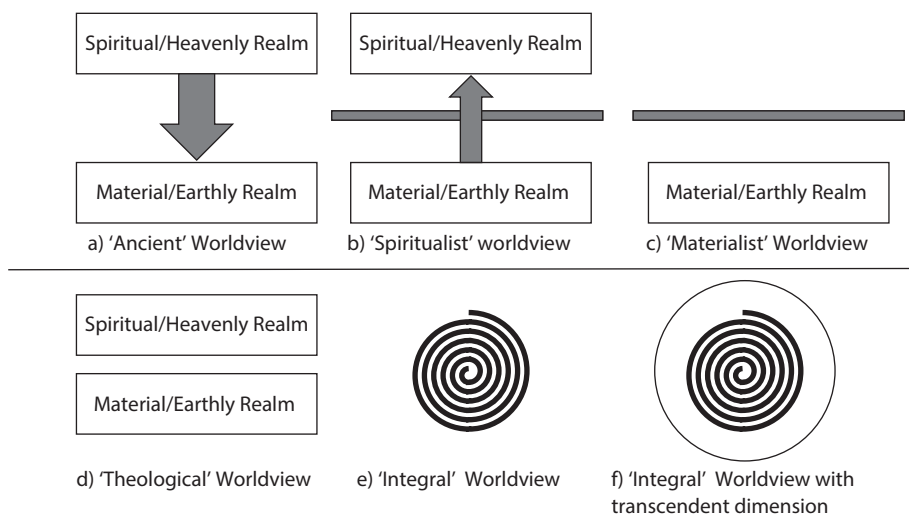
Figure 1.2 Different worldviews (27). The spirals represent an inner spiritual aspect and an outward material aspect.

which the whole of spirituality is associated with the material world (Figure 1.2e) and in one of which the existence of some kind of a transcendent, spiritual dimension beyond the material world is postulated (Figure 1.2f).

All of these worldviews and variants on them are still held by different people. Some are more powerful in one culture, some in another. Because these worldviews are largely unconscious, an individual's worldview may not be immediately obvious. Practitioners need to develop an understanding of their own underlying worldview and be sensitive to the potentially different worldviews of those they seek to help. To some extent our worldviews are culturally conditioned, but there will always be room for individual variation.

The Culture (Spirit) of Organisations

The focus on spiritually competent practice is one of the distinctive features of this text. The other theme that runs through the book is the importance of the organisational culture (what some might call the 'spirit' of the organisation) in facilitating or obstructing spiritually competent practice. Leadership is, amongst other things, about *inspiring* the organisation. In the armed forces people talk about *esprit de corps*, the shared spirit or morale of the service. Some see organisational spirituality as instrumental — a means to an end — as perhaps reflected, for example, in the title *The Handbook of Workplace Spirituality and Organisational Performance* (28). Karakas (29) conducted a detailed literature review on spirituality in organisations. He described problems in the workplace in defining spirituality (and distinguishing it from religion) similar to the issues we find in health and social care. Whilst recognising

the inherent moral and ethical objections to treating spirituality as a means to an end, he nevertheless concluded that attention to spirituality could improve organisational performance. He summarised his review under three headings:

- A human resources perspective (improved well-being and quality of life)
- A philosophical (or existential) perspective (sense of purpose and meaning at work)
- An interpersonal perspective (sense of interconnectedness and community)

Again, there are striking similarities with our discussions on spirituality in healthcare. Certainly organisations can foster a healthy spirit of co-operation and common purpose.

We agree with Karakas that spirituality is more than a means to an end. For us, an organisation has a corporate existence and just as individual spirituality is concerned with meaning, purpose and values, so corporate or organisational spirituality is concerned with the meaning, purpose and values of the organisation. What is the organisation *for*? The declared purpose of healthcare organisations is usually concerned with improving the health of those they serve. However, neo-liberal political theorists have argued that public services were subject to producer capture (30). This, it was alleged, resulted in them being run in the interests of the staff rather than the people using the services. Competition was claimed to be more efficient. However, a privatised health system can end up being run for profit rather than for the benefit of patients. Compromises don't always work well, either. Handy (31, p.20) argued that the internal market in the British NHS, designed to deal with inefficiency and to open up the NHS to commercial providers, was artificial and substituted bureaucracy for choice (perhaps a different kind of producer capture). What should be the chief aim of health and social care organisations: profit, producer needs or providing health and social care? What should be their values? To most of us the answers seem self-evident.

