Spirituality in cancer care

Introduction

The clinical developments that have occurred in the field of cancer now mean that many people may be cured of their disease or live longer with significant improvements in treatment related toxicities. However, a cancer diagnosis continues to carry with it a significant amount of fear and anxiety with concerns over relapse and death often present. The lived experience of an Illness such as cancer with all the uncertainty it brings leads not only to changes to a physical body but many other changes in a person's life. Such changes lead many people to re-examine and re-evaluate many of their beliefs and values including what may be described as their spiritual needs.

Although the spiritual needs of people with cancer are often overlooked and ignored, the reality is that such needs demand attention. If we are committed to addressing the whole person then these spirituality needs must be addressed. The intangible nature of this issue, the lack of clarification of what is understand by spirituality and the lack of resources may lead the clinician to avoid the issue or to leave such matters to members of the chaplaincy team. While chaplains have a vital role in addressing spiritual concerns and supporting the team, each member of the health care team has an important part to play.

Learning objectives

The activities and content of this module are built around the following learning objectives:

- To critically explore the concept of spirituality in the context of the lived experience of cancer
- To critically examine the beliefs, values and practices of the major religions
- To critically explore the expressions of spiritual pain
- To develop skills in recognising and addressing spiritual needs in clinical practice
- To develop critical thinking about one's own spiritual beliefs and values.

Exploring spirituality

Being prepared to participate in the exploration of spirituality with another person in whatever form it may take demands time, courage, sensitivity and humility from the carer. Although the word spirituality is rarely mentioned in care plans or patient notes unless the chaplain has come to visit, studies have shown that health carer workers do recognise they have a role to play (Quinn, 2002; Johnston Taylor et al, 1994). More importantly, patients value health care workers role in supporting them as they address these issues (Quinn, 2005; Georgesen & Dungan, 1996). The reality is that health care workers are often involved in supporting people with spiritual concerns even when they may not recognise this as such. By exploring the concept of spirituality health care workers may be able to recognise this fact and be even more alert to patients' and families' needs

Health care workers may make the mistake that because someone has no religious affiliation that they will have no spiritual needs or that because that person has a religious affiliation that the chaplain alone can attend to any spiritual concerns. The reality is that the patient will choose who they want to talk to about their spiritual beliefs and concerns which may be any member of the health care team.

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In most Western societies spiritual care was closely associated with religious care up until the 1970s and while many people continue to address their spiritual needs through a formalised religion, the reality is that many people now choose to address their spiritual needs in other ways. For this reason it is good to clarify what we mean by religion and what we mean by spirituality and how they both may be linked.

The term religion usually refers to a set of beliefs about a higher being or a transcendental quality. All of the major religions of the world including; Islam, Christianity, Judaism, Buddhism, Hinduism, Sikhism, hold a set of beliefs which followers are asked to adhere to which are normally linked to a belief in a deity (God). The word religion may stem from the Latin term 'religare' which means 'to tie fast' alluding to the close association with the deity.

The word spirit may come from the Latin term 'spiritus' which means 'breath', meaning to give life. Therefore spirituality may be defined as anything and everything that gives meaning to a person's life. Spirituality has been defined by Stater (1995) as everything that makes a person unique including their; successes/failures, joys/sorrows, strengths/weaknesses, their background, culture, work, home and social life. It is therefore difficult to see how any aspect of life can be separated from one's spirituality.

Lunn (1993) writing in his role as a hospital chaplain describes the spiritual dimension as the deepest part of who we are as persons, and is concerned with ultimate concerns, our search for meaning and values. Rolheiser (1999) describes spirituality as the 'all embracing ache' that lies at the centre of being human, it is our response to this longing that makes up our spiritual nature. Frankl (1963) writing of his own personal and professional reflections on the subject describes spirituality as the continual search to find meaning throughout one's life which we are all involved in. Although our search is constant and our meaning and values may change, he argues that spirituality is at the core of what it means to be human.

According to this understanding of spirituality it is easy to see how many people will choose to express their personal spirituality through a formalised religion. And while it is possible to think of people who do not believe in any form of deity or who do not have any religious beliefs, it is impossible to think of any person who is not spiritual or does not have beliefs and values that give meaning to their life.

