The qualitative development of a practical and ethical framework for the integration of spiritual aspects into the health practitioner's consultation

A thesis submitted in partial fulfilment of the requirements for the degree of

Doctor of Philosophy

in Health Ethics

Ellenore D Meyer van den Heever

Supervisor: Professor Werdie van Staden

Centre for Ethics and Philosophy of Health Sciences,
Faculty of Health Sciences, University of Pretoria,

South Africa

November 2019

Summary

Spiritual care of patients is considered a fundamental component of quality, compassionate health care. In the African context spirituality is seen as a vital component of whole-person care (Louw, 2014; De la Porte, 2016). However, a practical and ethical framework has not been available by which to integrate spiritual aspects into the consultation between patient and practitioner. The development of a framework in this study expands on the recommendations made by the authors of the standards for spiritual care (Puchalski, Vitillo, Hull & Reller, 2014). This accounts for the structure, process and outcome elements of spiritual care within health service design (Daaleman, 2012). The framework is the product of this study, rooted in the perspectives of various role-players in spiritual care.

This qualitative study used a case study design that accounted for the perspectives of three kinds of role-players within health care, viz. spiritual health care scholars, health practitioners and patients, sampled purposefully from private practice, Daspoort Clinic and the University of Pretoria High Performance Centre in South Africa respectively. Practical guidance items extracted from literature were drafted into an initial framework. They were then subjected to a process of development, revision and refinement through participant contributions through individual interviews and a focus group. Structural coding was used in the analysis as to yield various iterations of the practical and ethical framework presented in its final format in this thesis.

The framework describes eight principles for quality spiritual care, with specific quality requirements for each principle. It makes recommendations on how to implement the principles. The framework also describes possible catalysts and impediments to quality spiritual care. Findings are also presented on how the framework was derived from the contributions of the various participants. From the health experts, the benefits and ways of incorporating spirituality were underscored and taken up in the framework. Patients contributed to the framework mainly by underscoring the importance of a suitable attitude of the practitioner and a sincere person-to-person engagement. The inter-disciplinary team underscored the importance of incorporating spiritual rituals and accounting for their potential complications.

The framework may be used to inform and guide individual practice, inter-disciplinary health management and policy development. In research, the framework may be developed further to address what the ethical boundaries would be for introducing spiritual rituals within the health context, anticipating that such will need to be context-sensitive and responsive.

Keywords: spirituality, religion, rituals, culture, healthcare, spiritual healthcare, holistic health, person-centred healthcare, principles, framework

Acknowledgments

I would like to thank the following people without whom this research would not have come to life. Some shared their personal stories, others helped with the construct of a framework through continuous positive critique. Some motivated me throughout the process to keep going.

I would like to thank Professor Werdie van Staden, my supervisor, for the perfect balance between asking questions, directing and creating an environment for me to learn, explore and refine the research product. I also have to acknowledge and give thanks to the important role of the research participants in allowing me to hear and see the need and value of spiritual care through their experiences and stories.

Lastly, I would like to thank my husband Jaco, for listening to my ideas, believing in me and creating space between our busy home lives for me to do this research.

The Research Ethics Committee, Faculty Health Sciences, University of Pretoria complies with ICH-GCP guidelines and has US Federal wide Assurance.
- FWA 00002567, Approved dd 22 May 2002 and Expires 28 August 2018.
- IRB 0000 2235 IORG0001762 Approved dd 22/04/2014 and Expires 22/04/2017.

UNIVERSITEIT VAN PRETORIA
UNIVERSITY OF PRETORIA
YUNIBESITHI YA PRETORIA

Faculty of Health Sciences Research Ethics Committee

23/02/2017

Approval Certificate
New Application

Ethics Reference No.: 40/2017

Title: The qualitative development of a practical and ethical framework for the integration of spiritual aspects in the health practitioner's consultation

Dear Dr Ellenore Dorette Meyer-van den Heever

The **New Application** as supported by documents specified in your cover letter dated 14/02/2017 for your research received on the 20/02/2017, was approved by the Faculty of Health Sciences Research Ethics Committee on its quorate meeting of 22/02/2017.

Please note the following about your ethics approval:
- Ethics Approval is valid for 4 years
- Please remember to use your protocol number (**40/2017**) on any documents or correspondence with the Research Ethics Committee regarding your research.
- Please note that the Research Ethics Committee may ask further questions, seek additional information, require further modification, or monitor the conduct of your research.

Ethics approval is subject to the following:
- The ethics approval is conditional on the receipt of **6 monthly written Progress Reports**, and
- The ethics approval is conditional on the research being conducted as stipulated by the details of all documents submitted to the Committee. In the event that a further need arises to change who the investigators are, the methods or any other aspect, such changes must be submitted as an Amendment for approval by the Committee.

Additional Conditions:
- Approval is conditional upon the Research Ethics Committee receiving permissions from the Spiritual Health Conference, High Performance Centre and InterCare Siver Lakes.

We wish you the best with your research.

Yours sincerely

Dr R Sommers; MBChB; MMed (Int); MPharMed,PhD
Deputy Chairperson of the Faculty of Health Sciences Research Ethics Committee, University of Pretoria

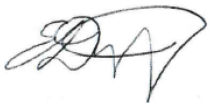
The Faculty of Health Sciences Research Ethics Committee complies with the SA National Act 61 of 2003 as it pertains to health research and the United States Code of Federal Regulations Title 45 and 46. This committee abides by the ethical norms and principles for research, established by the Declaration of Helsinki, the South African Medical Research Council Guidelines as well as the Guidelines for Ethical Research: Principles Structures and Processes, Second Edition 2015 (Department of Health).