More importantly still, where the organisation's stated purpose and values are different from its real purpose and values, a kind of organisational dishonesty arises because of incongruence between what an organisation says it is there for and what it is really there for. If the stated aim is to provide healthcare but the governing principle is really an easy life for the workers (producer capture — not that we have ever witnessed that in the UK NHS!) or return on investment for shareholders, the spirit of the organisation is twisted and inconsistent. An organisation with a healthy spirit is one that is focused on its main purpose in life. In the case of health and social care organisations this means providing care for people that is not only technically effective and efficient but also compassionate and attentive at the interpersonal level. If we look at the spiritual competency equation discussed earlier in this chapter, the organisation with a healthy spirit optimises the conditions for practitioners to provide fully competent care. In other words, the organisation represents the opportunity (or in some cases the lack of opportunity) in the equation.

Some would argue that many of the current problems faced by the NHS have been the result of excessive focus on finance rather than healthcare, a proposition supported by the findings of the Francis enquiry (32).

No healthcare organisation is perfect, but some do more than others to 'provide an environment in which clinical excellence can flourish'. This was the stated purpose of *clinical governance* (33) introduced to the English NHS by the then Chief Medical Officer Liam Donaldson in the late 1990s. Scally and Donaldson (33) emphasised that they saw a danger in financial matters and activity targets coming to dominate NHS

Board agendas at the expense of clinical care and believed *clinical governance* would be an antidote to this. They believed that financial control, service performance and clinical quality should be approached in an integrated way. However, finance and targets have tended to dominate the agenda. There are many reports of falling quality of care resulting, at least in part, from external political pressures pushing for an NHS governed by market forces (see, for example, Francis [32]). However, as Griffiths (30) pointed out, the market is not in itself a source of morality and social justice. The NHS or any other health or social care provider needs to have an ethical and moral code and a spirit with values that focus first on good healthcare.

Perhaps not surprisingly, clinical professions have codes of practice that put patient care first. The General Medical Council (34) asks doctors to 'make the care of your patient your first concern'. The Nursing and Midwifery Council (35) expects registrants to put the interests of people using or needing nursing or midwifery services first. The Health and Care Professions Council (36) expects registrants to act in the best interests of service users. The British Association of Social Workers' ethical standards also expect members to 'respect, uphold and defend' the physical, psychological, emotional and spiritual integrity and well-being of every person (37, p.8). However, when practitioners work in organisations that have double standards it is hard to maintain professional standards. When organisations claim to put service users first but really focus their attention primarily on the balance sheet (or meeting centrally set targets) they unintentionally put obstacles in the way of staff striving to realise their professional standards.

Obstacles like these are not unique to healthcare organisations. Stephen Covey opens his book, *The 8th Habit* (38) with a series of statements, including:

> 'I'm stressed out; everything's urgent.'
> 'I'm micromanaged and suffocating.'
> 'I'm beat up to get the numbers. The pressure to produce is unbelievable. I simply don't have the time or resources to do it all.'