This spiritual dimension is not to be found in any exploration of cancer as a clinical disease but through the personal stories of life and illness which people share. Sometimes the team may be so preoccupied with completing a patient assessment that they fail to really hear the personal story of illness and what it means.

Although the spiritual quest is part of all our lives bringing immense joy and meaning, facing the reality of cancer forces many people to re-evaluate some of the certainties of life. The team may make the mistake of thinking that spiritual concerns only arise as a person faces the reality of death but the need to address spiritual questions is ever present. This spiritual dimension is not just thought about, but is a lived experience as people continually make sense of the world about them. Elements of the spiritual quest can be expressed in many ways but is often revealed through the questions a person must face. 'Why?', 'Why is this happening to me?', 'What is the point of my life?', 'Where will all this lead?' Where is God in all of this?' Sometimes a question about some aspect of disease or treatment may contain a spiritual component; 'What is the meaning of this pain?', 'What does this blood result mean?' It is important for the team to consider the deeper questioning that can lie below the surface of such questions. Sometimes this searching can simply be seen in the concerned look on a person's face or the body language they use. The nature of the search and the questions asked often do not require an answer but simply someone who will listen and be attentive to the person's need.

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Activity 1 (allow approximately 60 minutes for each task)

Task 1
Critically examine the literature on spirituality cited in the Background Reading section below. Take some time to reflect on what spirituality means to you and talk to a colleague or friend about their ideas on spirituality. What similarities/differences did you find?

Task 2
Ask someone who has cancer to tell you their story of how they came to know they had cancer, and what has happened since. Be aware of the personal story beyond that of the medical disease of cancer and treatment. Reflect on how it has impacted on their life and the changes it has brought.

Thinking Point:

- Do you think the spiritual dimension is adequately addressed in your clinical practice?
- While spirituality may be expressed in religious terms, many people express spirituality in other ways, what other ways do people express their spirituality?
- Spiritual; beliefs, values, concerns and needs may be heard through the stories that people tell and the questions they ask, how might you better attune yourself to such issues?

Resources required to complete this activity

Useful websites
Spirituality
www.personal-development.com/webspirit.htm

www.spiritualityatwork.org/websites.htm

www.sacredspace.org.uk

Spirituality in Cancer Care
www.cancer.gov/cancertopics/pdq/supportivecare/spirituality

www.cancer.gov/cancertopics/pdq/supportivecare/spirituality/Patient/page2

Personal stories of cancer
www.dipex.org

Background reading
Confoy, M. (2002) The Contemporary Search for Meaning in Suffering. In: Rumbold, B. Spirituality and Palliative Care: Social and Pastoral Perspectives. Oxford University Press. Victoria. 22-37.

Frankl, V.E. (1963) Man's Search for Meaning. Hodder & Stoughton. London.

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Johnston Taylor, E., Highfield, M. & Amenta, M. (1994) Attitudes and Beliefs Regarding Spiritual Care. Cancer Nursing. 17(6) 479-487.

Quinn, B. (2002) An Exploration of the Nurses' Experience of Supporting a Cancer Patient in their Search for Meaning. European Journal of Oncology Nursing. 37(6).

Quinn, B. (2005) Cancer and the Treatment: Does it make sense to patients? Haematology. 10(1) 325-328.

Rolheiser, R. (1999) The Holy Longing: The Search for Christian Spirituality. Doubleday. New York.

Rumbold, B. (2002) From Religion to Spirituality. In: Rumbold, B. Spirituality and Palliative Care: Social and Pastoral Perspectives. Oxford University Press. Victoria. 5-21.

Stater, D. (1995) 'Spiritual Care'. In Penson, J. & Fisher, J. Palliative Care for People with Cancer. Arnold. London.

Wilber, K. (2001) Grace and Grit. Gateway. Dublin.

Spirituality and the search for meaning

According to Frankl (1963) our main concern in life is not to avoid pain or to gain pleasure but to discover a meaning in life. While an inmate of a concentration camp during the Second World War, Frankl began to question the meaning of the suffering he witnessed and experienced. While not advocating that unnecessary suffering should not be removed or relieved, Frankl believed that his fellow human beings in the camp were able to endure much hardship and suffering while holding on to their humanity because they were able to find meaning despite what they were going through. Building on his experience and reflection Frankl argues that it is the ongoing search for meaning in which each human being is involved that makes us distinct from the animals. No animal has the ability to reflect on the meaning of life. Frankl argues that although much of the way we live today frustrates that search to find meaning, nevertheless the search continues (Frankl, 2004). For Frankl much of what is described as mental illness in today's world stems from the fact that individuals have lost sight of what gives meaning to their lives. In addressing one's search each individual must also address the concept of wholeness including the often forgotten spiritual dimension (Frankl, 2000).