☎ 012 356 3084 deepeka.behari@up.ac.za / fhsethics@up.ac.za http://www.up.ac.za/healthethics
✉ Private Bag X323, Arcadia, 0007 - Tswelopele Building, Level 4, Room 60, Gezina, Pretoria

Declaration of originality

I declare that the thesis, which I hereby submit for the Doctor of Philosophy in Health Ethics programme at the University of Pretoria, is my own work and has not previously been submitted for a degree at another university. Referencing of all secondary material used has been applied throughout this thesis in accordance with University requirements. I am aware of the University's policy and implications regarding plagiarism.

Name: Ellenore D Meyer-van den Heever

Signature: 

Date: 22 Jan 2020

Table of contents

Thesis summary

Acknowledgements

Declaration of originality

Contents

The findings of the study may potentially contribute towards improving policy in South Africa and Africa as they address practical components required to assess spiritual distress and implement care towards spiritual well-being in a multi-cultural and multi-religious context. Health policy and how health services are organised within a health system can have a major impact on whether spirituality in health care is addressed effectively and perceived to be of good quality and value for patients utilising the services offered. Health policy should acknowledge the importance of spiritual health, and legislation should support the offering of such services within clinical settings. Health care systems should adopt a wellness approach to patient care that accounts for the spiritual. This should filter down to how health services are offered on different levels of care. Traditionally, the disease-based approach to health care focused primarily on the patient's presenting complaint. A welcome shift in health care to a wellness approach has been adopted, at least at the policy level, by many countries. The wellness screening in resource-constrained settings currently focuses mainly on prevention of the most prevalent chronic conditions. The spiritual influence on wellness and adherence to care should be accounted for at both the policy and service delivery levels. In the

Chapter 1
Introduction and background

1.1 Introduction

Patients report a need for spiritual care, and although some practitioners have begun to express a desire to address this need, the competence and confidence to offer spiritual care are often lacking (Ruder, 2013; Taylor, 2012). The benefits of incorporating spiritual aspects into personal health care have been related by several authors (e.g., Wright, 2005; Strydom, 2013; De Wet, 2014; Koenig, King & Carson, 2012). These are possible positive effects, not only for patients, but also for their families, and could enhance perceived job-satisfaction amongst the practitioners. Koenig, King and Carson (2012) did an extensive review of existing research showing that religious and spiritual care activities improve the mental and physical health of patients (and families) when attended to throughout the care process. The application and expression of spirituality in different health contexts are subjected to cultural relevance. From the East, where scientists have validated the physical and emotional impact when health professionals prescribe *Forest Therapy* or *Forest Bathing* (Nakamura, 2008) as part of a holistic care plan, to the West, where surgical disciplines such as orthopaedic surgery recommend incorporating spiritual care for patients who have undergone surgery, as it improves, amongst other things, overall satisfaction with the treatment outcomes (McGraw, 2011), spirituality as part of a holistic health approach is receiving renewed attention in the scientific health field.

Although there seems to be much openness in the health profession regarding the fact that spirituality should be incorporated into health care, there is still uncertainty on a number of areas:

- What is meant by spirituality and spiritual care in the health context?
- Who should incorporate this care and take the lead within the inter-disciplinary team?
- What would be the best approach to satisfy a person-centric approach, best practice and patient perception of good quality and relevance?
- What are the components of spiritual care within an ethical and practical framework?

This thesis explored this topic with experts in the field, patients and an inter-professional team. Chapter 1 describes the motivation for the research and the approach followed within the context of existing literature on spiritual health care. The chapter explores the current evidenced-based knowledge available on the topic and argues the need for qualitative research that describes an ethical and practical framework within healthcare to incorporate spirituality within the African context.

1.2 Background literature

1.2.1 Defining spirituality

As is well-established, definitions for higher-order concepts like spirituality are notoriously problematic in logically capturing the scope of the items that fall under it. Nonetheless, the various attempts to define spirituality serve as ostensive descriptions of the items falling under the concept. Defining spirituality may be as elusive as trying to capture and bottle the wind – a fitting metaphor considering that the word *spiritus* is derived from the Latin meaning 'breath' and is akin to the Greek word *pneuma.* Nonetheless, the Oxford Dictionary Online (2014) defines the spiritual as "relating to or affecting the human spirit or soul as opposed to material or physical things". Another definition given by the dictionary is "having a relationship based on a profound level of mental or emotional communion".

Puchalski, Vitillo, Hull and Reller's (2014:11) description is "Spirituality is considered an essential element of humanity. It encompasses individuals' search for meaning and purpose; it includes connectedness to others, self, nature, and the significant or sacred; and it embraces secular and philosophical, as well as religious and cultural, beliefs and practices".

Koopsen and Young (2009:33) list the following descriptions of spirituality by various authors:

- It is a personal set of beliefs not directly linked to church practices
- A belief in a greater source or force and a sense of interconnectedness
- It includes aspects of *transcendence*, self-reliance, self-efficacy, love, faith and provides a common bond amongst people and believes in a higher being e.g. Jesus
- Spirituality is a transcendental relationship between a person and a higher being, it goes beyond religion
- Spirituality is like breathing, it is the essence of life and of who we are
- It can be the meaning of life and existence

- The focus of spirituality is on the immaterial things. That which transcends the temporary
- It encompasses a focus on the *whole: body, soul and spirit*

Considering these descriptions of spirituality, I take it for the purposes of this study that the concept of spirituality includes religious aspects, but that someone has spiritual aspects to his/her person even when he/she is not religious. Cloninger's (2013) work and the focus on transcendence as a way to enable better health and wellness of the person underscores that spirituality, as described above, has a place within a health and wellness context. Louw (2014:30) states that spirituality is a layered concept and that the reflection of its implications for wholeness and healing in (health) care-giving is difficult.