This sounds like working in the health and social services. Yet this and other comments come from Covey's experience of people at work in many organisations around the world. He describes these employees as neither fulfilled nor excited but frustrated. He asserts that there is an eighth habit that adds an extra dimension to the areas discussed in his best-seller, *The 7 Habits of Highly Effective People* (39). Covey describes the eighth habit as 'the voice of the human spirit'. He defines the management problem simply: 'We live in a Knowledge Worker Age but operate our organisations in a controlling Industrial Age model that absolutely suppresses the release of human potential' (38, p.15). He characterises the management task as 'finding your voice and inspiring others to find theirs' (p.26). According to him, this is not a linear addition to the seven habits but as an extra dimension that cuts across the other seven. Covey believes that we need a paradigm shift so that people are not treated as cogs in some vast machine. The paradigm he proposes is a whole-person paradigm symbolised by a circle with three segments representing mind, heart (emotions) and body, with the human spirit in the centre. Spirituality is something which is integral to human functioning. It needs to be found and nurtured in ourselves and in other people. It is the antidote to the poison of mechanistic ideas of management.

Only a spiritually healthy organisation will create the conditions in which the human spirit of employees can flourish and reach their full potential. This will create opportunities to support the human spirit

of people who use our services. One of the most important factors in providing spiritually competent care is the opportunity that the organisation offers (or fails to offer) to practitioners to make person-to-person contact with the people who use the services. Of course, resilient, spiritually competent practitioners will find ways to work around the system and be fully 'present' with the person, even when the organisation is dysfunctional. The self-care and organisational support which enables this is discussed in Chapter 6. How much better, however, if practitioners can work *with* the system rather than having to work *around* it or even *against* it to deliver spiritually competent care. In Chapters 11 and 12 we give two examples of organisations and projects that have, at least in part, created conditions that open the door to and encourage spiritually competent practice.

Different Ways of Knowing

Nomothetic Knowledge

In the context of providing healthcare with a spiritual dimension, John Swinton makes the very helpful distinction (based on Kant's philosophy) between *nomothetic* and *idiographic* knowledge (40). He describes nomothetic knowledge as knowledge gained by scientific methods such as experimentation and randomised controlled trials. This kind of knowledge is particularly valued in the materialist worldview and proceeds by developing and testing hypotheses. It is often concerned with *measurement*. According to Swinton, it has three key characteristics. It is *falsifiable*, *replicable* and *generalizable*. Knowledge is *falsifiable* only if it can be proved, at least in principle, to be untrue. A statement such as 'I love my dog' may be true, but it is not capable of absolute proof or disproof so does not belong in the nomothetic realm of knowledge. To be *replicable*, knowledge must be reproducible in situations other than the original experiment or clinical trial. Thus clinical trials are arranged on the basis that sufficient numbers of patients are enrolled in controlled circumstances to ensure that any differences between active drug and placebo are very unlikely to have arisen by chance. If a well-designed trial is repeated with a different group of patients with the same conditions, it is expected to replicate (yield similar results to) the original trial. Finally, nomothetic knowledge is *generalizable* to other populations with the same condition as those in the original studies. This kind of *empirical* knowledge figures strongly in the education of healthcare professionals and fits well with the notion of evidence-based practice.

Idiographic Knowledge

Idiographic knowledge is no less valid. It cannot be proved or disproved in the same way that nomothetic knowledge can be proved or disproved. It tends to be undervalued in the materialist worldview. However, it is open to rigorous scientific study mainly using qualitative rather than quantitative research. Qualitative studies are often concerned with *meaning*. As well as yielding results that cannot be found by quantitative enquiry, they sometimes enable hypotheses to be generated which are then open to a degree of verification using empirical methods.

How One Kind of Knowledge Can Lead to Another

Carl Rogers' classical research on psychotherapy provides a good example of how idiographic knowledge can lead to nomothetic knowledge. It is discussed here at some length because it is also relevant to how we teach and enact spiritually competent practice. Rogers' work initially depended on his detailed and honest exploration of what was happening as he worked as a child therapist. From reflection on these observations he described 'core conditions' of the therapeutic process (41), commonly summarised as follows:

Empathy — The therapist or counsellor understands the thoughts and feelings expressed by the client and communicates that understanding to the client.

Congruence — The therapist or counsellor is genuine and real in the relationship. This helps build trust in the relationship, and combined with the last of the core conditions it helps the client to have faith in their own perceptions and judgement.

