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CRITICAL REFLECTION ON PRACTICE DEVELOPMENT

An enquiry into the spiritual

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Abstract
Background: Responding appropriately to the spiritual needs of patients can be contentious and complex yet faced with the overt suffering of a patient, nurses or therapists find themselves in a position where they must respond. The complexity of response is illustrated through a narrative of my work with one patient in a hospice setting. Narrative opens a dialogical space to invite and explore such ideas and practice in a critical manner with the aim of creating better worlds for both patients and practitioners.
Aims:

- To reveal the complexity of spiritual response through reflection on one particular experience constructed as a narrative
- To problematise the idea of suffering as something easily reduced into the physical, psychosocial and spiritual

Conclusions: The spiritual response is not something that can be prescribed as technique. Rather it is a reflection of the practitioner's own spiritual being and not confined to a dichotomy between the scientific and theological.
Implications for practice:

- Practitioners can use reflective practice as a powerful means for practice development on individual and organisational levels
- Suffering is the major focus for care in that it transcends any reductionist attitude
- For those patients approaching death, issues of the 'spiritual' are often of greatest concern and yet disguised, requiring a sensitive and empathic approach free from attachment to concrete ideas of what the spiritual means

Keywords: Spirituality, suffering, reflection, narrative, practice development

Introduction

As a therapist working in a hospice, I continuously enquire into the nature of dying for the patients and families with whom I work. It is this enquiry that shapes my response to the dying process and challenges any habitual responses to dying that govern practice across the various disciplines that constitute the 'healthcare team'. As part of this team I am invited to offer feedback about my practice and, in doing so, contribute to an ongoing interdisciplinary dialogue that is concerned with achieving best practice. Such dialogue is laudable but much of clinical practice is grounded in routine that is largely non-critical and resistant to change, even in the face of evidence in favour of such change.

An area of persistent concern is the spiritual realm of practice, and the question of what mystery lies beyond the mortal veil. Working in a hospice, I face this mystery within each encounter I have with patients and relatives. It could be the subject of endless debate yet from a practical point of view I, like all healthcare practitioners, must endeavour to come to terms with the finite nature of life. This is not necessarily an easy task given that cultural patterns render death hidden, embarrassing and ultimately lonely, as if it were a plague on the living (Elias, 1985). We may try to shrug these attitudes aside but they remain a constant background to clinical practice.

I believe that all professional clinical practice development, on an organisational or individual level, should be focused towards realising a vision of practice as a lived reality. Through reflection on experience, the practitioner is able to reveal any contradiction between their vision and their actual practice. There is a learning opportunity in understanding why this contradiction, or creative tension, exists and ways in which it can be resolved. An analysis of creative tension allows the factors that prevent a vision being realised as a lived reality to be understood and addressed (Johns, 2013). Within this process, the practitioner can explore the meaning of their vision as something lived. However, as we shall see, visionary words are seductive but not so easily realised. This learning or development is more likely to be effective within an expertly guided community of enquiry, leading to shared insights and a culture of practice development: the old maxim 'many heads are better than one'.

My vision as a therapist working in a hospice is to ease suffering, a vision enshrined in the World Health Organisation (WHO) definition of palliative care (1990):

> *'Palliative care is an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of* ***suffering*** *by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and* ***spiritual****' (emphasis added by author).*

This definition identifies the spiritual as a potential problem within the broader concept of suffering. Yet, without doubt suffering is complex and not easily reduced into parts, contrary to what is suggested by the WHO definition. Cassell's (1982, p 639) succinct description of suffering is 'distress brought about by an actual or impending threat to personal integrity'. My perspective is to view suffering as a disruption of the spirit that manifests itself in specific behaviours unique to the individual. Yet, what is spirituality? Obviously, it is related to the spirit rather than anything tangible or material but there is much debate over its meaning and the role of the healthcare practitioner in responding to the patient's spiritual needs. A review of the contemporary nursing literature shows that a spiritual approach has historically been divided between the scientific and the theological. The scientific approach is fundamentally instrumental, in that spirituality can be known and responded to as a technique. Proponents of this approach include Leeuwen and Cusveller (2004) and Gordon and Mitchell (2004). The theological approach suggests that the spiritual is a quality of the practitioner that manifests itself as a way of being. As such, it is not instrumental but played out within each human encounter. The theological perspective is reflected by Wright (2002, p 125):

> *'Spiritual care is based on the assumption that all people are spiritual beings. It recognises the relationship between illness and the spiritual domain and acknowledges the possibility of a search for meaning in the big questions of life and death. It responds to religious and humanistic needs by meeting both the requirements of faith and the desire for another human being to "be there". Fundamentally, spiritual care seeks to affirm the value of each and every person based on non-judgmental love.'*

In contrast to these prevailing views, I view spirit as the potency of the life force, by which I mean the energy that infuses the body with life. As a therapist I work with energy and, through experience, I

have come to feel or sense a person's life force, especially in people who are dying. The focus of my practice is to work with the person's life force, not to strengthen it but to balance it so they are most comfortable. I intend to illuminate this intention through my narrative of working with a particular patient, Lily (see below).

