Chapter 2 Spiritually Competent Practice and Cultural aspects of Spirituality

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Abstract

In this chapter we introduce the concept of spiritually competent practice as a way of avoiding disputes about the definition of spirituality and avoiding confusion with religion. Spiritually competent practice is described. It involves compassionate engagement, supporting people in sustaining a sense of meaning and purpose even when it is challenged by suffering and illness. It addresses the whole person' as a unique individual, in the context of their family and cultural connections. As well as specific competencies it requires personal qualities, including the capacity to form *I-Thou* relationships and a managerial system that enables practitioners to attend to personal as well as technical aspects of health care. An ontological model for lifelong learning through reflective practice is presented. Availability and vulnerability, a framework relating to personal qualities and specifically developed in research with APNs, is described and illuminated by a case study. This can also be understood within the overarching description of spiritually competent practice. We have looked briefly at how to take into account cultural issues without forgetting that individuals within a culture also have their own personal understanding of what spirituality means to them which is not necessarily congruent with their cultural background.

Key Words

Spiritually Competent Practice, cultural competency, compassionate engagement, Trans-cultural nursing care.

2.1 Why Spiritually Competent Practice?

The first chapter explored the difficulties of defining (and measuring) spirituality. The different definitions and the overlap with religion have caused difficulties both for research and practice. Although religion is one way of experiencing and expressing spirituality, *Spirituality* is not synonymous with religion (Richardson 2014, Wattis et al., 2017) especially in a multi-cultural, secular society. Because religious practice can be addressed in *quantitative* terms whereas spirituality is more subjective and harder to evaluate, religion is sometimes used as an imperfect surrogate for spirituality in research (Koenig, 2012). In practice too, entering a patient's religion on a form may be a substitute for addressing spiritual issues. We developed the concept of spiritually competent practice as a response to these issues. It embraces religious and non-religious manifestations of

spirituality and emphasises the pivotal importance of the relationship between practitioner and patient and the practice environment, as well as specific competencies. It arose from an observational study by one of our occupational therapy colleagues (Jones, 2016). She elucidated and described the behaviours that were characteristic of good practice in spiritual care. From her description members of our spirituality research group derived a description more generally applicable to all disciplines working in healthcare (Wattis et al., 2017). Subsequent research (Rogers *et* al, 2020) has caused us to modify the description and, in its latest iteration, we characterize it as follows:

> *Spiritually Competent Practice involves compassionate engagement with the whole person as a unique human being in ways which will help them find and sustain their sense of meaning and purpose, where appropriate maintaining or restoring connection with family and community, addressing suffering and promoting wellbeing, this includes the practitioner accepting a person's beliefs and values, whether they are religious in foundation or not, and practising with cultural competency.*

2.1.1 The core: helping people sustain a sense of meaning and purpose

When a group of health care educators were asked to provide personal definitions of spirituality, several themes emerged (Prentis et al., 2014). Firstly, an understanding of the self, person (or personhood) and being, were central to our respondents' understanding spirituality in education and practice. Second, spirituality was that which gave a sense of direction, meaning and purpose to life. Finally, far from being "other worldly", spirituality in healthcare was practical, affecting people's values and how they lived and acted in relation to others. Sensitivity to a person's sense of direction, meaning and purpose, their connection with other people (as well as the transcendent) and their beliefs and values are fundamental in spiritually competent practice. This is true, whether or not these are linked to religion. That is why, rather than arguing about a precise definition of spirituality, we preferred a brief description of how practitioners operationalise spiritual care in practice.

The importance of finding meaning in life was also at the core of Viktor Frankl's understanding of how people coped with the immense suffering in the concentration camps of the second world war (Frankl, 2004). His observations led him to assert that finding meaning, through love, through dedication to a life's work or even through coping with unavoidable suffering was a fundamental part of human nature. All of these are relevant to spiritually competent practice. Compassionate engagement cannot happen without love. Many practitioners can and do find meaning in their work and we are often in contact with people who need to find meaning in unavoidable suffering.

2.1.2 Relationship: compassionate engagement with the whole person

This issue of compassionate engagement reflects the person-centred care movement, originating in various strands of 20th century thinking and practice. The philosophical roots of this can be found in the works of Martin Buber whose seminal work *Ich und Du* was first published in German in 1923 and translated into English as *I and Thou* by R.G. Smith in 1937 (Smith, 2013). Buber described two 'basic words' *I-It,* through which we experience other people as objects and *I-Thou* through which we relate to them person-to-person. *I-It* described an attitude in which the other is an object to be understood analytically (corresponding to the neo-Kantian concept of rule-based *nomothetic*, knowledge) (Swinton, 2012). Buber argued that we can (and often do) treat other people, as well as inanimate things, as objects; but when we truly *relate to them* as other *subjects,* then this is a person-to-person *I-Thou relationship* (equivalent to Swinton's subjective, experiential *idiographic* knowledge). Both *I-Thou* and *I-It* modalities are necessary in clinical practice. Abramovitch and Schwartz (1996) conceptualised this as a 'three stage dialogue' in which the opening phase is establishing the *I-Thou* relationship, the second stage involves various *I-It* analytical procedures

(examination, tests, etc.) designed to identify or exclude specific disease entities and the final stage involves *I-Thou* integration through dialogue or "healing through meeting". This over-simplifies the process but reminds us that the both the *I-Thou* relationship and the *I-It* approach of analytical science have important parts to play in the healing encounter.

