Résumé

Les soins spirituels à la jonction de la religion, la culture et l'État

Sheryl Reimer Kirkham, Barbara Pesut, Heather Meyerhoff et Rick Sawatzky

En réponse à une diversité sociale croissante parmi les bénéficiaires de soins de santé, les infirmier(ière)s-chercheur(euse)s ont tourné leur attention vers l'élaboration de fondements théoriques qui permettront de mettre en place des pratiques infirmières respectueuses des croyances spirituelles. Toutefois, malgré la possibilité d'harmoniser ces deux volets, il existe peu de recherches portant sur les intersections potentielles entre culture et spiritualité. Les auteur(e)s présentent les résultats d'une étude pilote axée sur la description interprétative qui a pour objectif l'examen des contextes dans lesquels a lieu la prestation de soins spirituels interculturels, selon la perspective des infirmières, des infirmiers et des aumôniers. Les résultats révèlent des besoins qui invitent les professionnels de la santé à cultiver un espace intérieur à partir duquel ils peuvent dispenser des soins spirituels et rechercher des points spirituels communs en présence de diverses croyances et traditions culturelles. Les environnements de pratique actuels et le milieu social inhérent à un État pluraliste et séculier façonnent les dynamiques entourant les soins spirituels. Les résultats indiquent la nécessité de mener une analyse critique postcoloniale des conceptions contemporaines de la spiritualité et des soins spirituels, et de remettre en question la tendance à éliminer l'importance des *credos* dans la quête d'une expérience spirituelle universelle.

Mots clés : spiritualité, soins spirituels, religion, culture, ethnique, diversité, post-coloniale, description interprétative

Spiritual Caregiving at the Juncture of Religion, Culture, and State

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In response to the increasing social diversity of health-care recipients, nurse scholars have turned their attention to developing theoretical foundations for culturally responsive and spiritually sensitive nursing practice. However, despite the potential overlap between these 2 areas, there has been little exploration of the intersections between culture and spirituality. The authors present the findings of an interpretive descriptive pilot study that examined the contexts of intercultural spiritual caregiving from the perspectives of nurses and chaplains. The findings point to the need for health-care professionals to cultivate an internal space in which to provide spiritual care and to seek spiritual points of connection amidst diverse faith and cultural traditions. The contexts of current practice environments, as well as the social setting of a pluralistic and secular state, shape the dynamics of spiritual caregiving. The findings invite postcolonial, critical analyses of contemporary conceptions of spirituality and spiritual care-giving, and call for a rethinking of the trend towards de-emphasizing creedal religions in the quest for a universal spiritual experience.

Keywords: spirituality, spiritual caregiving, religion, culture, ethnicity, diversity, postcolonialism, interpretive description

As our societies become increasingly diverse, the nursing profession is faced with new challenges across its practice and scholarship domains. To support nurses in the provision of care across a breadth of ethnic, religious, gender, class, and sexual orientation diversity, significant attention has been directed to the areas of culture and spirituality over the past decade or two. Building on the ground-breaking work of Madeleine Leininger, and more recent theoretical influences in critical traditions such as postcolonialism and feminism, a rich body of nursing scholarship has developed to address culture, race, and ethnicity in health care. At the same time, the nursing profession has renewed its commitment to the integration of spirituality and spiritual caregiving, with a burgeoning scholarship base demonstrating a desire for a more universal approach to things spiritual. Yet despite these two growing fields addressing diversity within health care, there has been relatively little substantive exploration of the intersections between these areas of scholarship. In this paper, drawing on a pilot study examining the contexts of intercultural spiritual

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caregiving, we focus on the borderlands between spirituality, religion, culture, and ethnicity.

Background

The purpose of this study was to explore the moral dilemmas faced by nurses and chaplains in the context of intercultural spiritual caregiving and to increase our understanding of how these encounters are shaped by social context. To set the background for the study, we present the demographic diversity of Canadian society. We then discuss two theoretical trends in nursing that have emerged in response to that diversity: that of replacing religion with a more generic and universal spirituality, and that of conflating religion with culture and ethnicity.

Demographic Profile of Canadian Society

With the rise in global migration, cities around the world are becoming increasingly pluralistic. In the geographic area of this study, for instance, recent census data reveal over 80 language groups (Statistics Canada, 2001). As in other Canadian centres, more people reported a language other than English or French as their mother tongue than did in the previous census (1996), yet more citizens referred to themselves as "Canadian," challenging the longstanding construction of Canada as white and English- or French-speaking. In the province where this study was conducted, visible minorities account for 22% (a number rising to 37% in the urban setting of the study) of the total population, although this is well above the national average. Adding to the diversity of Canada's population, the Aboriginal population is also expanding, accounting for 3.3% of the nation's population in 2001 (up 22% from 1996).