Narrative is constructed from stories of experiences I have reflected on in order to communicate my insights. These insights are planted in the narrative for the reader to discern and to open a dialogical space with the text (Johns, 2010). The reader is invited to dialogue and to be challenged to reflect critically on their own experiences and their response to suffering. Dialogue, as communicative action, requires an honesty about one's assumptions, which needs to be cultivated in a climate of openness (Bohm, 1996).

Perhaps more powerfully, the narrative might be read at an interdisciplinary session to engender collective dialogue with the intention to move the group to social action and change. In such a situation, I might pose the questions:

'Are we perceptive enough of individual suffering and our response to it?'
'Are we good enough at discerning and responding to patients as spiritual beings?'
'Are our perspectives of the nature of the spiritual too restrictive?'

Narrative

Lily lies on her bed overlooking the green garden adorned by flowers in bloom. There are Zen-like stones, carefully placed to create an aesthetic sense of the spiritual perhaps. A gently flowing water feature holds the gaze. A hospice more a work of art to look at than a home to live in? You might think that such a pleasant view could transport Lily beyond her muted suffering but you might think the contrary, that it might reinforce the sense of being alone; dying is often lonely, experienced within an emotionally tiny, enclosed world (Elias, 1985).

I imagine Lily's silent cry across the garden: 'It is lonely facing death', despite the gathering family and friends who surround her, anxious to comfort in order to comfort themselves in the face of death. Her son sits in a shadowed corner playing with his camera. Lily is a water colourist, though she plays down the tab 'artist'. She is painting cards as a contribution to the charity shop. A legacy. Her art is exquisite. Simple landscapes. Possible views from a hospice window in greens and blues. There's an old wives' ditty: 'Blue and green should never be seen except with something in between.' But what does it mean?

Lily says:

'I have breast cancer and I'm now terminally ill. I had a stroke recently that affected the right side of my body. At first I couldn't use my hand. This interfered with my painting. Without my painting I have no reason for living. I did get back most of my arm and hand use through squeezing the sorbo-ball but I can't move my right leg. I am in despair at the loss of mobility and the increase of dependency on others for assistance.'

Lily's words drift into silence. I ask:

'How does your leg feel Lily?'

She says:

'It feels dead.'

I respond:

'Would you like me try and help?'

Earnestly she replies:

'Yes, yes please do something, anything to help me.'

Desperation ripples through her voice. The son takes this moment to bow his retreat. He seems uneasy and I wonder about his feelings.

The footboard at the end of the bed refuses to budge and so compromises my movement as I approach her feet for reflexology, forcing me to adapt my position. I mix my reflexology cream using lavender. Lily loves the aroma, it reminds her of her garden with its banks of lavender. I tell Lily that lavender 'gently lifts the weight when suffering covers the spirit like a suffocating blanket' (Worwood, 1999, p 225). I simply plant the idea, as if as a placebo.

My hands hold her feet, listening to her story and her body before I move into therapy. Listening deeply to Lily's anguish, I attune myself to the emotions or pain that lie beneath her words and actions of discord. She talks when I would prefer her to relax. Yet it is her therapy, her space; and I know that when someone is bothered and when another genuinely bothers to listen, such moments are precious.

I cannot feel any energy in either foot but after about ten minutes I feel energy begin to enliven her left foot. And then she wants the commode. She presses the orange call bell. In no time a care assistant enters the room. I introduce myself and offer to help with the commode. Although we have not met before, the care assistant ignores my greeting and declines my help, saying: 'It's nurses' work.' She presses the bell for assistance. We wait until another care assistant enters. Lilac uniforms bent on the task. I might ask: 'What price dignity?' I move outside the room. I sit in the corridor for about ten minutes and then the room is clear. A slight glance as they pass me. No word, no recognition. We have no connection. I am marginal to their existence. I am reminded of Rael and Marlow's (1993) work on lifting energy, and how these care assistants' response threatens to depress my spirit rather than lift it. Focused on the task, they miss the point. If every care worker was mindful of cultivating 'lifting energy', the impact on healing would be dramatic. Being lifted I naturally lift others. As Rael and Marlow write (1993, p 88): 'If we are being lifted, others are lifted as well without necessarily being conscious of the process.' As such, the 'spiritual' has this significant environmental presence that challenges any idea of the spiritual being an individual phenomena.