Many people do search for meaning at some level throughout their lives and are continually trying to make sense of the world in which they operate. But when people are faced with difficult and uncertain situations such as being diagnosed and living with cancer then that search to make sense or find meaning takes on a new emphasis and may become more apparent.

Taylor (1983) describes the search for meaning in illness as a struggling to comprehend why the event has taken place and the personal significance of that event. People with an illness such as cancer may spend time reflecting on what caused their illness and although a cause may not be found, nevertheless this searching is an important part of their story. It is not uncommon to hear people blaming themselves and their lifestyles for their illness. Through taking the time to listen to people's stories, members of the health care team can come to know how the cancer and the treatment demands impacted on the person's life. Lazarus and Folkman

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(1984) in exploring the search for meaning refer to both the 'situational' and 'global' meaning that may exist. The former is an attempt to ascribe meaning to a particular situation and the latter is an attempt to set that meaning into a more 'global meaning' reflecting the individual's perceived purpose in life, their goals, values and belief system. Each person's search to find meaning is influenced by their past experience; including their exposure to cultural, social, familial and possibly religious practices. It is always personal and like many aspects of life, is ever changing.

"I doubt whether a doctor can answer this question in general terms. For the meaning of life differs from man to man, from day to day, from hour to hour" (Frankl, 1963. 131)

The role of the health care worker is to be present, to accompany and to support the person in the searching process.

Activity 2 (allow approximately 60 minutes for each task)

Task 1
Take a critical look at Victor Frankl's work and other relevant literature, and reflect on how these thoughts might be applied to your own life and to your clinical practice.

Task 2
For one day in your clinical practice be aware of the search to make sense of the story of cancer that is being carried out by patients, families and the health care team. Write a brief reflection on your experience.

Thinking Point:

- The search for meaning is an essential component of the human experience, are you aware of this search within your own life?
- The search for meaning may be expressed in many different ways including in the personal story of the lived experience of illness and the searching questions people ask. What questions may lead you to think that a person is searching to find meaning?

Resources required to complete this activity

Useful websites
Victor Frankl:
www.webwinds.com/frankl/frankl.htm

www.logotherapyinstitute.org

Spirituality and prayer:
www.cancer.org/docroot/ETO/content/ETO_5_3X_Spirituality_and_Prayer.asp

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Background reading

Dirksen, S. R. (1995) Search for Meaning in Long Term Cancer Survivors. Journal of Advanced Nursing. 21. 628-633.

Frankl, V. E. (2004) The Doctor and the Soul. Souvenir Press. London.

Frankl, V.E. (1963) Man's Search for Meaning. Hodder & Stoughton. London.

Frankl, V. E. (2000) Man's Search for Ultimate Meaning. Perseus Publishing. Massachusetts.

Lazarus, R.S. & Folkman, S. (1984) Stress, Appraisal and Coping. Springer Publication. New York.

Taylor, S. E. (1983) Adjustment to Threatening Events: A Theory of Cognitive Adaption. American Psychology. 38. 1161-1173.

Different religions

One of the values of working in health care is being exposed to people from cultures and religions that are different from one's own. This is both an exciting but challenging opportunity for members of the health care team. Most religious faiths will have beliefs about prayer, diet, washing, clothing, fasting, special days, moral codes including respect for the sick, rituals focussing on caring for the dying and post death rites which the team should be sensitive to. Many of the religious faiths and indeed many people with no religious affiliations will share similar moral codes and practices and it is interesting to reflect on the similarities and the differences that exist.

An essential resource is the chaplaincy team and it is important that the team have access to chaplains or contact persons from each of the different religions. During the admission process the team member should try and ascertain the significance of a person's religious beliefs and in what ways the team can help meet those needs.