In the Francophone world Buber's ideas were taken up by Paul Tournier's *Medicine de la Personne* (Cox, et al., 2007). Tournier was described by Frankl as the pioneer of person-centred psychotherapy (Pfeifer & Cox, 2007). In the USA, Buber's ideas influenced Carl Rogers' development of the concept of client-centred therapy (Rogers, 2003; Anderson & Cissna, 1997). This developed into the widely applied person-centred approach (McCormack & McCance, 2017). In the UK, Kitwood (1997) developed person-centred care in dementia and explicitly acknowledged his debt to Buber, commenting that the *I-It* mode implies "coolness, detachment, instrumentality" whereas:

> "Daring to relate to another as Thou may involve anxiety or even suffering but Buber sees it as the path to fulfilment and joy." (Kitwood, 1997 p10)

The availability and vulnerability framework which Melanie Rogers presents in this book clearly relates to the *I-Thou* concept, highlighting the importance of holistic person-centred care.

The World Health Organization also endorses a 'people-centred approach' (WHO, 2015), the collective noun making room for a public health focus. In everyday practice, we prefer 'person-centred' over the terms 'people-centred', 'client-centred', 'consumer-centred' or even 'patient-centred' because 'person-centred' emphasises the whole person rather than casting them in a role as 'patient' or 'client' or 'consumer'. In England the policy makers who lead and direct the National Health Service (NHS) developed a new concept of 'personalised care' which focuses on the transactional aspects of care and seems to slightly miss the original point that person-centred care is focused on the quality of interpersonal relationship (NHS England 2020).

Person-centred care demands compassionate engagement. The deeper roots of this can be found in many religious traditions. The Hebrew bible uses the concept of *chesed (*חֶסֶד*),* commonly translated into English as steadfast love or loving kindness, the Greek new testament uses agapē (Ancient Greek ἀγάπη,) for a similar concept; Islam, Buddhism and several other religions have similar words (Templeton, 2000). Humanists, too, see the idea of loving kindness (like mindfulness, often borrowed from Buddhist thinking) as foundational to a good life. Educators of health professionals, including nurses have pleaded for humanism (in the sense of human connection) and compassion to balance the technical and corporate aspects of healthcare (Nelson, 1995; Gaufberg & Hodges, 2016, Younas & Maddigan, 2019).

Whole person or *holistic care* emphasises the importance of considering all aspects of the person when planning care: biological, psychological, social *and spiritual* (Sulmasy, 2002; Rego & Nunes, 2019). The old-fashioned biomedical model of care historically followed by medical colleagues (sometimes referred to simply as the 'medical model') focused on technical issues of diagnosis and treatment. The biopsychosocial model was proposed many years ago as an alternative to the biomedical model, initially in psychiatry, and soon extended to cover the whole of medicine (Engel, 1977, 1980, 1992). Borrell-Carrió et al (2004) reviewed 25 years of the biopsychosocial model and stressed the importance of relationship factors in its realisation. Nurses have often been seen to adopt holistic approaches to care which treat people as complete physical, mental and spiritual persons in a social context (McCormack & McCance, 2017, Sulmasi 2002). However, with the continuing emphasis on technology in healthcare, this has sometimes been neglected (Wattis et al., 2017).

2.1.3 Context: maintaining or restoring connection with family and community

This part of spiritually competent practice is another aspect of holistic care, important for all but especially important when caring for children, for those with long term health problems, for those receiving mental health care and for those in critical care or end-of-life care. Health care problems may disrupt relationships with family and friends so practitioners need to ensure contact is maintained where appropriate. This can be especially important in mental health care where family breakdown is common. Further, in some cases of alcohol or drug abuse re-connecting with a community where abuse is common may need to be discouraged and connection with a new community (such as Alcoholics Anonymous) may be better. In some mental health problems, a person's beliefs may be delusional and a sign of illness impacting how a practitioner manages them. Finally, though research shows that in most cases religious practice is helpful to mental health (Koenig et al., 2012), occasionally religious communities may have a negative effect on mental health.

In healthcare for children, the importance of family contact has long been recognised, especially when children are admitted to hospital, though there are issues about its implementation (Shields, 2010). In critical care and palliative care (Richardson, 2014) maintaining connection between patients and their friends and relatives is seen as an important part of spiritual care. This has been emphasised during the coronavirus pandemic when patients in intensive and critical care have not always been able to have visitors but clinicians, especially nurses, have found ways of maintaining the contacts in difficult circumstances. Beyond any current problems we are helping people through, life will flow on and we need to help maintain links between seriously ill people and their family and friends. If the person survives this will help them smoothly restore their relational context, in due course. But some of the most important consequences are for friends and relatives of those who die, if they can be assured that their loved one did not die alone and comfortless.

