Relationships hold key to spiritual care

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Relationships hold the key to giving terminally ill patients the spiritual care they need. However, researchers have pinpointed a mismatch between patients' expectations and understanding when it comes to spirituality, and what medical and family caregivers offer. New recommendations to improve this situation appear today, in the journal *Palliative Medicine*.

The terms 'spirituality' and 'spiritual care' are becoming buzzwords in palliative care. But although most terminally ill patients rate care for their spiritual needs as very important, the professionals caring for them often have trouble defining what that means.

Using the definition of spirituality 'a personal search for meaning and purpose in life, which may or may not be related to religion,' Cardiff University's Adrian Edwards together with Hong Kong based researchers Naomi Pang, Vicky Shiu and Cecelia Chan scoured the palliative care literature to create a systematic meta-study of spirituality. They incorporated qualitative data from 19 studies on 178 patients and 116 healthcare providers in their analysis.

Edwards' team found that although policy organizations advocate integrating physical, psychosocial and spiritual aspects within palliative care, not all patients understand the term 'spirituality.' Having said that, according to quantitative studies, 87 percent of patients consider spirituality important in their lives, while 51 to 77 percent of patients specifically consider religion important. The initial challenge is to clarify what spirituality means in healthcare, and to reduce the gap between

policy and patient expectations.

The articles selected for the meta-study were published between 2001 and 2009, and encompassed patients from the UK, US, Australia, Taiwan and Japan, and included atheists, Taoists, Christians and Buddhists. The majority, however, were white, with a Judeo-Christian background, and suffering from cancer.

In their literature searches, the investigators found that spirituality principally focused on relationships, rather than just meaning making.

Some other conclusions include that the division between the terms 'spirituality' and 'spiritual care' in the literature was artificial, and in fact the terms were used interchangeably. 'Relationships' surfaced as crucial factors all areas: Relationships formed an integral part of spirituality; were a spiritual need; caused spiritual distress when they were broken; and were the way through which spiritual care was given.

The best caregivers practiced self-reflection and awareness. Stumbling blocks to trust included social, religious or cultural discordance, inappropriateness, judgement or proselytising. The way around this was to avoid religion but instead share common humanity - a 'spirit-to-spirit' relationship.

"A 'spirit to spirit' framework for spiritual care-giving respects individual personhood," says Edwards, "This was achieved in the way physical care was given, by focusing on presence, journeying together, listening, connecting, creating openings, and engaging in reciprocal sharing."

Unfortunately, family caregivers are 'under-utilised' when it comes to offering spiritual care, with barriers including lack of time, personal, cultural or institutional factors, and professional educational needs. "By

addressing these, we may make an important contribution to the improvement of patient care towards the end of life," Edwards suggests.

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