Along with this broadening ethnocultural diversity comes a shift in religious affiliation. Although 7 out of 10 Canadians still identify themselves, in recent census data, as Roman Catholic or Protestant, the number of Canadians who report religions such as Islam, Hinduism, Sikhism, and Buddhism has increased substantially. Statistics Canada (2003) explains that "much of the shift in the nation's religious makeup during the past several decades is the result of changing sources of immigrants, which has created a more diverse religious profile." Whereas earlier immigrants came predominantly from Europe, today's immigrants are most likely to come from Asia. Additionally, more Canadians (16%) report that they have no religious affiliation. Bibby (1993), a Canadian sociologist of religion, suggests that while association with formalized religion may be declining, a more personalized spirituality is flourishing. Canadians are also becoming increasingly concerned about religion as a potential source of social conflict (Montgomery, 2004).

Distinguishing Between Religion and Spirituality

Over the past several decades there has been a trend within nursing theory to separate religion from spirituality and to make spirituality the legitimate focus of nursing care. In 1987 Lane explored care of the human spirit and suggested there were two types of care, one that was dependent upon the beliefs and needs of the patient, typically those associated with religious affiliation, and one that applied to all patients. This second form transcended particular belief systems to encompass universal acts of care. These acts were typically sacrificial and characterized by "inward turning, surrendering, committing and struggling" (Lane, 1987, p. 334). Building on this line of differentiation, scholars such as Burkhardt (1989) and Emblen (1992) concluded that religion and spirituality are distinct yet related concepts. They characterized religion as a rational belief system with certain worship practices, whereas they characterized spirituality in terms of mysteriousness, transcendence, and connectedness. At the same time, Reed (1992) was making an argument for a broad understanding of spirituality as part of the foundational ontology of nursing. She claimed that nursing was moving beyond the positivistic, materialistic worldview to embrace the dimensions of humanity related to connectedness, transcendence, and meaning — the characteristics of spirituality. Over the past decade a number of other analyses have treated spirituality and religion as either discrete or hierarchal concepts whereby religion becomes an optional element of spirituality (e.g., Dyson, Cobb, & Forman, 1997; Goddard, 1995; Long, 1997; McSherry & Draper, 1998).

This separation of religion from spirituality in nursing discourse may be related to the changing role of religion in society. Pre-modern societies were based primarily in religion, which provided both legitimacy and meaning to existence. Modernity saw primary legitimacy move from religion to science (Armstrong, 1993; Henery, 2003). This change was clearly reflected in nursing theory, where little was written about the religious dimension of care. Postmodernism has challenged the worldviews of both theism and science, creating a worldview characterized by pluralism and relativism. Within this worldview, spirituality is in large part considered intensely personal and based upon the assumption that all spiritualities are equally valid and true (Salladay, 2000). This perspective promises benefits for nursing practice by offering a conceptual lens through which to provide spiritual care within a context of diversity.

Emerging definitions of spirituality have not been without criticism. Dawson (1997), in reaction to Goddard's (1995) definition of spirituality as integrative energy, argues that this definition has stripped spirituality of its social and historical context, removing much of its meaning.

Henery (2003) views the trend of trying to separate religion from spirituality as one that reconstructs spirituality as religious or scientific discourse. He illustrates that many of the emerging definitions remain highly value laden and create a new religion that lacks the moral and conceptual substance of traditional theologies.

Given such controversy, key questions remain regarding the implementation of this conceptual separation. Does separating religion from spirituality and universalizing the concept of spirituality make spiritual nursing care easier to implement, particularly in the face of diversity? Are current definitions of spirituality congruent with how patients and caregivers define their spirituality? Most importantly in the context of this study, how would this separation be viewed from various cultural perspectives? Would it be seen as a worthy distinction, or simply as a dichotomous product of Western, secularized society? Wright (2002) raises the question of whether spiritual care is transferable across cultures and faiths. Certainly, our constructions of spirituality and religion have the potential to influence that transferability.

Subsuming Religion Under Culture and Ethnicity

Nursing scholarship, influenced by anthropological and sociological perspectives, has tended to subsume religion under the umbrella of culture. From this stance, all cultures are seen to have important religious aspects, and, therefore, to understand ethnic or cultural identity, one must take into account religious identity. Davidhizar, Bechtel, and Cosey (2000), for example, state that "religious practices are usually rooted in culture, and each culture typically has a set of beliefs that define health and the behaviours that prevent or treat illness" (p. 24). Informed by such anthropological views, nursing literature has tended towards descriptions of circumscribed cultural-religious practices, often at the expense of critical analyses of the social, historical, economic, and political contexts in which spiritual and/or religious beliefs are held.

Along with critiques of predominantly culturalist theorizing in nursing (see, for instance, Culley, 1996), several specific concerns arise from the conflation of religion and culture. Close linkages between culture and religion result in essentialist tendencies in which assumptions are made such that ethnocultural affiliation determines religious orientation. Although certain ethnocultural groups tend to affiliate with particular religions, there are always exceptions (e.g., not all Arabic people are Islamic). Moreover, significant variations in beliefs and practices exist within each religious group. Identity politics are such that one's affiliation with any particular group, whether ethnic or religious, shifts over time and context. A broad brush that subsumes religion as a dimension of culture tends not to differentiate specific spiritual care issues, and may

leave nurses bereft of direction in situations of spiritual need. This is particularly the case in liberal-democratic states such as Canada that have secularized public life so that the role of religion/spirituality in public life has been de-emphasized. Conversely, cultural meanings may be lost or attributed to religious affiliation. For example, Narayanasamy and Andrews (2000) recount a situation in which a focus on the religious needs of Muslims overlooks cultural aspects of care that can be of equal importance. Undoubtedly, considerable overlap exists between culture and both religion and spirituality. Our intention here is not to deny this relationship but, rather, to call for more careful conceptual unpacking of this intersection in order to reach a clearer understanding of the implications of conflating one with the other.