Louw's pastoral anthropology also reflects the difficulty in definitively capturing the scope of the concept of spirituality. It purports six essential components to being human and human spiritual dynamics (Louw, 2014:31), being about the:

- affective: the dimension of emotions and feelings;
- cognitive: dimension of the human mind including the capacity to think, reason and understand;
- conative: dimension of the human will and its connection to motivate and inspire;
- body: represents the dimension of corporeality and the link between the physical, psychological, neurological and hormonal aspects of human embodiment. This embodiment includes our desires, senses and basic drives;
- environmental and relational networking: the orientation between human existence as embedded within a culture, community and social context and larger eco-system; and
- the spiritual realm of wisdom thinking and its connection to a sound conscience, moral awareness, insight, accountability. This represents the purposeful devotion in soulfulness, a God-directed space of sacredness in all relationships with an ethos of unconditional love.

1.2.2 Spirituality in health care

Puchalski, Vitillo, Hull and Reller (2014:10) underscore that spirituality in health care had been central for centuries and only in the early 20th century did it become overshadowed and even displaced by technological advances. To some extent, a counterbalance was brought about with the bio-psycho-social model being introduced to personal health care, as the impact of environment and psychological experience on the disease and health of the patient was acknowledged and brought into the consultation of patients and training of medical students (Dogar, 2007:11). For many years most caregiving models have focused on pathology and emergency management, giving less attention to prevention and health promotion. The focus on being 'whole' was not seen as part of the healing process/consultation (Louw, 2014:1). In recent years, approaches to health and health care with a person-centred focus have been developed. The treatment of the person as a whole and not only managing his/her biology, pathology, or disease has become part and parcel of the training of medical students, although the practical application of this in many patient consultations or in-hospital

management is still lacking, particularly in relation to the religious and spiritual aspects of their lives.

However, the management of the patient as a whole person is complex and demanding. Limited time and resources and perhaps also a lack of know-how has forced many patients in the private and public sector to be managed for the problem or disease with which they present and they are not sufficiently acknowledged and supported as a person with specific religious and spiritual aspects and attributes situated in a larger society. These aspects may be part of medicine's recent acknowledgment that up to 87% of all disease may have a causal link to one's psychological make-up and emotional experience. Yet this has not been integrated in the way that the health profession manages its patients (Strydom, 2013:7). Another concerning statistic is that despite all the knowledge and medical advances, over 80% of diseases are incurable (Strydom, 2013:3). With this, chronic diseases, including psychiatric disorders, are on the rise worldwide. Puchalski, Vitillo, Hull and Reller (2014:10) argue that the current health care culture has saved countless lives, but the scientific focus has moved the health profession from a holistic model to functioning with a reductionist approach. An integrative approach to personal health and health management is required, which reclaims the spiritual roots of medicine (Puchalski, Vitillo, Hull & Reller, 2014:10).

There are empirical reasons for integrating spiritual and religious aspects into personal health and health management. The extensive research of Cloninger (2013) on the question "what makes people healthy, happy and fulfilled despite current world challenges" resulted in the conclusion "spiritual development of greater self-transcendence is the key to the future survival of the human species" (Cloninger, 2013:18). He has developed a well-recognised theory of psychobiology of well-being, personality and evolution of the human brain, corroborated in many health studies across the world. This theory underscores that health and wholeness in terms of physical, mental and social well-being are directly linked to certain character traits (Cloninger, 2004; Cloninger, Zohar & Cloninger, 2010; Cloninger & Zohar, 2011; Josefsson et al, 2013). These character traits are measured on a temperament and character scale (Cloninger, 2004). The specific character traits that one should display to flourish are self-directedness, cooperativeness and self-transcendence. Considering the low and high endpoints of the character traits, patients that self-report the best health are those who consistently measure high in self-directedness and cooperativeness (Cloninger, 2013:18). People who measure high in these two character traits are again divided into two broad categories: "creative" and "organised" characters.

- "Creative" characters measure high not only in self-directedness and cooperativeness, but also in self-transcendence;
- "Organised" characters measure high in the first two traits, but low in self-transcendence.

Cloninger's conclusion that "spiritual development of greater self-transcendence is the key to the future survival of the human species" may be contrasted with typical leaders in Western society today who display character traits of the "organised" character structure. "Creative" characters are associated with leaders of the transformative civilisations such as the

Renaissance and the Enlightenment period and are generally considered to be happier (Cloninger, 2013:19). People who have a creative character have the same strengths in terms of helpful cooperation (i.e. highly tolerant, helpful and forgiving) and self-directedness (i.e. self-confident, purposeful, responsible and resourceful) as organised characters. The primary difference is that creative characters are more intuitive and meditative and identify with nature, humanity and perhaps a spiritual whole. Creative characters are driven to express their potential through self-realisation in harmony with others and nature. They are also more tolerant of ambiguity and uncertainty than organised characters and more receptive to radical change.

Encouraging is that such character traits can be learned. This means the work of Cloninger and others underscores the need to consider and integrate the transcendental aspects of the person in the personal health and health management of a patient from a holistic perspective. A holistic approach to care that includes spiritual attributes has already emerged in "third-wave" psychotherapies such as dialectical behavioural therapy, acceptance and commitment therapy and mindfulness-based cognitive-behavioural therapy. Research on whole-person psychotherapy reports that physical, mental and social outcomes are improved by adding spiritual practices and promoting self-transcendence (Cloninger, 2004; Cloninger et al, 2010).