Picking up the thread I retune into Lily's wavelength. Regarding the care assistants' manner, I reflect that Lily is not a task unless you reduce her to an object to do things to. Perhaps the core of any spiritual encounter is its humanness.

This time I hold Lily's right foot. Again the energy is slow to kick in. Another ten minutes have passed when Lily exclaims:

'Why won't God take me?'

Taken by surprise I say:

'Lily, what is it?'

She replies:

'I'm being moved into a nursing home on Saturday. I don't want to go. I want to stay here.'

I sense the dilemma: she is comfortable here. Shifting her adds to her suffering. Yet the hospice needs to free the bed for other, more needy people.

She laments:

'God has forsaken me.'

A cry I have heard before from others in despair. How should I respond for the best? I sense there are no ready solutions to such questions. As it is, I say:

'God will come for you when he is ready.'

A throwaway line that arose from somewhere within. My pulse quickens from moving onto more sacred ground. Lily is silent. We are silent. After 20 seconds or more I break the silence. Any longer and the silence would have become uncomfortable.

I offer:

'Perhaps you have things to do? Your watercolours for example?'

Again Lily is silent.

Perhaps I should simply dwell in the silence, mindful of its therapeutic value, but after about 20 seconds I add:

'Have you talked to the chaplain?'

The stereotypical band-aid – hand the problem up a level. Yet I feel the limits of my capacity to respond well. Lily's eyes engage mine:

'Yes, but to no avail.'

The ball is back in my court. Her eyes move across the garden. I sense the turbulence deep within her. We scratch at its surface as if it were an itch. I am being drawn into her suffering. Sensing I must respond to help her fix her despair, I say:

'Would you find comfort in the scriptures. Perhaps daily reading?'

I am falling back on old tactics. I remember the benefit of daily readings for Margaret when I had not known how else to respond (Johns, 2004). How it had helped her ease her angst with God. But Lily responds:

'No, nothing I read makes any sense.'

Persevering, I add:

'If I was in your predicament I would read the Dharma, preparing myself for death as best I can.'

She is a Christian. I am a Buddhist. Does that make a difference? I am mindful not to impose my values onto the situation.

Lily is again silent. I imagine she thinks about what I say. Silence is not passive. It is active and compassionate listening to the other's story. Indeed, silence nurtures empathy and compassion; what has been termed compassionate silence, in contrast with an awkward silence where I might feel uneasy. Salzberg (1997, p 103) writes:

> *'Compassion is the strength that arises out of seeing the true nature of suffering. Compassion allows us to bear witness to that suffering, whether it is in ourselves or others, without fear; it allows us to name injustice without hesitation, and to act strongly, with all the skill at our disposal.'*

Perhaps this is what Wright (2002, p 125) means by 'non-judgmental love'?

I continue to hold Lily's feet, gently massaging them in the renewed silence as if touch connects me with Lily and lifts her despair. A further ten minutes have passed when I finish. Lily opens her eyes. She smiles:

'My foot feels warmer, I felt tingling up the leg into my hip. It was the dead leg coming alive.'

A spark of hope and with it, a moment's optimism. Tangible outcomes bring comfort. She says:

'The touch was so comforting, I was transported into another place.'

I imagine a place beyond suffering. Jones and Jones (1996, p 184) write:

> *'Touch is the harmonic healing the grieving spirit craves. Then experience the peace that follows. It will close the circle.'*

I like the idea of closing a circle that has been broken open. It is symbolic of wholeness and healing.

My parting words to Lily, 'I wish you well on your journey' were meant on two levels: first, her transfer to the nursing home and second, her death and union with her God. On reflection, I wonder whether I helped Lily in some small way? Did she become more reconciled to her God? Was she less lonely? I doubt it. However, these are not easy questions and I must not get drawn into them. The task of finding the right word and gesture falls heavily on me (Elias, 1985). Spontaneous discourse with the dying requires a letting go of reserve. An opening of the spirit rather than the mind. As Elias (1985, p 28) writes:

'Unembarrassed discourse with or to dying people, which they especially need, becomes difficult.'