The critical traditions of postcolonialism and cultural studies, offering analytic mileage in uncovering damaging effects of race in everyday health care and accounting for intersecting and historical oppressions, serve as more recent theoretical influences on nursing scholarship (Anderson, 2000, 2002; Browne & Smye, 2002; Reimer Kirkham & Anderson, 2002). However, postcolonialism has tended to write out religion, naming it as an instrument of colonialism but offering little analysis of the confluences of religion, state, and ethnicity. A notable exception is the work of Stuart Hall, who provides a postcolonial commentary on religion, citing its political influence:

> In one historical-social formation after another, religion has been bound up in particular ways, wired up very directly as the cultural and ideological underpinning of a particular structure of power. …religion is not free-floating. It exists historically in a particular formation, anchored very directly in a number of different forces… Its meaning — political and ideological — comes precisely from its position within a formation…these are not inevitable articulations….They can potentially be transformed, so that religion can be articulated in more than one way. (cited in Morley & Chen, 1996, p. 142)

Hall recognizes the contradictory nature of religion within colonial contexts, using the example of missionaries helping the same Jamaicans whose enslavement the church previously sanctioned. Such work signals that a postcolonial reading may offer important insights into the realm of spirituality and health care. Overall, the lack of critical conversation at the intersections of religion, spirituality, culture, and ethnicity has resulted in a dearth of theoretical work to draw upon in the examination of intercultural spiritual caregiving. Yet real practice dilemmas face nurses and other health-care workers as they seek to meet the spiritual needs of patients from a range of ethnocultural backgrounds.

Clinical issues at the intersection of religion and culture became visible in an earlier critical ethnography exploring the social organization of intergroup health-care provision (Reimer Kirkham, 2000, 2003) in which nurses told of distressing situations related to spiritual and religious matters, especially in the realm of care at death (e.g., facilitating grieving, death rituals). This finding raised the question of intercultural spiritual caregiving and prompted an extensive literature search. A growing body of prescriptive literature was retrieved, with less empirical evidence pertaining to intercultural spiritual caregiving. McSherry and Ross (2002) explicate the dilemmas inherent in spiritual assessment. Various barriers have been identified. These include demanding workloads that prohibit spiritual caregiving, the perception of spiritual caregiving as low priority, insufficient education in spiritual caregiving, lack of confidence, differences in faith between patient and nurse, and confusion over the distinction between proselytizing and providing spiritual care (Narayanasamy & Owens, 2001; Vance, 2001; Van Dover & Bacon, 2001). The diversity of Canadian society and the trends within nursing to separate religion from spirituality and to subsume religion under culture and ethnicity formed the background for this study. We were particularly interested in how the intersection of these important concepts played out in intercultural encounters within health care.

The Study

The purpose of the study was to explore moral dilemmas faced by nurses and chaplains in intercultural spiritual caregiving, and how these moral dilemmas are shaped by social context. The research questions were: *How do nurses and chaplains describe spirituality and spiritual care? How do they provide spiritual care in intercultural situations? How do they provide spiritual care to someone who does not share their spiritual and/or religious beliefs? What contextual factors influence intercultural spiritual caregiving?*

As a pilot study, this project forms the basis of a larger ethnographic study examining religious plurality in health care. The interpretive descriptive method developed by Thorne, Reimer Kirkham, and MacDonald-Emes (1997) was employed. The base of interpretive description is the smaller-scale qualitative investigation of a clinical phenomenon of interest to the discipline of nursing. The method provides "direction in the creation of an interpretive account that is generated on the basis of informed questioning, using techniques of reflective, critical examination, and which will ultimately guide and inform disciplinary thought in some manner" (Thorne, Reimer Kirkham, & O'Flynn-Magee, 2004, p. 6).

Persons were invited to participate on the basis of their known expertise and/or commitment to spiritual caregiving. Four nurses (three female, one male) and two chaplains (one male, one female) were interviewed. Although representing various denominations (e.g., Catholicism and mainstream and evangelical Protestantism), all of the participants self-identified as holding to the broader Christian tradition. The participants were all English-speaking Canadians but reported various cultural heritages. Following approval by the Institutional Review Board, informed consent was obtained from each participant. Interviews were conducted by the principal investigator in various locations identified as "convenient" by the participants (e.g., cafés, homes, workplaces). These interviews were guided by broad open-ended questions such as "How do you understand spiritual care?" "How do you provide spiritual care in intercultural situations?" All interviews were audiotaped and transcribed. A follow-up focus-group interview with the same participants was used to validate meanings and extend the discussion. Each investigator coded the transcripts using a mutually agreed upon code book, and main themes emerging from the data were synthesized into a thematic framework representing the whole.