Unconditional Positive Regard — The positive and non-judgemental attitude of the therapist or counsellor enables the client to speak about difficult areas without fear of criticism.

These conditions must also, at some level, be perceived by the client.

Rogers's core conditions have been verified by subsequent hypothesis-testing research over many years, summarised recently by Kirschenbaum and Jourdan (42). They also apply to human growth and personality development in the educational field. We believe they apply particularly to spiritually competent practice, supporting people in times of crisis, existential threat and ill health.

Preparing for Spiritually Competent Practice

Medical students and other health and social work students used to be encouraged to develop professional detachment to protect them against emotional exhaustion. This, coupled with the need to focus on the immense scientific and technical advances we have seen in the last 50 years or more, led to a curriculum that was unbalanced with too much focus on the more mechanical aspects of practice and not enough on the softer, interpersonal skills. Many older professionals learned their interpersonal skills from senior clinicians they worked with, in something akin to an apprenticeship model. More recently areas like communication skills have been incorporated into the curriculum but issues of spirituality and spiritual competency are only now creeping back onto an already over-crowded curriculum. In the United States, Puchalski has written extensively about and campaigned for spirituality in healthcare (especially medical) practice and education. Her work is summarized in her chapter Restorative Medicine (43) in the *Oxford Textbook of Spirituality in Healthcare*. Much of the impetus for these developments has come from practitioners working in end-of-life care like Puchalski, or geriatric medicine, where these issues are particularly pressing. There has also been input from the mental health field (44,45). In the UK, spirituality in nursing has been advanced especially by Wilf McSherry and colleagues (46–49).

Preparing students to practice competently in the area of spirituality involves much more than just teaching competencies. It involves different methods of learning. Respondents to Prentis et al (8)

commented that there were areas where teaching on spirituality appeared to have particular relevance. These included specific subject areas such as oncology and palliative care and more general topic areas, for example morality and ethics. They also commented on how spirituality could be taught, including stressing the following:

- Encouraging self-awareness
- Reflective learning
- Sharing and modelling by the lecturer
- Empathy and compassion

Strategies for learning included discussion, sharing, narrative and poetry. When teaching about spiritually competent care, educators found themselves working in a more equal relationship with students. Indeed, a feeling of lack of expertise was one of the obstacles to teaching cited by respondents to the survey.

Respondents to the same survey suggested that the necessity to cover so may topics in education tended to push issues like spirituality out. Whilst around 90% of the respondents agreed or strongly agreed that spiritual values were relevant to their subject area and nearly half thought that spirituality was integral to teaching and learning, only 17% agreed that it was actually integrated into their curricula. There is still a long way to go, despite obvious progress in recent years. One respondent summarised it neatly: 'the time-intensive reflective methods of teaching needed in this area tended to be squeezed out in a performance-oriented culture that valued activity above developing skills of self-awareness and empathy' (8, p.49).

At the postgraduate level, spiritually competent practice can be encouraged and supported by discussion in the multidisciplinary team setting and through continuing professional development (often also conducted on an interdisciplinary basis) and by supervision, coaching and mentoring.

Chapter 5 of this book is devoted to how we can integrate spirituality into undergraduate and postgraduate education across the health professions (including those social workers who practice in the healthcare setting), and Chapter 6 looks more specifically at how organisations can support practitioners in caring for themselves and maintaining their own motivation and mental health when working in stressful situations.

Importance of the Personal Connection in Education

In their discussion of the role of the humanities in professional formation, Carlin et al (49) focus on the educational application of person-centred approaches. They report four characteristics based on the Rogerian core conditions that facilitate learning. The first is a perceived 'realness' (congruence) in the facilitator of learning. Then there is 'acceptance' or a non-possessive caring for and trust in the learner (unconditional positive regard). The effective teacher has to have empathy with the situation the students find themselves in (and to teach the students to have empathy with the situations patients find themselves in). Finally, the students must be able to perceive these conditions to be present in the facilitator.