There is a danger that because a health care worker has had a negative experience of religion or has never been exposed to a particular religious practice that they may fail to be sensitive to the central role religious beliefs play in a person's life. Or the health care worker may have such strong and certain faith in their own religion that they fail to appreciate the value of another's faith or try to impose some of their beliefs and values on the person they care for. Spending time with someone whose religious beliefs and values are different from one's own can be an enriching experience but in order to do this one needs to be aware of their own personal belief system and values and respect the beliefs and values of the person they care for.

The health care worker should not presume because they know a little about a particular religion that they understand what that religion means to that person. There are many sects and denominations within a particular religion and it is important that the person is aware to which sect or denomination the patient belongs. Within Christianity one denomination may highly value expressions of ritual and sacraments while another denomination may avoid such rituals and value more simple expressions of faith and belief. Within Islam, one sect may highly value adhering to a strict dress code for men and women as part of their faith while for another sect this may be less important. Within Judaism certain sects will request that only people of the

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Jewish faith care for the body after death and for others sects this will not be necessary. Even within particular denominations and sects, individuals will value different things. In order to understand a person's religious beliefs and needs it is essential to talk with the individual and family concerned. The team should be particularly sensitive to people who may feel ostracised from their religion because of life circumstances and chosen lifestyles.

Activity 3 (allow approximately 60 minutes for each task)

Task 1
Talk to someone with a religious affiliation which you are not part of and find out about the following; prayer, washing, dress, diet, special days, fasting, important rituals surrounding dying and death. How do these differ from your own beliefs and values?

Task 2
Visit a religious centre such as a mosque, synagogue, temple or church. Be aware of the religious symbolism that exists.

Task 3
Using the literature and the websites listed below, take one religion that you are not familiar with and do some reading try to identify the core beliefs, values and practices of that religion.

Thinking Point:

- The major religions of the world have many commonly held values, what are some of them?
- Religions have rules and customs surrounding; diet, fasting, clothing, washing, death which health care workers need to be sensitive to. How might you familiarise yourself with these needs?
- Each person will express their religious beliefs and values in a way that is personal to them. How might you be more sensitive to these beliefs and values?
- What might cause people to feel ostracised from their religion?

Resources required to complete this activity

Useful websites
World religions:
www.geocities.com/Athens/Forum/1699/

www.sacred-texts.com/world.htm

www.mnsu.edu/emuseum/cultural/religion/

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Background reading
Aldridge, A. (2007) Religion in the Contemporary World. 2nd Edition: A Sociological Introduction. Polity Press.

Bowker, J. (1999) The Oxford Dictionary of World Religions. Oxford University Press. Oxford.

Bowker, J. (2006) World Religions: The Great Faiths Explored and Explained.

Esposito, J.L., Fasching, D.J, and Lewis, T. (2006) World Religions Today. Oxford Univeristy Press. Oxford.

Markham, I.S. (2000) A World Religious Reader 2nd Edition Blackwell Publishing Oxford.

Spiritual pain

While spirituality can bring tremendous meaning and joy to life, part of the spiritual quest will mean that many of us will experience spiritual pain sometime in our life. Often spiritual pain is not addressed in illness and yet it can be described as the greatest pain of all. It may not be addressed because it is misunderstood and is rarely treatable by any medical intervention. Frankl (1963) who had his own personal experience of pain and discomfort and worked with many people in pain believed that real suffering was not necessarily deprivation or physical discomfort but the loss of meaning and purpose in life. When we consider the many challenges a diagnosis of cancer brings it is not surprising that spiritual pain may be present in the person's experience. People have to face significant morbidity related to both the disease and treatments, and the impact on their life brings many changes. The disease and treatments may force people to reflect on many things that they have previously taken for granted. People may question their role in life and relationships with others, they may fear the loss of roles including; being a partner, a parent or a friend, they may fear being unable to work or to take part in life activities. For many people their diagnosis of cancer is closely associated with death, and many of those they have previously known with cancer have already died of the disease.

In a world where many of us seek for certainty and control the person with cancer, their family and friends are faced with the reality that they are not in control and are left with the uncertainty of relapse and what this might mean. Amidst such uncertainty and change, people do try to make sense of their experience. The meaning of a physical symptom may lead to deeper questioning and to an expression of spiritual pain. The following statement was made by a Christian Religious Sister with advanced lymphoma who spoke at her distress at being incontinent, a distressing symptom that lead her to question her own faith

"I had explosive diarrhoea….and for no reason, well to me it seemed like no reason, the emotional distress of it, but very definitely the psychological distress of it…..and, then that all gets translated into…..spiritual distress, faith….you know…..What do I believe in? Because you sort of presume in your body, don't you in a way?" (Anne)

An expression of spiritual pain is not always obvious and only the team member who is truly attentive to this need may observe a person's distress. Sometimes spiritual pain may not be seen and remain hidden, the following statement was found in the personal diary of a twenty-three year old man following his death from Leukaemia.