The clinical consultation setting, although professing a person-centred approach, lacks a framework to integrate the religious and spiritual aspects of the person. Cloninger's work provides for a spiritual resource inventory that may inform the health practitioner in doing focused interventions to support and develop spiritual aspects in someone to be healthier and happier, including having more interest in others and their environment.

The benefits of self-transcendence are summarised as follows (Cloninger, 2013:22): "The development of self-transcendence has a radical transformative impact on self-directedness and cooperativeness. The purposeful striving of self-directedness is transformed into hope and letting go of fighting and worry. The tolerant empathy of cooperativeness is transformed into love and working in service of others. Essentially an outlook of unity allows a person to function with plasticity and virtue." Self-transcendence is accordingly key to spiritual strength in well-being and health.

1.2.3 Spirituality as crucial for a holistic approach to health care

How may the health practitioner integrate the above theory into practice? How may the practical integration of the spiritual aspects of the person be done in the patient consultation and management, and how should it be done ethically?

Informing these questions is Family Medicine's pledging the following principles (Albertyn, 2001:6): The family physician (FP) should connect to a person (rather than a group of diseases or a body of knowledge). The FP should seek to understand illness within its context and should utilise every opportunity for health promotion and prevention of disease. The FP should attach value to the subjective aspects of medicine and should see him/herself as part of a larger community of practice.

Furthermore, current medical practice utilises the Three-stage Assessment to account for the spiritual aspects of the patient links to his/her community. The Three-stage Assessment consists of (Albertyn, 2001:6):

- A clinical diagnosis – This pertains to the biological part of assessment or traditional diagnosis.
- An individual diagnosis – This deals with how patients experience illness, including a person's fears, feelings and reactions.
- A contextual diagnosis – This assesses the patient's environment (e.g. family, work, community) and how this affects the patient and the illness.

There is, however, a lack in the training of health practitioners and in the practical management of patients in the areas pertaining to the individual and contextual diagnosis. Puchalski, Vitillo, Hull and Reller (2014:15) advance the notion that spirituality should be integrated into routine clinical practice. They have defined a list of competencies or behaviours that students and clinicians should demonstrate:

- Incorporating and use of the patient's spiritual network and support system
- Performing of a detailed spiritual history
- Spiritual screening (when appropriate)
- Ongoing assessment of a patient's spiritual distress
- Collaborating with a health team to manage the spiritual care
- Inviting patients to explore their own spirituality and inner life
- Responding appropriately to verbal and non-verbal signs of spiritual distress
- Timely referral to a spiritual counsellor
- Respecting of a patient's spiritual belief systems

Another approach for providing spiritual care is that of Van Dover and Pfeiffer (2007), which depicts the health professional as the means to link a patient and his/her loved ones to the presence of God. This approach is applicable to those who link their spirituality to God, such as in Christianity, but does not provide specifically for those who view their spirituality from a different perspective, such as spirituality originating from or being located in themselves. By this approach, step one involves the health practitioner identifying and developing his/her own spiritual resources and needs and working on this through his/her relationship with God. Step two is to establish a relationship of trust with the patient and family and to journey in discovering the patient's spiritual (and other) needs as well as those of his/her family. Step three involves becoming open to God and his presence in the patient's situation. Step four is to activate faith and nurture it through prayer, music, etc., and lastly, step five is to recognise spiritual growth in each other. This five-step approach is a rather involved process, but can be followed in the course of a few hours (Bowers & Rieg, 2014:48).

Another shortcoming of the approach of Van Dover and Pfeiffer is its applicability to specific medical conditions. It also does not account for the patient's responsibility in his/her specific condition. For example, the patient's underlying psychological and spiritual disposition is

considered an important causal factor for the condition. Although steps one and two could provide the opportunity for a patient to identify reasons for his/her unhealthy eating habits, merely activating faith would not remedy the situation. In contrast, Cloninger's approach underscores additionally that the patient's emotional character should be assessed, and the need for unpacking his/her spiritual resources by growing in transcendence that may help them overcome current emotional and physical problems.

In Nov 2014 HospiVision, in collaboration with the Centre for Contextual Ministry (University of Pretoria), hosted the first national conference on Spirituality and Health Care: Caring for the life of the whole person (Hospivision, 2014). The conference was well attended by the multi-professional team. Presenters at this conference included social workers, medical doctors, nurses, psychologists, chaplains and spiritual mentors. Themes addressed in this workshop included:

- Spirituality as a source of strength: a holistic multidimensional praxis approach to the health and well-being of individuals and communities;
- Conceptualising and integrating worldview/spirituality in a psychotherapeutic process to spur mental health;
- Rational behaviour therapy and spiritual health: a health mind is a healthy body;
- Wholeness in spirituality, health and hope care: nurturing the beauty of the human soul; and
- Current trends and challenges in spirituality and health care.

Organisers and attendees of this conference emphasised the need for inter-disciplinary research to be done in this area and for the acknowledgement of the various roles that individuals and the various disciplines play in offering holistic care. The need for health care professionals and the health care system to improve on the bio-psycho-social model and move more towards a wholeness approach was reiterated. The role of the patient in exploring an approach to spirituality as part of holistic health care was considered as critically important.

Within the context of existing literature and the need for a framework that can direct appropriate and quality spiritual care within the African setting, the research was undertaken. The research problem, along with the aims and objectives and structuring of the results in the chapters to follow, is described below.