Conclusion

The issues of *meaning*, *purpose*, *hope*, *connectedness* and *values* are at the core of our understanding of spirituality. In healthcare practice, whole-person care must include attention to spiritual issues. The concept of spiritually competent practice provides a more solid basis for practice, education and research than trying to tie down the nebulous concept of spirituality itself. Spiritual competencies can be defined for educational purposes but spiritually competent practice requires more than just the competencies. In addition, it requires compassionate motivation, commitment and opportunity. Motivation and commitment are usually strong in students and one of the tasks of education and continuing professional development is to nurture, sustain and strengthen that motivation and commitment. Healthcare systems and organisations need to be set up to facilitate opportunities for (and not obstruct) spiritually competent care. The distinction between religion and spirituality is important even though it is acknowledged that, for many people, they overlap and are integrated. The place of religion and spirituality in a secular, multicultural society needs to be negotiated. This involves understanding different worldviews concerning spirituality; being self-aware and recognizing that patients and colleagues may have different worldviews. Being explicit about these differences can help avoid misunderstandings.

Not enough attention has been paid to the culture (spirit) of organisations. Organisations that have stated aims in conflict with each other or with their behaviour create a spirit of confusion which can obstruct spiritually competent practice. Healthcare organisations must give the highest priority to delivering good holistic healthcare, and financial and other centrally imposed targets must never take precedence over patient care. Attention to spirituality in the workplace can enhance staff and patient well-being and enhance the sense of community in the workplace. Neglect of spirituality and a conflicted spirit can obstruct good practice and result in poor quality healthcare. The principles of clinical governance introduced into the NHS in the late 1990s support the same conclusions but have sadly not been implemented in a wholehearted way, perhaps because of repeated re-organisations and conflicted purposes.

A different but related form of organisational conflict results from current management practice often being too mechanistic and failing to provide opportunities for staff to truly fulfil their potential. We believe this over-directive kind of management is ineffectual in getting the best performance out of people and additionally tends to reduce opportunities for spiritual care. As Covey (38) stresses, we all need to find our spiritual voices and support and develop systems in which others can find their voices, too. Later in this book (Chapters 11 and 12) some of our authors show that this kind of development is possible.

Issues concerning worldview are also reflected in different kinds of 'knowing'. The materialistic worldview privileges a reductionist (nomothetic) kind of understanding where that which can be quantified or measured is valued above the other kind of knowledge (idiographic) which can be investigated using qualitative methods. Idiographic knowledge is fundamental to human relationships and sense of meaning. These different kinds of knowledge are summed up in the aphorism 'what counts can't be counted; but what can be counted doesn't (necessarily) count' (51, p.13).

Developing and sustaining spiritually competent practice depends on the kind of idiographic relational interpersonal knowledge that complements the kind of nomothetic knowledge, usually used as a basis for evidence-based practice. Idiographic knowledge can be just as valuable as nomothetic knowledge. This is

demonstrated by the principles of empathy, unconditional positive regard and congruence derived from Rogers' qualitative reflections on his own therapy practice, subsequently confirmed using quantitative techniques and extended into other fields such as education.

Spiritual well-being overlaps with psychological well-being and spiritually competent practice overlaps with concepts like compassionate care and person-centred care. These overlaps will be further considered in later chapters, particularly Chapters 2 and 4. In Chapter 3 our authors develop more fully the understanding of what spiritually competent practice looks like. In Chapter 4 we have invited our authors to give examples of ways in which practitioners can exercise spiritually competent care. Chapter 5 examines educational aspects and Chapter 6 issues around how we support practitioners to maintain spiritual competency, particularly in less than ideal organisational environments. Then there are several practical chapters looking at how spiritually competent practice can be delivered in different healthcare settings. Throughout these chapters we have asked our authors to consider the quantitative and qualitative research evidence base but also, when appropriate, to include illustrative narratives. We finish with a chapter looking at how we might change healthcare education and delivery systems to better attend to the spiritual needs of practitioners and patients and how we might use research to improve the already extensive evidence base for good practice in this area.

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