Strategies for ensuring trustworthiness of the data-collection and analysis processes involved triangulation of theoretical schemes (Lather, 1991), reflexivity (enhanced through field notes), and member checking in which emerging analytical structures were discussed in a follow-up focus-group meeting with participants. Construct validity (Lather) was sought through repeated immersion in the data while grounding analyses in the above-mentioned theoretical perspectives, thus maintaining a dialectic between theory and research. Detailed notes recorded during group analysis served as an auditable decision trail.

Limitations of the study include those intrinsic to self-report and a small non-representative sample. We also acknowledge dangers stemming from our position as researchers, particularly as our Christian affiliations lent to a reading of data from the perspective of a shared lens. To counter these limitations, we engaged in reflexive application of various theoretical perspectives, including those of postcolonialism, philosophy, and theology. This reflexivity prompted us to continuously evaluate our interpretations through these various theoretical lenses. Postcolonialism, for example, alerted us to the possibility that our analysis might be inscribed by dominant Western interpretations of spirituality.

Findings

The central question of this study — What are the moral dilemmas faced by nurses engaged in intercultural spiritual caregiving? — served as the

basis for our initial analysis. As the study progressed, however, the theme of moral dilemma became less central as we struggled to understand how culture, spirituality, and spiritual caregiving are constructed, and what contextual factors and philosophical positions influence these constructions. Indeed, this illustrates how challenging it can be to construct spirituality and culture or to differentiate these concepts from religion except in a purely theoretical sense. Although we present our findings using personal, interpersonal, institutional, and sociopolitical levels as the organizing framework, we seek an integrated understanding of how everyday person-to-person encounters are shaped by larger social processes.

Personal Context: Cultivating an Internal Space for Spiritual Caregiving

All of the participants identified the importance of the internal space of the caregiver to the effectiveness of spiritual caregiving encounters. This internal space had certain characteristics such as a posture of learning, a willingness to connect, and a level of comfort with things spiritual. However, creating this space was often portrayed as challenging, risky work in which caregivers were forced to confront their own conflicting beliefs and agendas.

Participants spoke of an evolving level of comfort with what they referred to as spiritual issues. One participant recounted an experience she had had as a new graduate that opened the door to the possibility of spiritual caregiving and enabled her to feel more confident with this sensitive topic:

> *There was a young boy who was 17 and he was dying of leukemia. One night he just couldn't sleep. We sat down and we were talking about death, dying, and heaven and what his beliefs were. And it was a really, really wonderful, wonderful night.*

Thus, there needed to be a determination that spiritual caregiving was a legitimate part of the nursing role. Once that decision was made, nurses needed to make it a part of their routine consideration. Several participants spoke of the importance of keeping spiritual caregiving foremost in their minds as they went about their day. When spiritual caregiving was understood as integrated into the day-to-day care of the patient, as one participant pointed out, careful listening to cues would often provide an opportunity for further exploration of spiritual matters:

> *As a nurse, I think the first step has to be something at the forefront of your mind. So if you're coming in to look after a patient, it is not so much about asking but being aware in yourself. So that when those kinds of things come up in conversation, whether a feeling of anxiety about something or not feeling support, these are windows of opportunity.*

This comment reflects the importance of the nurse's own positioning and self-awareness as a precondition to reading the cues a patient might provide.

Beyond the holding of the consciousness of spirituality, participants spoke of cultivating an attitude that allowed them to enter what one referred to as the "god space":

> *In many different ways I am a healer, and I'm not up here looking down on you who's weak and in the bed, and you have nothing to offer me. But it's now I'm a healer and if I'm open, and I'm honest, and I'm vulnerable to you, then that will again create sort of a god space. We're two human beings and we're struggling in different ways. But I have something in common with you. To realize that in fact…they were becoming a healer for me.*

This statement reveals that a caregiver's openness, vulnerability, and desire to genuinely understand the beliefs of another facilitate connection and exchange. Overall, it meant being comfortable with things spiritual, shaped by one's own sense of meaning, experiences of transcendence, and/or religious beliefs. Interestingly, one participant eloquently expressed the belief that this level of comfort could also be achieved through education.

One theme that emerged was that of addressing personal fears, agendas, and motivations. To engage with others, one had to be willing to take risks, such as being seen as interfering or as imposing one's views. Personal agendas were particularly challenging from the perspective of the evangelical worldview. Participants reflected on how they came to terms with the larger evangelical agenda of proselytizing (e.g., "sharing the good news") and their awareness of this as crossing professional boundaries. Caregivers spoke of considering the potential of harming the patient. They imagined themselves in a vulnerable position in a society where different beliefs prevailed and wondered how they might feel. For some, this fear was so strong that they had avoided the subject of spirituality altogether with their patients. One participant thoughtfully reflected on her longstanding relationship with a Thai family:

> *I'm so careful about not transgressing professional boundaries. Since she hadn't brought it up, I hadn't. The way I approached it is if I can build enough trust that they'll bring it up, then I'm happy to talk about it and encourage them to talk about it. But I'm not going to bring it up. I've been too paralyzed by these fears of imposing my religion. …being so respectful that you avoid the subject.*

This participant realized, however, that because of her guarded approach she was missing an entire dimension of her patients' lives. When she tact-

fully brought up the topic, the client "opened like a flower; she wanted to talk about it." A rich spiritual relationship ensued. Thus, while the fear of imposition represented a moral dilemma for the participant, by reframing her understanding of spirituality and spiritual caregiving she came to a place where she had the freedom to address spirituality in client-sensitive ways.