1.3 Research problem

1.3.1 Defining spiritual care in the African context

Although spiritual care of patients is considered a fundamental component of quality compassionate health care (Puchalski, Vitillo, Hull & Reller, 2014:11), health practitioners need a framework by which to integrate spiritual aspects in the personal health management during clinical consultations. The definition of spirituality within in health care and the practical implementation of such care is still under development (Pike, 2011; Daaleman,

2012). Research is required on the structure, process and outcome elements of quality spiritual care (Daaleman, 2012; Puchalski, Vitillo, Hull & Reller, 2014). Qualitative research is required that defines the components of spiritual care in greater detail (Daaleman, 2012). Consensus has not been reached on what is considered as part of quality, ethical spiritual care within the practitioner-patient relationship. Some spiritual health experts conclude that the boundary for spiritual care includes prayer (Koenig, 2007), whilst others say that prayer should not be initiated by a health professional as this crosses a professional boundary (Puchalski, 2001) and that specific spiritual needs should be addressed by a spiritual carer. A framework is needed that defines the components of spiritual care to help the professional navigate an approach that will address the patient's needs without crossing a professional boundary.

This study explored how patients, various health disciplines and experts approach spirituality or would want to be approached on this topic within the clinical setting. The research related in this thesis focuses on the spiritual relations between patient and practitioner during a health consultation in a clinical context. It expanded on existing research of what is considered as spiritual care and how this is expressed in practice. Spirituality is a vital dimension not only of health, but of holistic care (Walker & Breitsameter, 2017; Sulmasy, 2002; Koenig, King & Carson, 2012). A study (Walker & Breitsameter, 2017) that explored with health carers on how they approached spirituality and spiritual care in an end-of-life clinical setting revealed an unanswered question that needs to be clarified to the benefit of patient and practitioner: "When speaking about spirituality, what are we actually talking about?" (Walker & Breitsameter, 2017:1). Defining spirituality within the health care setting is complex, because the boundaries for expressing what is considered spiritual within health care have not clearly been defined. Thus, individual spiritual needs are often relegated to specialised spiritual carers. One of the findings of the research done by Walker and Breitsameter (2017) was that the advantages of a broader definition of spirituality lie in the "spiritual care no longer being bound to one single profession, namely that of the chaplain." This research explored what form spiritual relations take between health professionals and staff in an African context and how this could be standardised within an ethical framework.

1.3.2 Describing a quality and ethical approach for incorporating spiritual care

Various tools have been published on screening or taking a spiritual history during a health consultation. These include CSI-MEMO (Koenig, 2007); FICA (Puchalski & Romer, 2000); three other tools, HOPE (Anandarajah & Height, 2001), FAITH (King, 2002) and SPIRIT (Maugans, 1996); and lastly FACT (LaRocca-Pitts, 2012), a comparative tool to examine the various spiritual screening tools listed (LaRocca-Pitts, 2012). These tools offer a strong foundation to explore with further research the practical know-how needed, ethical guidelines required and personal preferences of patients and practitioners within a multi-spiritual/religious and inter-professional context. This was also a motivational force for this research. If the biomedical model that currently offers health care through the public and private system of South Africa want to adequately attend to the needs of their patients and ensure adherence to medical

care, then greater understanding of the spiritual needs of the typical South African (and perhaps the continent of African) patient is necessary.

LaRocca-Pitts (2012) argues that "*a spiritual history forms its own genre"* – in this instance a piece of literary composition that is characterised by a particular style, form and content. Spiritual screening tools include five distinct criteria critical in taking a spiritual history (LaRocca-Pitts, 2012), namely that the spiritual history should be brief, be easy to remember, obtain appropriate information, be person-centric and be validated by experts in the field. Further research was needed to add to that which existed on not only *what* to ask, but *how* to approach this in a manner that obtains relevant information and is person-centric. A framework was required on how to do this, particularly in an ethically acceptable way.

Considering the great variety of spiritual expression, working towards an ethically acceptable framework that accounts for individual preference required a multi-party exploration in the qualitative development of this framework. Examples of such health care frameworks that were helpful in identifying the components of a spiritual care framework are seen in publications of the United Kingdom's Department of Health, constituting their National Service Frameworks. These include "The Ten Essential Shared Capabilities: A Framework for the Whole of the Mental Health Workforce" developed by the National Institute for Mental Health England and the Sainsbury Centre for Mental Health Joint Workforce Support Unit, in conjunction with National Health Service University (Hope, 2004); "The National Service Framework for Long-term Conditions" (Department of Health (UK), 2005); the "National Service Framework for Older People" (Department of Health (UK), 2001); and the "National Service Framework for Diabetes" (Department of Health (UK), 2003).

During the course of the research process, health experts in holistic and spiritual care, patients and an inter-disciplinary team were all asked to give their inputs on how spirituality is best approached with a patient during a health consultation. The views of the research participants throughout the research shaped each subsequent draft framework until the final version which is written up in this thesis.

1.4 Reasons for the study and significance

The literature reveals that patients have a need to be offered holistic care. The value of spiritual care within health care has also been established. Research is required into how to implement this in a practical and quality manner. The following reasons where identified to motivate for the need for this research:

1.4.1 To have a framework that assists the practitioner to include spiritual care during the consultation that is appropriate for individual patients' culture, worldview and spirituality

Medicine encourages evidence, objectivity and best practice. Spirituality, because of its personal variability, is often avoided, if not ignored in the health consultation. A framework is needed on how to incorporate spiritual care during the consultation within a multi-cultural and multi-religious context. Although there have been a number of spiritual screening tools

published in recent years, practitioners are still unsure about the practical implementation of the spiritual enquiry tools and how to address an identified need in an ethical and quality manner as part of the treatment plan.