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"Many of my friends wonder how I maintain a positive outlook and indeed suggestions have been made that I am in fact in a manic depressive state. I am happy during the day because I cry at night…….too put it simply, I'll do my smiling during the day and I'll leave the painful parts until dark" (Jonathan)

The reality is that people may not choose to share their pain with someone else but the team should be aware of the reality and presence of such pain and distress. It is interesting to note that the word suffering rarely appears in patient records or documentation and yet suffering is truly part of the cancer experience. In order to come closer to the person in illness we need to move beyond the presence of pain to address the suffering in an individual. Cassell (1991) and Kearney (2000) two physicians reflecting on their own clinical practice examine the overlooked reality and avoidance of suffering in illness. Both agree that unless spiritual issues are addressed, effective pain management will not be achieved. In discussing the concept of total pain, Kearney (1996) talks about the hidden pain and suffering that lies below the surface that needs to be addressed. He argues that if spiritual and emotional pain is not addressed then such suffering must find an outlet and may be expressed in some other form, and often it will be in the expression of physical pain. He suggests that if physical pain appears to be unresponsive to medical interventions it may be worth exploring whether this pain has a spiritual dimension. Johns (2004) writing about the importance of reflecting on our clinical interventions says that there may be a temptation to treat emotional and spiritual pain and suffering with medication. While such an approach may mask the pain and leave the team feeling more comfortable, the true nature of the pain and the suffering it expressed has not been addressed and 'the anguished cry' is merely stifled.

Activity 4 (allow approximately 60 minutes for each task)

Task 1
Critically read one of the following chapters from Eric Cassell's book addressing suffering in illness.

Chapter 3. The Nature of Suffering (pp30-47)

Chapter 4. Suffering in Chronic Illness (pp48-65)

Applying these insights to clinical practice consider the indicators that might alert you to a person who is suffering. How might suffering differ from pain?

Task 2
A twenty three year old man with advanced sarcoma has just been told that by the team that there is no more medical treatment available. At first he is very angry but then he begins to talk about the pain behind his anger. He recalls that only last year he was playing football and had been studying at university, which he can no longer do. He talks about his girlfriend, his supportive friends and family, his part time job and all the good things in his life. Now he feels his advancing illness and the reality of dying has separated from all these things he loves and values. He says, "It's as if there is a wall between me and my life"

List the barriers that would inhibit you from responding to this man. What resources would help you to attend to this man?

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Thinking Point:

- Reflecting on your clinical practice in what ways have you seen spiritual pain being expressed?
- Suffering may be part of the lived experience of cancer, how is suffering expressed in illness?
- Being present to the suffering of another can be challenging and uncomfortable, how do you feel when you are with someone who is struggling to make sense of difficult circumstances?

Resources required to complete this activity

Background reading

Bolen, J.S. (1996) Close to the Bone: Life-Threatening Illness and the Search for meaning. Touchstone. New York.

Cassell, E. (1991) The Nature of Suffering and the Goals of Medicine. Oxford University Press. New York.

Ersek, M. & Ferrell, B.R. (1994) Providng Relief from Cancer Pain by Assisting in the Search for Meaning. Journal of Palliative Care. 10(4) 15-22.

Frank, A.W. (2002) At the Will of the Body: Reflections on Illness. Mariner Books. New York.

Georgesen. J. & Dungan J.M. (1996) Managing Spiritual Distress in Patients with Advanced Cancer Pain. Cancer Nursing. 19(5) 376-383.

Johns, C. (2004) Being Mindful, Easing Suffering: Reflections on Palliative Care. Jessica Kingsley Publishers. London.

Kay, J. (2005) Staring at Ceilings. Matadour. Leicester.

Kearney, M. (1996) Mortally Wounded. Scribner. New York.

Kearney, M. (2000) A Place of Healing: Working with suffering in living and dying. Oxford University Press. Oxford.