Another participant spoke of redefining spiritual care, from talking about God and the Bible to being an authentic "listening presence" of god for the person; she found it hard work to remain conscious of that:

> *The challenge and the discipline of that was to go in and leave my own self outside the door, just walk in, available…it's discipline and hard work to really be in tune. You leave the room realizing if you believed your traditional things, I didn't provide spiritual care because we didn't talk about God, read any Bible verses, and I didn't even pray with him. So how did I provide spiritual care? Well, I was aware of his spirituality. I was present for him.*

For this particular caregiver, internal reframing entailed cultivating an awareness that God was at work beyond her ability, and that work was often mysterious and surprising.

In summary, participants described a conscious internal context, characterized by connectedness, learning, and an ease with things spiritual. The development of this context required one to confront personal agendas and motivations and come to terms with how they fit into the context of a pluralistic society.

Interpersonal Encounters: Narratives of Connection

Spiritual caregiving as essentially relational in nature was another theme, one that is in keeping with a construction of spiritual caregiving as primarily a matter of "being" rather than "doing." While specific actions (e.g., facilitating prayer, listening to music with the patient, making referrals to chaplaincy or other spiritual providers) were identified as examples of spiritual caregiving, the data more often revealed spiritual caregiving as a combination of being present, reading cues provided by the patient/family, and creating spaces for spiritual expression. As participants described their evolution through the "work" of valuing and gaining comfort in tending to the spiritual, many of their narratives suggested the centrality of human connectedness in intercultural spiritual caregiving.

Participants emphasized trusting relationships as foundational to spiritual caregiving. One nurse commented: "I don't think I could go into a room and start talking about religion with someone I didn't know. I feel more comfortable doing that with my primary…patients." Another nurse observed: "I don't believe we'll get anywhere near enough to a person to

talk about spirituality…because that is probably pretty core for them…unless we build a relationship." Inherent in the need for a pre-existing relationship, then, was the conviction that spirituality can be an intensely private or personal aspect of a person, one that cannot be tapped into without trust and caring. Other participants, particularly chaplains, recounted situations in which they did not have an opportunity to develop a relationship with the patient and had to "go in cold." In such situations, they paid close attention to the patient's cues and sought to follow the patient's agenda or expectations.

Participants told powerful stories of connecting with clients through the dimension of spirituality. The theme of seeking common ground was evident in a range of situations. In the context of caring for patients with chemical dependencies ("drug abusers, alcoholics"), one participant spoke to the importance of "finding that common ground." Another nurse, reflecting on her relationship with a Thai family, observed that "true spirituality cuts across all these barriers." She understood spirituality as a point of connection with her patients, regardless of their religious or spiritual affiliations. This connection is aptly reflected in her description of a visit to the home of a Sikh woman:

> *I feel I have a spiritual bond with many of the Sikh and Punjabi patients — they are so devout. When I come to a woman's house and I know that she has had a prayer shawl over her head and then she comes and beckons me, I feel like I'm almost walking on holy ground. And I feel an immediate bond. So I don't feel, oh, you're from a different religion. I admire her devotion and so it's a bond for me. Not such a barrier.*

Such a propensity to seek connections in the face of what might be constructed as a considerable religious difference (between a Sikh and a Christian) reveals a high level of regard for others and an understanding of spirituality as at the core of each person. This same participant had visited various religious/spiritual sites (Sikh temple, First Nations longhouse) at the invitation of clients, which again suggests openness to a range of spiritual traditions.

Connections were facilitated through "presencing," or what one chaplain referred to as the "ministry of presence." As an aspect of presencing, participants described how they created sacred spaces through subtle but intentional movement towards a discussion of things spiritual. A simple question such as "Did the priest come today?" or "It looks like your representative from the Sikh faith was here" could be used as an opportunity to explore a patient's spiritual concerns. The participants also cited the importance of establishing a physical environment conducive to meditation, prayer, or spiritual reflection. One nurse explained: "I'll hear chanting and I'll know it's 7 o'clock — that's prayer time, so I don't

disturb them…or you close the curtain so that they have more privacy, that sort of climate."