Selman et al (2013:1) state that spiritual care as part of health consultation and management is often neglected in clinical practice because of a lack of confidence and competence amongst health professionals. Another reason for the reluctance to offer spiritual care amongst health professionals is the diversity in which people practice their spirituality. Culture, tradition, religion and faith/belief all play a role in how one interprets and lives out one's spirituality. Selman et al (2013:2) researched spiritual well-being amongst cultural groups in Africa. They analysed concepts for construct validity and reliability that cut across cultural variability. Two themes emerged as universally applicable amongst various cultures in eight countries in sub-Saharan Africa. These were a life worthwhile and peace (Selman et al, 2013:2). The two themes were found to be relevant as a component of how various cultures interpret their spirituality in practice. These themes are recommended as constructs for inclusion in a spiritual/wholeness assessment instrument. These concepts are nonetheless rather limited in practically addressing the various nuances of spiritual practice and interpretation of its effect on health and wholeness.

1.4.2 Clarifying the role of the health practitioner in integrating spiritual care into health

The health practitioner has an opportunity to tend to the patient holistically by bringing into account the resources and issues in the patient's social, environmental and spiritual life and assisting the patient to deal with his/her emotions together with a strategy to take control of his/her life through the spiritual, emotional, social and other resources available to him. Daaleman (2012) reviewed three previous studies in attempt to construct a health services framework that incorporates spiritual care. The findings of Daaleman's (2012) research describe that patients identify family or friends (41%), clergy (17%) and health care providers (29%) as spiritual care providers. Health professionals are identified by patients are pertinent role-players in offering spiritual care. Questions remain regarding how this role should be fulfilled; what the boundaries of spiritual care are; beyond screening, what is considered as part of spiritual care that can be offered by a health professional and when should the patient be referred for specialised spiritual care; how the health professional should integrate spiritual care with patient beliefs in the African context (De la Porte, 2016); and where ancestors and traditional medicine play a crucial role.

The value placed by patients on the role of the health professional in offering holistic care should not be underestimated. Patients often seek out spiritual care on their own when diagnosed with a serious illness, with the view to supplementing the health care offered to them. The spiritual care provider could be any one of the following (Koopsen & Young, 2009:21):

- Physicians
- Nurses
- Traditional healers

- Chaplains
- Psychologists or another mental health provider
- Spiritual mentors
- Social workers
- Friends and family

The role of the health professional in collaborating with specialised spiritual carers and in taking the lead in co-ordinating a holistic care plan needs to be described. In South Africa many patients consult with a traditional healer who purports to offer a wholeness approach to health and wellness, as the 'treatment' plan often involves counselling that is culturally relevant and rituals that amend the spiritual needs of the patient in a society where illness is thought to be caused by witchcraft, contact with impure objects (pollution) and through ancestral neglect. Up to 80% of the black South African population consult traditional healers in conjunction with utilising biomedical services (Peltzer, 2006). Traditional healers have an important social and political role in the community. They are consulted to do counselling, but also perform healings and treatments including divination, healing physical, emotional and spiritual illnesses, directing birth or death rituals, finding lost cattle, protecting warriors, counteracting witches, and narrating the history, cosmology, and myths of their tradition. Traditional healers often receive their training as a result of apprenticeship, experience or personal study (Koopsen & Young, 2009:54). The lack of standardisation has created great variability in the health care provided, and sometimes the consultation with a traditional healer can cause more harm than good because of lack of medical knowledge.

Uncertainty remains on where the boundaries within the health profession lie when incorporating spiritual care. The findings of Daaleman (2012) and Walker and Breitsameter (2017) both note the value that patients place on spiritual care being offered by various care givers, including that of the health professional. The content of such care, however, has to be defined within a framework. In terms of spiritual rituals and care practices, the findings of this research have some distinct differences from what is written in current literature in terms of what is happening in practice and where the line is drawn in terms of professional boundary. The findings of this research suggest that certain patients seek out health professionals that are both skilled in medical knowledge and spiritual care integration. Patients interviewed during this research were open to exploring spirituality and receiving care from a health professional (with most specifying that the health professional should share a similar religious/spiritual belief). This care included prayer and the health professional making space for the patient to express a spiritual need through a ritual as part of a treatment plan. Professionals interviewed during both the health expert interviews and focus group cited numerous patient cases where in-depth spiritual counselling was offered and/or prayer as a spiritual ritual. The African perspective and importance of incorporating spiritual rituals throughout the health experience suggests a difference from the Westernised current worldview on *how* and *to what extent* spirituality should be incorporated.

1.4.3 My personal reasons for doing this study

The research reported in this thesis has developed over many years. My observations of how patients express their spirituality and needs for spiritual care within a clinical context, in combination with my own spiritual needs and desire to express this in my profession in an authentic and ethically acceptable manner, have shaped the questions raised and addressed during the research over the last decade or two.

As a young medical student I realised that I had symptoms of diseases that appeared as we rotated at certain clinical placements, but would again disappear upon departure to the next clinical rotation. I also became more aware of the impact that the social environment, personal cognitive and emotional strength and the spiritual beliefs of a patient had on his/her ability to respond and improve on treatment.

I had contemplated various PhD topics over the years. My personal experiences catapulted me towards seeking deeper truths about a bio-psycho-socio-spiritual connection and how to implement this in practice in a manner that accounts for individual preference and a scientific approach.