2.1.4 Purpose: addressing suffering and promoting wellbeing

Suffering can be physical, emotional and/or spiritual. Physical and emotional suffering must be addressed in any holistic approach to care; but it is easy to neglect *spiritual suffering.* This can best be understood by the existential questions people ask (and answers they give themselves) when going through ill health (Wattis et al., 2017). Patients newly diagnosed with cancer may ask themselves "why me?" or "why now?". The relatives of people who die unexpectedly in an accident may ask "why did it happen to them/us?" Family carers for people with serious chronic illnesses may seek meaning for themselves and their loved ones in coping with the problems it brings. Essentially, these "what's it all about?" questions are about the meaning of an illness or death for the people concerned. People need space to ask these questions and support in finding their own answers. Practitioners who relate to people in a *I-Thou* way can help provide that space by being present, engaged and attentive. As far as possible we need to support people in finding answers that help them to resolve their spiritual distress in a way that helps them move forward positively. This is one way of promoting wellbeing.

2.1.5 Respect: for the person's beliefs and values

Provided they are not pathological, respecting a person's individual beliefs, values and culture are essential in any helping relationship and flow naturally from embracing their status as a person. This respect demands that we are self-aware about our own beliefs and values and aware that the person we are dealing with may be different from us in their way of responding to ill health. This, of course, includes cultural sensitivity and competency which are explored later in this chapter (and throughout much of this book).

2.2 What is needed for Spiritually Competent Nursing Practice?

Spirituality and Trans-cultural Nursing care perspectives:

It is a fundamental aim of nursing and midwifery to promote patients' holistic care needs including; mental, physical and spiritual wellbeing (Jubilee Centre for Character and Virtues 2017). Spiritual and existential care competencies are best expressed within the context of person-centred practice and compassionate presence (Ali and Lalani, 2020; Benner 1994). A competent nursing care practice necessitates a compassionate- caring presence with authenticity and vulnerability (Ali and Lalani, 2020; Wattis et al, 2019). Such nursing care, requires embracing spiritual care core values such as; availability, active listening, respecting privacy, dignity, providing support and reassurance with empathy (Schwartz et al, 2021; Rogers, 2016).

Over the last three decades, spirituality has received special attention in nursing education and practice (Ali et al, 2018). There has been a continuous development around understanding the scope of relating spirituality, spiritual concepts: such as spiritual experiences, spiritual pain, spiritual distress among patients and families in diverse cultural settings (Lalani and Ali, 2020). Several nursing theorists have recommended that nurses should embrace transformative care practices that can accelerate the process of developing self-awareness in a patient by expanding subjective consciousness and enabling transcendence on an intuitive level, to promote inclusive and holistic care (Ali, 2017; Newman, 1999). Self-awareness is essential in developing nurse-patient therapeutic relationships and personal reflection in recognising culturally competent, equity-based, existential and spiritual care needs for empowerment (Wattis et al, 2022; Ali and Lalani, 2020). However, many nurses have reported lack of preparedness in meeting the spiritual needs of their patients due to; '…mismatch between the expectations of education and the reality of practice' (McSherry 2000, p. 40; Ali et al, 2018). Challenges were identified in addressing spirituality in nursing education. These challenges included fear of rejection by offending others due to lack of clarity about diverse cultural values and religious beilefs, confusion related to role expectations of nursing professionals, and the inadequate representation and emphasis on spiritual care in nursing education and practice (Ali, 2017). It requires strong nursing standards based on sound philosophical structures, to guide the curriculum and practice environment reflecting the core aspects of spiritual care competencies.

Following paragraphs propose a way forward to integrate trans-cultural spiritual care competencies into nursing education and practice:

Spiritual care competencies and Nursing care:

The conditions for spiritually competent practice are threefold. People need to learn *spiritual care competencies* relevant to their area of practice. They need to develop and sustain *personal (ontological) qualities* relevant to their vocation (sometimes known as "professional formation"; Carlin et al., 2012) such as compassionate motivation. Finally, they need a working environment that it is organised in such a way as to provide *opportunities* for good practice. These three conditions are interdependent and interrelated. For example, when a person is learning to work in a new field their competencies may be gradually developing; but if they have the requisite personal qualities their practice may already exhibit a degree of spiritual competency. However, even a person with well-developed competencies and personal qualities will find it hard to provide spiritually competent care in an environment which does not allow time for developing compassionate engagement with the patient. Sometimes this is difficult to avoid if a practitioner is called away to an emergency when a patient is in the middle of sharing their spiritual needs; but even in this sort of situation a spiritually

competent practitioner may be able to find ways of compensating, perhaps by apologising when they are called away and promising and remembering to return to the conversation later. An 'industrialised' task-oriented approach to nursing, seen by some politicians and managers as a way of increasing productivity, makes it much harder to deliver truly competent care. The 'Tyranny of Metrics' (Muller, 2018; especially chapter 9) with a centralised style of management focused on performance targets can add to this problem. Managers, too, need spiritual competencies and a person-centred approach to *their* work. For a fuller discussion of management and political issues see Wattis et al., (2022).