Participants recognized the challenges, however, in seeking spiritual connection in the face of differences in religious affiliation, language, and cultural identity. As with other dimensions of intercultural care, the issue of language was raised in the context of spiritual caregiving:

> *My experience has been that the faith group they belong to often involves a language barrier and therein is the problem. It is not so much that I wouldn't be there for the person who is experiencing, say, the Baha'i faith, or they are Hindu, or Muslim…. That's not the problem. The problem is frequently the language link.*

Moral dilemmas arose for participants when patients/families held divergent worldviews that resulted in disagreement over treatment options. One participant reflected on a case in which active oncological treatment, including bone marrow transplantation, was withdrawn when the patient, a young man with leukemia, "failed his treatment; his disease came back":

> *His family wanted us to do everything, but we couldn't do that because we have policies laid out. In order to have a bone marrow transplant, you have to go through all of this criteria. It was very difficult. There was a lot of argument. There was a lot of anger and resentment. They would say, "You don't understand." It certainly caused a lot of stress for the nursing staff. Actually, initially we didn't understand why they were acting like this and we had to be told that this was part of the religion that they certainly didn't give up on life.*

This story demonstrates the need for the clear communication of basic values between families and caregivers, and the tension that stems from discrepant values and beliefs. It also speaks to the breadth of knowledge regarding religious and cultural practices required of nurses in today's diverse societies.

Another participant mused about the challenges of providing spiritual care to someone with vastly different beliefs:

> *It would be very difficult if a person, nurse X, has, for the sake of discussion, a fairly conservative Christian position…. This nurse is going to have some real personal struggles if they find out that the patient is Wiccan; the patient says, "I'm a Wiccan, I'm a witch." This witch lying in the bed is dying and is struggling with some issues. What on earth does that nurse do with those sets of values? How do you be there to respect that person when every fibre of your religious orientation says that is what I live in opposition to?*

Participants in this study, then, spoke to the importance of building spiritual connections across worldviews and belief systems, but also recognized the difficulties inherent in such efforts.

Health–Care Context: Workloads, Professional (De)Valuing, and Curative Agendas

Not surprisingly, current practice environments were described as barriers to addressing spiritual matters. Maintaining an awareness of the spiritual dimension was particularly challenging because of the heavy workloads of the nurse caregivers, and the invisibility of the spiritual domain within biomedical agendas and secular culture.

Participants spoke of the amount of time and energy it takes to perform basic physical care and the sheer fatigue that could prevent them from engaging with the often emotionally demanding spiritual dimension. One nurse described the priorities embedded within patterns of caregiving:

> *You've got this hideous morning rush that starts at 7 a.m. and doesn't end until 10ish. It is the magical 3 hours during which all nurses, according to the good little books — I'm being sarcastic here — are supposed to have done all of the nice things, the bed baths, make the beds, get them up, get them dressed. Now, in the larger scheme of things, if I don't get three of the patients up and bathed by 10:30 because I've spent some time with the patient meeting spiritual needs, for me that's not a problem. However, one of the problems we have within the context of nursing is that my colleagues might look at me with more than a little disgust. "What the blank blank blank is he doing? I just saw him sitting talking to a patient. Well, doesn't he know we have work to do?"*

As revealed in this comment, nurses might be made to feel irresponsible for engaging in a "non–essential" aspect of care. Nurses and chaplains alike experienced a marginalization of spiritual care. In the words of one participant:

> *It doesn't have that validation stamp, that societal validation stamp. Right now, society, thank goodness, is just now, in the last 5 years, starting to say, yeah, there's a whole area of mental health that is just as legitimate as the broken arm, cut hand. What we have yet to do is take that societal step and say there is a whole spiritual crisis that is just as legitimate as the psychological/physical.*

To counter this devaluing of spiritual matters, participants recommended stronger endorsement of spiritual caregiving by the profession's leaders. This same participant asked, "How many nurses feel [they have] permission from their supervisor, the hospital administration, their own

professional association, to pursue spiritual issues with their patients?" Administrative decisions were seen as vital in the valuing or devaluing of spiritual care. For example, the provision of chaplaincy services (delivered by paid or unpaid hospital staff), as evidenced during interdisciplinary rounds, was seen as communicating a valuing of spiritual matters. On the other hand, hospitals that did not have paid chaplaincy but relied on volunteers from the pastoral community were perceived as placing less value on spiritual care.

Participants posited that the spiritual dimension was more visible and attended to in non-acute settings such as the community or palliative care, citing as barriers the overarching curative agenda of biomedicine and the fiscal priorities of today's health-care management. One participant commented on the curative focus of the unit she worked on:

> *You would think spiritual care would be really important on an oncology unit, but surprisingly it's not….We're so acute, the focus is cure, cure, cure. We're constantly boosting, boosting, boosting. Then, when we have to deal with palliation, we have to change gears quickly… It's weird to sit down and talk.*

This "changing of gears" raises the question of how spirituality is integrated into acute settings, and how spiritual caregiving issues are addressed within curative agendas. Another participant reflected on the potential incongruence between contemporary emphases on evidence-based practice and spiritual caregiving: "The whole realm of faith issues, by their nature, are not always evidence-based. By definition, spiritual matters are intrinsically internal."

A subtext of moral dilemma, sometimes in the form of guilt, was evident as participants reflected on how practice environments mitigated their attending to things of a spiritual nature. Although they were committed to integrating spirituality into their practice, they were constrained by heavy workloads (driven by fiscal agendas), curative foci, and widespread devaluing of the spiritual, leaving them dissatisfied.