Before attending to the stories of patients, health professionals and experienced spiritual health practitioners, I related decisive events in my life that influenced my undertaking this research and which may have influenced my interpretations in interactions with participants and in the analytic process. When I fell pregnant with our first-born child, I read a book on using one's spiritual resources to have a painless and non-complicated birth. During my first pregnancy my husband and I spent many hours at night talking to our unborn son, preparing ourselves emotionally and spiritually, while also focusing on diet and staying fit. It was one of the best experiences we ever shared. Our son Levi was born within three hours of us arriving at the hospital. When I realised I was in labour earlier that day, we invited a friend over, cooked together and went for ice cream before going to hospital. During the labour I used no pain medicine, but rather played music that worshiped God and spoke to our spirits. We all had a very positive and almost pain-free experience.

During my second pregnancy, something upsetting happened in our family that, I believe, caused me to go into labour prematurely. Our second child died a few days later. Unpacking the spiritual-emotional reactions that triggered physical reactions in my body was part of the healing journey. Something that came out in the research and that I realised more and more was that although medicine taught us objectivity, our approach in practice is inevitably filtered through our worldview and personal narrative. Goldberg (2009) reflects on the linguistic and philosophic roots of the concept of a worldview and how it can refer to socio-political orientation, a hypothesis of the world or the collective views of a group as seen through a religious or ethnic lens. Each of these domains of worldview impact on what we construct as relevant and true. Our beliefs are interlinked with our biological make-up and physiological responses.

As you read the framework yielded by this research, you will note the colours assigned to the quotes of the various people interviewed. The narratives shared by the participants shaped their views and preferences on how spirituality should be addressed best, by whom and in which context. Health and spirituality and their connectedness are real to the participants, as it is for a growing number of patients who seek such care and for professionals who want to meet their patients' needs and have a more fulfilling professional career.

1.5 Research outline

The research reported on in this thesis explored the views of three distinct groups to explore the incorporation of spirituality in the health care consultation and treatment plan. the first group of participants comprised scholars in the field of spirituality and health care, the second comprised patients, and the third comprised health professionals. The research will make practical recommendations for practice that is person-centric, thus acknowledging both the patient and practitioner in the room, but also the wider social context that each represents. It is also intended to serve as a stimulus for individuals or health teams to reflect on current practice, including personal self-care, and to be the beginning of a conversation that hopefully many more will comment on, do research on and apply, whether in the academic field, health care or at home.

The framework developed through this research expands on the spiritual needs model (Monod, Rochad, Bula & Spencer, 2010) that describes the dimensions of spirituality and corresponding needs by listing and describing principles that should be adhered to, to assist the health practitioner in understanding how this can be achieved in practice. Practitioners often need guidance in the practical aspects of how to help a patient identify ways to cope with his/her illness (find life balance) and reconnect with what is good and beautiful. Practitioners can also enable the experience of self-control by the manner in which they interact with patients and recognise the patients' individual strengths and needs.

As one of the outcomes of this research, part of the framework described in chapter 3 also recommends a number of principles with competencies and requirements to fulfil these principles. There are certain 'tricks of the trade' that could either be facilitating to a perceived quality spiritual health experience or a barrier; these are discussed as catalysts (fertiliser for our spiritual health care tree) or impediments (weeds for our spiritual health care tree). Recommendations are also made on how to implement this best in practice based on the experiences of the participants. The framework is presented as a *Spiritual Health Care Tree* approach and unpacks a number of principles to frame and guide practice within the given context, including: an evidence-based approach, the professional attitude, creating context, structuring a quality consultation that is relevant and person-centric and that supports existing spiritual resources and enables resilience.

The next chapter describes the research aims, objectives and methodology, including a description of the various participants and how data were gathered, analysed and reported. The framework for spiritual care in a consultation as the distilled product of the research is

presented in chapter 3. The three chapters that follow unpack the detailed perspectives of participants by which the framework was informed and developed. These chapters describe the codes and depict the individual narratives that emerged during the data gathering with the experts (chapter 4), patients (chapter 5) and an inter-professional focus group (chapter 6). The narratives of the individuals and groups were profound. To stay true to the individual voices, the narratives of the participants are represented in different colours in this thesis. Chapter 7 comprises my personal reflections and experiences during the research process. Chapter 8, the final chapter, appraises the findings of the study, how they were methodologically derived, and their implications and applications.

Chapter 2
Methods

This chapter outlines the research methodology followed during the research. It describes the aims and objectives and research approach followed, including the procedures followed during data collection and analysis.

2.1 Research aims

The study aimed to develop qualitatively a practical and ethically sound framework that would assist health professionals in the *how to* of the integration of spirituality into a patient-practitioner consultation.

2.2 Research objectives

The study objectives were:

1. Extraction from relevant literature practical guidance items for potential inclusion in the framework;
2. Compilation of an initial draft framework that included potential practical guidance items from the literature;
3. A qualitative process of evaluating and refinement of the potential items in the further drafting and development of the framework in various versions until the final product, through qualitative exploration with participants from various roles – the roles included those of scholars in the field (spiritual health experts), health practitioners and health users (patients) with an interest in this work;
4. An exploration of which components should be part of the framework for integrating spiritual aspects into the health practitioner's consultation;
5. An exploration and articulation of what surfaced in interviews and discussions with participants from various roles, which included additional items that were raised to be considered for inclusion in the framework;
6. An exploration with participants from various roles of impediments to the integration of spiritual aspects and how these could be addressed in the framework;
7. An exploration with participants from various roles of how practically useful the framework was, which was used to refine the framework accordingly;
8. An exploration with participants from various roles of the ethical acceptability of the guidance items, which was used to refine the framework accordingly;
9. An exploration and articulation with participants from various roles of an ethically sound attitude toward diverse spiritualties, which was incorporated explicitly in the framework;
10. An exploration of reservations and concerns that participants from various roles might have had about the framework, which were incorporated into the framework;
11. Obtainment of the perspectives of the various participants on the potential practical worth of the framework.