Addressing spirituality in cancer care

One of the greatest barriers to addressing spiritual care stems from the fact that it is hard to define often misunderstood and does not fit into the 'Scientific model of health'. In a busy clinical situation the lack of awareness of our own spirituality may mean that the spiritual needs of people with cancer may be considered a low priority. Our own unexamined biased notion of what spirituality is, may mean we presume that another's spirituality is similar to ours leading us to fail to hear our patient's concerns. Many health care workers report that they lack the training,

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the skills and experience to deal with this aspect of health care. There is some concern among members of the team that they may cause offence and so like other sensitive issues in health care they avoid the subject.

Often we make the mistake that it takes an expert to address spiritual concerns in health care, but a supportive practitioner is someone who is able to be sensitive and respectful of another's spiritual needs knowing when to access other resources available. Twycross et al (1991) believe that spiritual care is something that we all deliver when we give someone our full attention. Such an attentive approach can be present in every clinical task we undertake, whether it is doing a washing and dressing assessment, helping someone to walk, assessing a patient's symptom or administering a chemotherapy agent. Because of the nature of spirituality the role of the health care worker in addressing spiritual needs requires the worker to take the focus of merely achieving the task and to be truly present with the person. This can be difficult if we have been trained to seek for solutions and we work in an environment where our workload is measured by the amount of tasks we complete and not the quality of the time spent with patients and their families.

Campbell (1984) encourages those who work with the ill to be a 'skilled companion' to those they care for. As nurses, doctors, chaplains and allied health professionals, we participate in another's journey of illness because our clinical skills are required but we will also be invited to journey with the other as companions to that care. Elias (2001) in his book 'The Loneliness of the Dying' describes how as a death denying society we have largely distanced ourselves from those who are dying. But those who face the uncertainty of cancer and the changes it brings may also feel separated from much of life and may fear being left alone. In her book 'Sharing the Darkness', Cassidy (1988) says that part of our role as health care workers is to support people when they are in distress and there will be times when such distress strips us leaving us feeling uncomfortable. But she says that if we can simply stay with that person in those difficult and uncomfortable moments then we will have not only demonstrated that we cared but we will have truly supported them in their time of darkness. Our role at such times is not to provide answers but to be someone who the person can trust, who listens and is simply present.

"If we want to support each other's inner lives, we must remember a simple truth: the human soul does not want to be fixed, it wants simply to be seen and heard" (Palmer, 1998. 150)

Twycross et al (1991) focus on the importance of touch as a way of demonstrating care. While there is the instrumental touch that is used to perform a clinical task, such as carrying out a physical assessment and examination or delivering treatment, more may be required. Alongside such touch there may also be a need for expressive touch that shows we care, through touching someone's hand or giving a hug. But expressive touch may also be demonstrated in the way we are attentive to those we care for demonstrating that we have really heard what the person has said. In using expressive touch it is important for the team to be sensitive to what is considered appropriate to the individual mindful of their cultural and religious values.

The following are some useful guides to addressing spiritual needs:

- Be aware of the cues that may indicate someone needs to talk
- Listen to the person's story
- While all people may not be religious, most people will have spiritual needs
- Be aware of the religion and culture of the person you care for
- Be particularly sensitive to those who feel ostracised from their religion or culture because of chosen lifestyles

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- Help the person and family to prepare and plan for religious/cultural needs and rituals. In planning care and treatment be sensitive to diet, prayer, clothing, and washing needs
- Pay particular attention to tasks that the person may wish to complete in the terminal phase of their illness and post death care requests
- Remember that addressing someone's spiritual needs requires privacy and time
- Spiritual care may include the ordinary things; offering a cup of tea, offering to take a patient to the garden or to the prayer room, arranging a wheel chair for a family outing, giving permission for hospital leave, taking time to say hello.
- Remember that a patient may choose to die fighting and angry (witnessing such a death can be difficult for both the family and the health care team)
- Use the chaplaincy team as an important resource
- Have the humility to admit, "I don't know".

It is very difficult, if not impossible, to care for another human being until we have learnt to care for ourselves. It is not possible to journey with another human being unless we have learnt to be in tune with our own spiritual journey. Nouwen (1979) in his role as a chaplain talks about those who work with those who are suffering as 'wounded healers', such people need to be aware of their own wounded-ness and suffering, and their own human searching. The nurse author, Verena Tschudin (1997) rightly states that we cannot be a friend, a partner, a nurse, a doctor, or chaplain to another until we learn to be these things to ourselves. In order to perform this role, Confoy (2002) believes that health care workers need to be aware of their own humanity.