2.2.1 Spiritual Care Competencies

Spiritual care competencies have been developed in Europe for undergraduate nurse training (Enhancing Nurses' Competence in Providing Spiritual Care through Innovative Education and Compassionate Care (EPICC), (McSherry et al 2020). Briefly, competencies include reflective practice and focus on self-awareness, skills in connecting with and addressing spiritual issues with patients and skills in developing a practice environment that enables these skills to be exercised and emphasised in specific areas like critical care (Savel & Munro, 2014). In palliative care in the United Kingdom specific competencies have been developed on a multidisciplinary basis (Marie Curie Cancer Care, 2004). Spiritual care competencies in the context of Advanced Practice Nursing are discussed in chapter 3 of this book. The important thing to note here is that *spiritual care competencies* are best expressed within the context of person-centred practice and compassionate, trusting, open relationships that demand personal qualities in the nurse to enable compassionate engagement.

2.2.2 Personal (ontological) qualities

This refers to who (or what kind of person) we are, rather than what skills or knowledge we possess. The ability to be truly present with a patient, the moment we meet them and throughout a consultation, demands qualities of self-awareness and self-discipline. *Compassionate engagement* flows from a well-developed capacity to connect with the other person through person-centred, *I-Thou* relationships.

Rogers' (2016) availability and vulnerability framework for developing this capacity is discussed in detail in chapters 5 and throughout the chapters from different countries. Here we offer an additional model, based on the philosophy of humanistic psychology to completement the necessary personal qualities needed by health care professionals to offer spiritually competent practice. The core of this is ***S****elf-exploration* that focuses on ***O****ntological,* ***P****henomenological,* ***H****umanistic,* ***I****deological and* ***E****xistential questions* (SOPHIE figure 1) (Ali, 2017, Ali and Snowden 2019, Ali and Lalani, 2020). This is a way of developing a mature authentic presence which enables a person-to-person (*I-Thou*) engagement that embraces ethical values. The focus of SOPHIE is on developing the personal qualities that enable a practitioner to function autonomously to develop and maintain self-efficacy and empowerment (Schneewind, 1998; Dworkin, 1988).

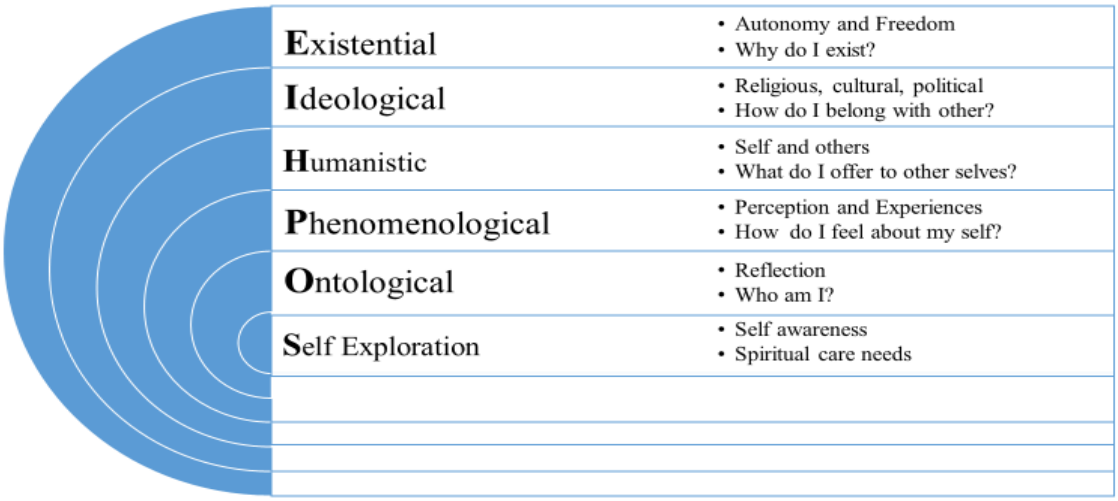

Figure 1. SOPHIE—Self-exploration through Ontological, Phenomenological, and Humanistic, Ideological, and Existential expressions) (Ali G, 2017).

Self-exploration= I vs Me

Starting from the basic premise that there is a need for continuing ***S****elf-exploration* and reflexivity this model provides a series of questions that can assist in this task to enable congruency, transformation and leadership in trans-cultural nursing practices.

Ontological Aspect-Who am I?

At the ***O****ntological* level, the questions surround the issues of *who I am* and specifically, in this context: "Who am I as an Advanced Practice Nurse (APN)?" "Do I really embrace the nursing values and practice wisdom as my professional conduct?" These questions can be addressed in personal reflection and supervision or professional peer-group discussions to establish professional authenticity and self-determination.