Sociopolitical Context: Negotiating Secularism, Pluralism, and Relativism

While significantly shaped by the commitment of each caregiver at the personal level, by the degree of interpersonal connection achieved, and by the demands and agendas of the health-care environment, spiritual caregiving is also influenced by sociopolitical context. In particular, the confluence between secularism and pluralism at the level of state polity entered into the dialogue of this study. Several participants commented on Canada's official position of secularism, noting that this policy prohibits proselytization, or "missionary work," in health-care settings while at the same time fostering pluralistic spiritual/religious expression. One

chaplain explained: "It's a public institution. If that man wants the witch doctor, get him the witch doctor. You cannot control a public environment from a specific religious point of view." However, in a pluralistic environment, especially under an official state policy of secularism, the tendency is towards what one participant referred to as "relativizing" religions:

> *There is a tendency in Canada that toleration becomes relativism, that people aren't allowed to be specific people. That is dangerous. What do you do with the Sikh? The Hindu? And with a Jew? You want to relativize them? Make no mistake. You look just at what happens in the world today. There's no way you can relativize religions. You have to respect the particularity of the people you're working with.*

Such comments alert us to the challenges inherent in a society that professes cultural and religious plurality. It may be that in some situations, secularism, rather than opening up space for dialogue, actually constrains open expression of religious/spiritual beliefs. Further, the secularism of Western society may be interpreted as an instrument of assimilation, whereby the role of religion is downplayed and religious distinctions are quietly erased or "relativized."

The exclusion of religion from the state, characteristic of secular societies such as Canada, also intimates that spiritual matters fall within the domain of the personal and therefore may have less relevance in the public administration of health care. Several participants raised the notion of the spiritual as private and, in turn, spiritual caregiving as potentially intrusive. Yet others recognized the political nature of religion:

> *What if a committed Catholic nurse working in Emerg in Dublin [sic] finds herself having to treat an Orangeman who's just come in from a riot? The Orangeman opens his eyes, recognizes he's likely to die shortly. Now this deeply Catholic nurse has to be there spiritually for the person who has just killed her family members or friends. What do we do with that?*

This participant is astutely observing the dangers of assuming an apolitical interpretation of spirituality and religion.

The findings also suggest a pervasive conflation of religion and ethnicity, with the associated tendency towards essentialism and exoticizing of "foreign" beliefs. While the participants acknowledged the range of diversity within the Christian tradition, they made generalizing assumptions about religious groups, such as that all people of Punjabi heritage would be devout believers in the Sikh faith, or that followers of Eastern religions are "more devout." A participant who worked closely with Aboriginal communities observed that although public discourse makes much of indigenous "spiritist" beliefs, this picture may not fit all

Aboriginal peoples. She quoted an Aboriginal woman as asserting, "Christianity is a strong part of our tradition; there's this thought that it is foreign, but as far back as I can remember our family…are Christians." This example highlights the need for a more careful approach to the matter of religious affiliation, and illustrates the non-static, political nature of religious/spiritual affiliations as played out in particular sociohistorical contexts.

Overall, the findings of this study suggest that nurses and health-care providers are caught in the currents of social change as they respond to the diverse spiritual and religious needs of those they care for. The curative emphases of biomedicine and science; the postmodern reawakening of the spiritual; Western ideologies of individualism and secularism; increased global migration; and the inevitable managerialism occurring in the large health-care organizations of our free-market societies all enter into contemporary constructions of spirituality and spiritual caregiving.

Discussion: Constructing Spirituality, Operationalizing Spiritual Caregiving

The issues raised by this study have implications for how we theorize spirituality and operationalize spiritual caregiving within health care. As portrayed in this study, spiritual caregiving, when founded on the belief that all humans are spiritual beings, is capable of crossing boundaries of faith and tradition, serving as a vehicle for intercultural connection in a broader sense. We concur with Wright (2002), who observes that while we must recognize the inherent dangers in ascribing a Western concept of spirituality to other cultures or religions, we ought also to acknowledge the capacity of human beings to make contact with each other through humanitarian gestures such as being present, listening, respecting, and loving. Herein lies considerable potential for interfaith, intercultural community in a pluralistic society. Yet, perhaps more fundamentally, this study raises questions regarding our theorizing of spirituality and religion.

Much is said in the nursing literature about the need to clarify the rather elusive concept of spirituality. With this study, we add our voices to this call for conceptual clarity. At a rudimentary level, the findings echo current tensions in both nursing scholarship and nursing practice: Is spirituality a constituting energy, resulting in a view of spiritual caregiving as integrated into all of what one does as a nurse, or is it a discrete aspect of a larger whole, in which case spiritual caregiving might well be compartmentalized (as is the case when relegated to chaplains, the "spiritual care specialists"). This tension was evident in many of the transcripts.

As researchers, we also found ourselves struggling with such a dichotomy, initially coding specific actions as spiritual caregiving and looking for antecedents and consequences of spiritual caregiving in the data. We soon found this coding structure constraining and difficult to apply, and therefore moved to a broader understanding of spirituality and spiritual caregiving, as integrated into the very essence of all nursing care. Both positions carry implications that require further analysis.