"Carers who have learnt to accept their own limitations and acknowledge their gifts are best able to companion others in their journey" (30)

One woman reflecting on her experience of living with the uncertainty of leukaemia and the many changes it brought to her felt that perhaps the greatest support she received was that of being held.

"Sometimes all you need in life is to be held, I think…..and I think that is a really important thing….which I think I knew anyway……but I have really felt it with the people that I have met in……or just during these two years" (Yvonne)

The holding she valued was not only that of being physically held but the holding that exists in each caring encounter when one human being attends to another which we all can offer.

Activity 3 (allow approximately 60 minutes)

Task 1
Take one of the suggestions above that you do not normally use and apply it to your clinical practice. Write a brief reflection on using it in practice. What other tools or guides might help to address spiritual care in clinical practice?

Task 2
Critically examine some of the spiritual assessment tools found in the resource section below. What aspects of these tools could you use in your clinical practice?

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Thinking Point:

- What do local, national and international guidelines on cancer say about addressing peoples' spiritual needs in clinical practice?
- How might you raise awareness of spiritual care among your team?
- What resources do you need in order to address spiritual care in practice?
- How might you care for yourself in order to continue caring for someone with cancer?

Resources required to complete this activity

Useful websites

Assessment tools

www.mywhatever.com/cifwriter/library/70/4966.html

www.endoflifecareforadults.nhs.uk/eolc/CS328.htm

Background reading

Barnard, D. (1995) The Promise of Intimacy and Fear of our own Undoing. Journal of Palliative Care. 11(4) 22-26.

Campbell, A. (1984) Moderated Love: A Theology of Professional Care. SPCK. London.

Cassidy, S. (1988) Sharing the Darkness. Darton, Longman and Todd. London.

Elias, N. (1985) The Loneliness of the Dying. Continuum. London.

Katz, R.S. & Johnson, K.T. (2006) When Professional Weep. Routledge. New York.

Mc Namara, B. (2001) Death, Dying and Care. Open University Press. Buckingham.

Nouwen, H.J.M. (1979) The Wounded Healer. Image Books. New York.

Palmer, P. (1988) The Courage to Teach. Jossey-Bass. San Francisco.

Piles, C. (1990) Providing Spiritual Care. Nurse Educator. 15 (1) 36-41.

Speck, P. (1988) Being There. SPCK. London.

Tschudin, V. (1997) 'The Emotional Cost of Caring. In. Brykczynska, G. Caring: The Compassion and Wisdom of Nursing. Arnold. London. 155-179.

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Discussion Board

The discussion board is a forum in which you can exchange ideas with other participants. This activity relates to the work you will have completed in earlier tasks and provides an opportunity for you to explore the difference in perspectives between the participants.

Discussion Board

When will it take place
For a 3 month period from date of publication of this article.

Which discussion thread
Addressing spirituality in cancer care

What is expected of you as a participant
In particular consider the following:

- What is your own understanding of spirituality and spiritual pain?
- What needs to be changed within cancer services to ensure that the important issue of spirituality is addressed more consistently and effectively?
- What barriers exist that make it difficult for members of the team to address this aspect of care?
- What practical guides could you offer to help colleagues address spiritual care?

Summary of this module

By completing this module you should have developed further insight into what is often seen as the elusive concept of spirituality. You should have had the opportunity to reflect upon your own clinical practice in cancer addressing the different components of spiritual expression and need. You should be better able to identify, address and support people with cancer with spiritual needs and concerns. The discussion board activity is aimed at expanding your thinking beyond your own current practice, to consider what changes may be needed at a local, national and international level if the issue of spirituality in cancer care is to be highlighted, addressed and managed in a more effective manner.

On completion of this module you will have had the opportunity to:

- Understand how the concept of spirituality is central to health care and how it may be expressed through the lived experience of cancer
- Gained insight into the beliefs, values and practices of the major religions
- Be more sensitive to the obvious and less obvious expressions of spiritual pain
- Have developed skills to support you in recognising and addressing spiritual needs in clinical practice
- Critically reflected upon your own spiritual beliefs and values

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