Phenomenological aspect- How am I?

At the ***P****henomenological* level of experience and consciousness the question might be "How am I (engaging in this situation)?" In the context of clinical work this might be: "Am I engaging in *I-Thou* relating with the person or am I just seeing the problems the patient brings"? Or even "Am I just seeing the patient as a problem?" (*I-It*). We can think of similar questions about how we relate to our colleagues to become aware of our underlying fears, doubts and motivations that could influence our care giving practices.

Humanistic aspect- What can I offer to others?

At the ***H****umanistic* level, the question might be: "What do I, as an APN, have to offer to the person I am with right now?" That might be someone who has come to me with a clinical problem or it might

be a colleague at work. Reflecting: "How I can connect with the patient or colleague practicing compassionate presence and availability for a therapeutic interaction".

Ideological aspects- How do I belong to others?

The ***I****deological* level asks us to consider *how* we relate to others who may come from a different religious, social, cultural or linguistic background. "What are the transcultural beliefs or dilemmas, that are required to be acknowledged and addressed during each clinical encounter, to assure equity and fairness".

Obstructions to spiritually competent practice	**Facilitators of spiritually competent practice**
Fragmented patterns of working	Good team-working
Time and caseload pressures	Good leadership and supervision/ self-care
Bad management systems and cultures	Good management systems

Existential Aspect-Why do I exist? What is the meaning of my life?

Finally, at the ***E****xistential* level, we return to questions of meaning for ourselves and others with questions like "What is the meaning of this experience (for me, for others)?" "What is the meaning of (my) life and my role as a care provider? , "Am I honest and genuine in performing my duty of *care?", "*What does care means to me?", "Is it all about task- based interventions"? "Is it all about symptomatic care?"

This model can be used as a professional developmental tool, as we pause on our journey through a busy clinical life, to ask some basic questions of ourselves. It also can be used educationally coupled with creative ways of teaching appropriate to personal development (Prentis et al. 2014, Ali and Lalani, 2020).

2.2.3 Opportunities in the working environment

As we have highlighted, the best possible person-centred care can only take place in the context of person-centred management. Management that focuses on tasks rather than people or that denies practitioners opportunity to develop spiritually sensitive relationships with patients or focuses too much on 'targets' and 'performance' indicators is inimical to spiritually competent practice (Muller, 2018; Rogers *et al 2020*). Even when higher and middle management focus on these approaches, clinical teams often (but not always) provide an environment in which spiritually competent care can flourish; but it is so much better when management recognises the need for person-centred care. Some factors which obstruct or facilitate spiritually competent practice are summarised in Box 2.1.

Box 2.1. Obstructions to and facilitators of spiritually competent practice (Wattis et al., 2019)

2.2.4 Case study of spiritually competent practice by an Advanced Practice Nurse

Rogers (2016) research-based availability and vulnerability framework for APNs is explained in depth in Chapter 5. The synergistic relationship between availability and vulnerability is a powerful vehicle for building authentic relationships (Rogers & Beres 2017). Availability relates to simply being present to those in our care, offering care and concern and ensuring we give patients a safe place to be heard and valued. It also encourages the APN to reflect on their own practice and values where

the questions suggested by the SOPHIE model may be useful. Vulnerability is often seen negatively in terms of being hurt, in this concept it is a positive attribute which includes being accountable and open to uncertainty, being willing to advocate for those in our care and fundamentally being authentic and honest with our patients, treating them as fellow human beings (see ongoing chapters for more detail).

This anonymised case study is based on the work of a Nurse Practitioner (NP) in primary care in the UK but all identifiable details have been changed. It relates to consultations which took place during the 2020 coronavirus pandemic.

Lydia is a 49-year-old lawyer working for a firm which offers subsidised services to those who are deprived or marginalised. She has been a lawyer for over 25 years and started working in her current practice 10 years ago as she disliked the corporate, money-driven ethos of her previous firm. The consequences of the pandemic were making her workload unmanageable.

She first consulted the NP by phone because the pandemic had severely restricted face to face consultations. Lydia had needed to wait for several weeks to get an appointment to talk to the NP. Consultations were still scheduled for 10 minutes per patient. The NP introduced herself and welcomed Lydia to the call, asking simply "how can I help" rather than bombarding her with multiple questions. This connects to the availability part of the framework offering a welcome to the patient, giving time and 'space' and being present and listening not just to the words but to the emotional tone and to what was not said.

Lydia told the NP that she had been feeling very tired recently; she was not sleeping and she was feeling anxious most of the day. She explained a little about her working life and about the guilt she felt for letting her clients down during the coronavirus "lock down". Restrictions meant she had to work from home and could not see any of her clients face to face. She still had to meet tight deadlines in her legal work. Several colleagues had already gone off sick or were self-isolating and Lydia was overwhelmed with work.

The NP listened for several minutes and showed her care and concern to Lydia by acknowledging the stress she was under and reassuring her that she was not alone and that the NP wanted to support her through this difficult time. The NP also took the opportunity of trying to build an *I-Thou* relationship which treated Lydia as a fellow human struggling to deal with the demands she was facing.