Later I meet with the chaplain to reflect on my work with Lily. In doing so, I seek communion but not affirmation. The chaplain reflects on her own conversations with Lily, recognising that, like me, she cannot fix Lily's despair but that opening a space for Lily to talk and be listened to is most beneficial. She, too, is sceptical of any technical approach to the spiritual.

In talking with the chaplain I recognise that Lily's art is a reflection of her spirit. It is her life force and that potency had been lost, which distressed her. Rather than talking about God perhaps I should have talked more about her art. But in the moment such things are obscure. Her lament about God had been a sign to the real problem, not the problem in itself.

Inspired, I ask Otter whether she might spend some time with Lily. Otter is both a nurse and artist. Some days later Otter takes me aside and shows me some artwork and words Lily has done with her. I am struck by the native American imagery and words. Just one example:

'Tipi smoke
Blue and black across the plains
I spin
For a moment caught by a wisp
Set me free oh wise one.'

In a 'light bulb' moment, I realise God is an interpretation and the futility of an instrumental-theological dichotomy on spirituality. Like the plains it is vast and ineffable. I realise how the specific nursing literature has narrowed my spiritual view.

The troubled spirit is deep and complex. There are no fixes for Lily's despair. All I can do is open a space for Lily to find her own way, her own reconciliation with her God, her true companion on her journey. Like Otter, I am an itinerant healer, someone Lily happened upon on the journey, and yet how we respond would seem vital in pointing her in the right direction. I can acknowledge my own discomfort in absorbing her suffering so my learning can become more poised and my compassion can flower. If we see the spiritual as a technique to be applied, we go down the wrong track – a track I sense we are led down by the development of spiritual competencies such as those prescribed by Marie Curie Cancer Care (2003), which promote a technical approach. There is a more diverse literature on spirituality, to which I turn for deeper enlightenment, for example, *Anam Cara* (O'Donohue, 1997), and which immediately transcends any spurious dichotomy between technical and theological approaches to the spiritual. It opens a broader vista, grounded in the human spirit. O'Donohue (1997, p 26) writes:

'Everything that happens to you has the potential to deepen you.'

These words illustrate the potential of reflective practice to enable the person (reflector) to pay attention to and learn through experience. Yet the word 'potential' hangs heavily; reflection benefits from guidance to nurture this potential.

I am left wondering what would have been the right thing to say to Lily. Might I have said the wrong thing and added to her suffering? Knowing the right thing to say is a tricky business. But perhaps a compassionate silence is more important. As I have explored before, nothing can be known for certain (Johns, 2009). For me, reflection is a constant enquiry leading to an increasing mindfulness that enables me to pause within the moment as if to weigh up my intuitive response. In doing so, I move out of the question into the mystery (Sweet, 2004) for, without doubt, everyday practice is uncertain and unpredictable – what Schon (1987, p3) describes as the 'swampy lowlands' where the problems that face practitioners have no determined solutions. Perhaps we get caught up in the question, in the futile search to create certainty. Dwelling in the mystery we can learn to become more mindful and open the gate to professional artistry so we can practice more easily and more effectively within the swamplands. For me, the key to professional artistry is the development of the wisdom to weigh up things for what they really are, rather than the application of knowledge. Hence knowledge loses any prescriptive power. Professional artistry is also the ability to respond skilfully and compassionately based on wisdom while mindful of potential consequences.

As I have mentioned, this narrative opens a dialogical space to invite an audience to reflect on its own experiences of finding practical meaning in such words as 'spiritual' and 'suffering', to challenge critically accepted ideas and practice, and to dwell within the mystery. Narrative does not merely refer to past experiences but creates experiences for the audience. Narratives mean to be provocative. As Mattingley (1998, p 8) writes:

> *'Narrative offers meaning through evocation, image, the mystery of the unsaid. It persuades by seducing the listener into the world it portrays, unfolding events in a suspense-laden time in which one wonders what will happen next.'*

I wonder, should I take the two care assistants aside and ask them to reflect with me on our encounter with Lily? This would seem to fit into a culture of practice development where every experience becomes a developmental opportunity. But I fear that their response would be defensive and as a consequence, my action might be counterproductive. Even within the interdisciplinary group, individuals might turn away and mutter 'this is rubbish', despite my opening gambit urging people to be open to what is shared. I might naïvely imagine that all people who work in a hospice are dedicated to best practice but it is not so. People are locked into habitual patterns of seeing and responding to the world that reflect a limited perception; words like dignity, diversity and compassion are interpreted within these limits. As McCormack et al. (2013, p x) write, practice development is to 'shake off a legacy of routine and ritual and embrace approaches to practice that privileges the individual in context'.

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