Where one's construction of spirituality falls on this discrete/integrated continuum is influenced in part by the objectivist, material emphases of science that continue to dominate biomedicine. Offering a countering tone to these strong social forces is the postmodern worldview with its criticism of the hegemonic hold of modernism's totalizing discourses. Contemporary nursing scholarship relies substantially on New Age spiritualities associated with postmodernism (see, for example, Watson, 2004) and views spirituality, on paper at least, as an integrated phenomenon. Yet in nursing, as in many other arenas, the gap between theory and practice is such that while spirituality and spiritual caregiving are carefully described in the literature, nurses continue to view spiritual caregiving as a discrete "add on," perhaps the responsibility of a spiritual expert and likely not a priority in the face of the endless demands characteristic of today's practice environments. Thus, a continuum of valuing or (de)valuing spirituality and spiritual caregiving can be roughly traced in conjunction with the integrated/discrete continuum, both of which are shaped by health-care contexts that privilege the scientific agendas of biomedicine and the fiscal constraints characteristic of today's pervasive managerialism.

The findings speaking to the tension between constructions of spirituality as personal/apolitical or public/political also have important ramifications. Nursing scholarship, in emphasizing spirituality as a universal phenomenon with its myriad individual expressions, rather than religion with its formalized institutions, attempts to transcend ideological and theological differences among religious groups, thereby establishing a common ground for discussion. But where the lens of spirituality in our theorizing has succeeded in opening a space for the re-entry of the immaterial — the spiritual — into our discourse, we run into danger when it closes the door on a whole range of religious expressions. It could be argued that nursing's turn towards spirituality as a universal phenomenon and its de-emphasis on religion has the inadvertent, paradoxical effect of writing out groups of people, many of them from non-Western, non-English-speaking backgrounds, who see their spirituality as integrally linked to creedal religion. With both Christianity and Islam growing quickly in developing countries, more migrants coming to Canada carry strong religious affiliations. Religion, as a fundamentally

social phenomenon, is intensely political, rooted in long histories of conquest, domination, and diaspora. These histories continue to penetrate the religious/spiritual experiences of many. While some leave behind institutionalized religion on account of these histories and seek spirituality outside of religion, others hold to their faith traditions. To move our theory exclusively towards spirituality is to risk being profoundly apolitical, in essence failing to understand people's lives contextually at a time when religion is deeply political, and increasingly racialized. If we agree with spiritual leaders such as Rabbi Michael Lerner (2002) and Matthew Fox (2000), that spirituality is experienced within and outside of religion, then we need to situate our theorizing across this grid of religious influence, not solely outside the realm of religion.

Assumptions about a secular society and the erasure of creedal religions from much of our nursing theorizing on spirituality may be "read" as a form of imposition by affiliates of such religions. However, this distancing from religion is only partial, in that religious traditions, particularly Christian ones, continue to deeply influence how spirituality is constructed. A review of our interview data and our analytic notes reveals that participants, in describing spiritual caregiving, relied heavily on Christian images. This dominant reference point raises further questions about how nurses interpret cues to spiritual need. Similarly, accounts such as that of the Christian nurse who connected with the Sikh woman in her prayer shawl illustrate an ambiguous position of openness to shared spirituality (ecumenism) while reproducing Western discourses of spirituality/religion as primarily personal and within the realm of the private. Our call, then, is for a re-evaluation of current nursing scholarship with an eye to unpacking the inscription of Western constructions of religion and spirituality onto spiritual experiences, while continuing to acknowledge the very real and often political role that, for many, religion plays in the everyday experiences of spirituality.

A handful of scholars offer similar cautions. Markham (1998) observes that all multifaith traditions may not identify with the term or share the same definition of spirituality, noting that the manner in which spirituality is being developed within health care is a secular version of Judeo-Christian spirituality, thereby running the risk of offending. Wright (2002) explains that Western definitions of personhood construct the person as individualized, intentional, the locus of thought, action, and belief. These ideas resonate with the notions that spirituality is about seeing the individual as a unique person, discovering the purpose of one's life, internal values, and a religious set of beliefs. In contrast, Eastern pantheist traditions view the spirit as non-local, timeless, spaceless, and immortal, and the world as a single interconnected entity with spirituality being synonymous with the forces of nature (Greenstreet, 1999).

Thus, while we have expanded our conceptions of spirituality to extend beyond religion, we question whether nursing scholarship has remained firmly rooted in Western thought, and whether it is at risk of failing to resonate with today's pluralistic society and further inscribing imperialist histories of Western domination.

We have drawn attention to shortcomings in current constructions of spirituality and spiritual care that are exposed in an investigation of the contexts of spiritual caregiving. Our caution is not to abandon development of the concept of spirituality, but rather to theorize spirituality in conjunction with careful analyses of related issues such as dynamics of power, opportunities for social support and identification, and political affiliations associated with religion. The intersection of ethnicity, culture, religion, and spirituality needs to be probed for the sake of conceptual clarity and direction for practice. The results of this study, then, raise questions for future research and underline the need for alternative analytic lenses, including those offered by postcolonial studies and philosophical inquiry, in order to understand the complex terrain at the juncture of religion, spirituality, culture, state, and health care.

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