This necessitated the NP being vulnerable by acknowledging that she also recognised the stress of not being able to see her patients face to face. She apologised to Lydia that this had to be a telephone consultation because face to face appointments were no longer available. She also acknowledged that work pressures meant that she had had to wait so long to talk to a clinician and had been left to struggle alone for longer than the NP would have liked. Being honest and open with patients can build rapport and shows patients that they are valued for who they are.

The consultation progressed with some general questions about Lydia's mood and also about her symptoms. The NP recognised the limitations of a phone consultation and made the decision not to overwhelm Lydia on their first consultation with detailed mental health assessments. However, she did tell Lydia that she would like to know more about her mood and offered to send her some questionnaires via email for her to fill out and send back before the next consultation. She also suggested that Lydia had some blood tests at the local phlebotomy service which was still offering face to face appointments.

As the NP ended the consultation she took some time to reflect, she felt frustrated that this was a short consultation and that some aspects of her assessment had to be conducted virtually, she thought that she could recognise a loss of hope in some of Lydia's responses. Although she had assessed her for suicidal ideation as part of her brief mental health assessment she felt she hadn't

had the time to try and look at what gives Lydia hope, meaning and purpose. She knew, though, that they had a longer consultation booked a week later.

As with some patients Lydia's consultation stayed with the NP who was very aware of the mental health impact the pandemic was having on her patients and the community as a whole. Mental health problems were common in her clinics but now almost all her patients spoke of the mental health impact self-isolation and lock down were having on their lives. Part of being available as an APN is being aware of the needs of the community and adapting practice to any changes. This NP had taken time with her colleagues to develop support information which was texted to patients or posted out. Although a small action, it was an important one which patients were grateful for.

The following week the NP reviewed Lydia's blood test results and the mental health assessments. It was clear that she had symptoms of a moderately severe depression with anxiety. However, the NP was more concerned at that moment by severely deranged liver function tests. She met with Lydia again by telephone and asked her how she had been in the last week. Lydia said that she was increasingly tired, she had generalised muscle aches and sometimes struggled to stand up. She felt very weak and was struggling to get through the day. The NP gently but openly asked Lydia if she could tell her if she was using any alcohol or drugs to get her through the day, this was asked without judgement. Lydia started to cry and said she was drinking 2 bottles of wine every day just to cope with her feelings and her exhaustion. She said she was ashamed and felt a failure. The NP supported her to talk more and reassured her that many people drank alcohol to reduce stress and that she would support her to look at other ways of dealing with her stress. However, it was vital to address the deranged blood results urgently. Lydia was shocked when the NP said she needed to admit Lydia immediately to hospital. She explained why and again told Lydia that she would support her on discharge from the hospital.

The NP had a consultation with Lydia ten days later. Lydia thanked her profusely for admitting her as she collapsed shortly after admission and was told she might have died if she had not been admitted for urgent treatment. She had been in hospital for nine days, had gone through detoxification and had received treatment for acute liver failure. She had been home for one day. The NP felt overwhelming empathy and care for Lydia as she realised how much stress she must have been under and how alone she had been feeling. She also reflected on how ashamed Lydia had felt. The NP took time to reassure Lydia that they would work together to address her stresses and treat her depression and anxiety alongside the care she was to receive for her alcohol problem.

Over the next few months Lydia opened up to the NP. She said for the first time in a long time she felt able to be open and honest about her own feelings because the NP had provided her a safe place where she felt understood and listened to without judgement. The NP asked open questions during these consultations and was able to explore what had brought Lydia hope, meaning and purpose in the past. It was clear her work was a vocation; but the demands had become overwhelming. She also had struggled in lockdown as she had become more isolated from friends and family. The NP helped her explore using technology to meet those she felt isolated from. Together they addressed her overworking and the demands placed upon her. Lydia, with support, began to address her stressors in a healthier way and reduced her working hours. She also began to be honest about her feelings with friends and found they too felt similar during lockdown. At the time of writing her depression has improved and she has stopped drinking.

In some ways there is nothing unusual about this case study. However, when you look closely you can see how the NP utilised availability and vulnerability throughout the consultations to help Lydia reconnect with her vocation, her friends and family and mostly her meaning and purpose in life. Spiritually competent practice was at the forefront of the NPs approach despite the difficulties with remote consultations.

2.3 Cultural aspects of spirituality and spiritually competent practice

2.3.1 Cultural narratives and worldviews

APNs work in multicultural societies. In the West the dominant culture is often secular materialism and many people will follow the dominant culture which favours personal autonomy and consumerism. However, many will not adopt the dominant culture and its values for religious, personal or family reasons. Whatever kind of society APNs work in, they need to be aware of cultural factors and how they impinge on people's spirituality. One way of understanding different cultures is through understanding the (often unconscious) narratives that people use to understand themselves and their place in society. These underpin worldviews which form the substrate of a given culture or society and have to do with matters of ultimate concern. Worldviews have been likened to tinted eyeglasses, habitually worn, that colour the way we see the world without us necessarily being conscious that this is happening. The worldview of people in a traditional monocultural society will be shared by many in the society. However, in multicultural societies the situation will be more complicated. Wright (1992) suggests that worldviews have four components:

- Assumptions about how the world is, expressed through narratives (stories).
- Answers to fundamental questions about existence:
    - who are we?
    - where are we?
    - what is wrong?
    - what is the way to move forward?
- Symbolic expressions through events and artefacts.
- A way of being and behaving derived from the worldview, its associated narratives, questions and symbols.

Today, Monbiot (2017, p15) asserts "the dominant narrative is that of market fundamentalism, widely known in Europe as neoliberalism". In this worldview the market is king and is believed to be able to resolve almost all problems in life. The narrative believes the state should be small and interfere with market forces, through regulation and taxation, as little as possible. In answer to the question about *who we are* the narrative has been that we are autonomous individuals, driven by self-interest and that economic growth is determined as we all compete for our 'share' (or more than our 'share') of the many consumer goods on offer. Relationships are often contractual and people may be treated as commodities whereas APN relationships are based on an ethical commitment and are more covenantal and personal in nature. As to *where we are* – until recently the narrative has been one of confident progress as we make and consume more stuff. Interestingly this reflects the last great period of capitalism in the late Victorian age that was mitigated in the mid-20th century by a brief flowering of social democracy. When we get to the question of *what is wrong*, until recently, the neoliberal answer has been 'too much state interference' and so public services have been privatized, public spending and taxes cut and some regulation on industries reduced. The way to move forward has been 'more of the same'. The events and artefacts that symbolise this culture include shopping malls, Wall Street, New York; the City of London and an obsession with financial indices like the *Dow-Jones* and the *FTSE.* The *way of being* involves competing in a consumer society and a tendency to treat other people in an *I-It* rather than *an I-Thou* fashion.

Following the 2008 global financial 'crash', the emergence of Covid-19 as a global threat and the looming threat of global climate catastrophe (and many other less immediate problems) this narrative is increasingly questioned (Dyke, 2020). Monbiot (2016) refers to it as 'the ideology at the root of all our problems'.

The symbolic events and artefacts of the middle ages in the UK would have been religious festivals, churches and cathedrals. Now January sales, 'black Friday', shopping malls and the towering headquarters of big banks fill the same place. Even Christmas has largely been converted from a religious festival to an orgy of consumerism. Whereas the dominant narratives in Western society in the middle ages would have been based on (Christian) religion, secular neoliberalism is the new normal and religious worldviews are more diverse. Secular neoliberalism has increasingly dominated the political world over the last 50 years or so. But its dominance has been at a largely unconscious level so that, even as we write in the middle of a coronavirus-induced crisis, people are still looking forward to a return to 'normal' when scientific evidence suggests that we would be wiser to aim for a less consumer-oriented recovery. The other problem with neoliberalism as a dominant worldview is that it does not have an intrinsic morality. It needs a morality derived from religion (Griffiths, 1982) or philosophy to *really* answer the question "what is wrong?"

However, within the current dominant culture of Western society there are many other groups with different worldviews, chiefly adherents of different religions and/or members of minority ethnic groups. In the 2011 census of England and Wales (Office of National Statistics, 2011) nearly 60% people classed themselves as 'Christian' and just over a quarter classed themselves as having no religion. Islam at nearly 5% came next, followed by Hinduism, Sikhism, Judaism and Buddhism, smaller but still culturally significant minorities. Even within these broad groupings there are differences in worldview. For example, only a small proportion of those identifying as Christian would be active members of churches and nominal Christians might have an underlying worldview more consonant with secular materialism and neoliberalism. Within religious groupings there will be difference in the emphasis placed on beliefs and ritual behaviours. However, at their root (as discussed above) nearly all have an emphasis on steadfast love expressed through compassion and kindness towards other people. As murdered UK Member of Parliment Jo Cox famously stated (and many of us believe) 'We have more in common than divides us' (British Broadcasting Corporation, 2016).

There are broad divisions between European-based cultures, with their emphasis on personal autonomy and individualism, and Eastern and African cultures which still often have a stronger feeling of family or collective responsibility and interdependence. These can affect how people experience illness, disability and ageing. There is a potential for cultural and even ethical conflict when practitioners from an individualistic culture are managing people from a more collective culture and *vice versa* (Kirschbaum & Rodriguez, 2017). During the earlier phases of the coronavirus pandemic the different responses of countries like Japan and South Korea on the one hand, and European-based cultures on the other, may have been based not only on previous experience with the SARS virus but also on these differences in underlying culture. The 'Eastern' cultures quickly took a collective approach to the problem, visible in the normality of wearing face masks to protect others in public places, whereas in the UK, for example, there was an initial reluctance to introduce such measures because of fears about constraining individual autonomy and freedoms.

2.3.2 Cultural Competence

Sharifi *et al* (2019) conducted a concept analysis of cultural competence in nursing. They briefly defined it as "the dynamic and evolutionary process of acquiring the ability to provide effective, safe and quality care to individuals from different cultures along with considering the different aspects of their cultures" (Sharifi etc al 2019, p3-4). They found six defining attributes:

1. Cultural awareness
2. Cultural knowledge
3. Cultural sensitivity
4. Cultural skill

5. Cultural proficiency
6. Dynamicity

Cultural awareness means firstly being aware of our own world view or 'cultural spectacles'. We need to understand our own culture which we have probably accepted as 'normal' as we have grown up in our own family and culture (though many challenge family culture in their teenage years). We need to be aware of how this worldview affects our understanding, beliefs and behaviours. Reflection upon our own culture and background is an important part of being able to be aware of other people's culture. This enables understanding of the similarities and differences between our own culture and other cultures and is the basis on which we can learn to recognise and respect these differences.

Cultural knowledge involves continually learning about other people's cultures when we come into contact with them. It means understanding their worldviews and particularly how they affect health related beliefs and practices. This enables us to better understand and respect how people from a different culture think and behave in relation to illness and health needs. For example, some cultures do not accept a woman receiving healthcare from a male doctor, nurse or midwife. Specific religious cultures may have specific dietary practices which need to be understood and accommodated. Continuing learning is important because we may come across issues we had not anticipated and we need to be sensitive to unexpected reactions from the people we are caring for and their relatives and to seek to understand what is behind these reactions. We also need to recognise that we need to take advice from others when we are uncertain of cultural issues.

Cultural sensitivity is based on the knowledge and respect we have for different cultures. We also need to pay attention to cultural issues and not to make assumptions or unwarranted generalisations about people from different cultures. A culture that appears homogenous from our point of view may, in fact be quite diverse to those who know it better (see *ecological fallacy* below). An important aspect of this is listening and clarifying issues in an *I-Thou relationship* with the person we are dealing with. Sometimes there may be language problems and an interpreter may be required and sometimes the interpreter can help interpret the cultural issues as well as the language. Once the cultural issues are understood, any health care plans need, as far as possible, to take them into account.

Cultural skill is about effective two-way communication with people from different cultures. People need to realise their concerns are heard, acknowledged and dealt with. Cultural skill enables us to effectively work with people of a different culture, respecting different beliefs, values and customs in partnering with them to provide acceptable healthcare.

Cultural proficiency is developed through the acquisition and transfer of new knowledge about culturally sensitive approaches. This is both an individual *learning from experience* process and a collective *learning from others* through well conducted and communicated research in this area.

Dynamicity stresses that cultural competence is a lifelong learning experience.

We would add that just as spiritually competent practice requires us to be aware of our own limitations and to seek help when we encounter spiritual issues that we cannot fully understand, so cultural competence requires us to seek help when we are out of our depth. In Western cultures this usually means seeking help, with the patient's agreement from family members or others from the same cultural or religious background. Always the understanding should proceed from a person-to-person compassionate engagement with the service user

2.3.3 A word of caution (the ecological fallacy)
The application of *cultural competence* to nursing encounters with individual patients has been challenged. Dreher and MacNaughton (2002, p181) asserted that:

Although individuals may belong to the same cultural group, the assumption that they are, in fact, the same is an ecologic fallacy

An ecologic/ecological fallacy results from drawing conclusions about the wrong unit of analysis – in this case making generalisations about individuals from data about cultural/subcultural groups. Dreher and McNaughton argued that individual differences were such that cultural generalisations should be applied with great caution at the clinical interface and even that "cultural competence is really nursing competence". Their argument is a good one and fits with our description of spiritually competent practice involving compassionate engagement with the whole person as *a unique human being.* It is clearly unreasonable to expect any practitioner to have an encyclopaedic knowledge of all the different religions or cultures. What is required is an awareness that they exist and a willingness to respect how, in a particular patient, a worldview different from that of the practitioner may need to be taken into account in the planning and delivery of healthcare.

2.4 Conclusion

In this chapter we have introduced the concept of spiritually competent practice as a way of avoiding endless disputes about the definition of spirituality and avoiding confusion with religion. At the core of spiritually competent practice is supporting people in sustaining a sense of meaning and purpose even when it is challenged by suffering and illness. It involves compassionate engagement with the whole person as a unique individual; but also respect for the person's family and cultural connections. As well as specific competencies it requires personal qualities, including the capacity to form *I-Thou* relationships and a managerial system that enables practitioners to attend to personal as well as technical aspects of health care. SOPHIE is presented as a model for understanding lifelong learning through reflective practice. Availability and vulnerability, a framework specifically developed in research with APNs, is illuminated by a case study which can also be understood within the overarching description of spiritually competent practice. Finally, we have briefly considered the importance of taking into account cultural issues without forgetting that individuals within a culture also have their own personal understanding of what spirituality means to them within their culture.

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