2.3 Study design

A qualitative research design was used. Myers (2000) describes qualitative studies as tools used in understanding and describing the world of human experience. In this study, the experiences involved were those of participants in various contributory roles – those of scholars in the field, health practitioners and health users (patients) with an interest in this work.

Within a qualitative design, a case study approach was followed. Here, the 'case' in 'case study' does not refer to an individual patient, but rather to specific research participants and their context as constituting the 'case' in this research project. This approach was well-suited to this study as the aim and objectives were explorative and co-constructive from the bottom up, so to speak (in contrast with a quantitative study that may have examined the validity and the reliability of an already constructed framework through hypothesis testing). The case study approach to qualitative inquiry has been described for its usefulness in health and social sciences where practitioners are interested both in unique dimensions of a case and their potential for more generalised applicability among other participants in other contexts (Hays & Singh, 2012:46).

The case study design drew on a grounded theory approach. Grounded theory is considered the most influential research tradition in social science disciplines (Patton, 2002). The purpose of drawing on this theory was to generate research data that were established and rooted in the ideas and perspectives of the participants regarding a specific phenomenon (Hays & Singh, 2012:48). In grounded theory, an inductive approach is followed by which knowledge grows from the specific (instance) to the collective, moving from simpler to more complex ideas in allowing rich data collection towards generating (new) theory. To this end, grounded theory often attempts to suspend prior knowledge and a literature review may even be deliberately postponed until after data collection. This study thus did not depart from a clean slate, which is thus considered an adaptation of pure grounded theory. Some grounded theory researchers are expected to minimise preconceptions to ensure the concept of interest is grounded in data, yet at the same time are required to evaluate existing literature to support institutional ethics and scientific review of the research proposal. "The issue of the literature review remains a conundrum and a controversy within the discourse on grounded theory methodology" (El Hussein, Kennedy & Mount, 2017). In this study, however, literature was used to draft an initial framework, but the yield, consisting of a draft framework, was submitted to exploration following the principles of grounded theory by which the initial framework was continuously revised and re-articulated on various components through the inductive process.

Congruent with grounded theory, the point of departure derived from the literature was subjected to radical revision without any part being sacrosanct, meaning participants were invited to reject any of the initial theoretical points of departure by which the initial draft framework was articulated and to introduce new ideas. This aligns with the evolution of the

grounded theory approach as described by, amongst others, Charmaz (2006) and El Hussein et al (2017), arguing that not only does the literature review offer the opportunity for the researcher to situate him/herself within the context of the research topic, but that a prior literature review (of some level) is important in preparation of adequate research exploration and new knowledge generation.

The intent of the approach followed in this research was to develop a conceptual, practical and layered framework with different layers of abstraction. The outcome of the research is presented in this thesis as a practical policy framework that will hopefully set the scene for offering spiritual care within the clinical setting and inform the attitude and approach of someone involved in integrating spiritual concepts in healthcare as part of holistic care. The framework was constructed to inform the requisite knowledge, attitudes and an approach that would be useful for the integration of spirituality in healthcare. Hays and Singh (2012:112–113) identify the following sources of a conceptual framework that were applied during the research process as a methodology to construct the framework:

- Prior theory and research
  Drawing from previous research and literature, important concepts on spirituality as part of a holistic health care approach were summarised and constructed into a theoretical framework that aimed to provide direction in terms of how to approach different ways of expressing spirituality within a health and disease context, anticipating problems and creating space for both practitioner and patient.
- Experiential knowledge
  The knowledge and experience of the participants (who were patients, health professionals from an inter-disciplinary team and health experts in spiritual care) contributed throughout the research process to the construct of the framework. The researcher's own previous work in the area of study, background and personal experience offered a lens through which connections between concepts and data were made (also known as researcher bias, because it could be a positive or negative). It did inevitably impact and partially inform the framework development, and this was described throughout the data collection and framework construction.

2.4 Paradigms adopted during analysis and interpretation

A paradigm is a shared worldview that describes shared beliefs within a discipline and how problems are solved (Schwandt, 2001). The paradigm that framed the lens through which the research problem was viewed was a constructivist approach. This paradigm is underpinned by the belief that the researcher is influenced by his/her values to such an extent that this determines the research topic, methodology and interpretation of the findings (Chilisa & Kawulich, 2012). "As a constructivist researcher, you admit the value-laden nature of the study and report your values and biases related to the topic under study that may interfere with neutrality" (Chilisa & Kawulich, 2012).

In this worldview the philosophical assumption that is often associated with qualitative research (Mèndez, 2013) is underpinned by the notion that truth and reality are constructed as humans interact with each other and their environment. In qualitative research (Cresswell, 2009), phenomena are examined from a humanistic perspective as seen through the lenses of the participants. This could also include the researcher's perspective. Mendéz (2013) defines it as follows: "Autoethnography can range from research about personal experiences of a research process to parallel exploration of the researcher's and the participants' experiences and about the experience of the researcher while conducting a specific piece of research". Ellis (2007) had the following to say about this research method: "Doing autoethnography involves a back-and-forth movement between experiencing and examining a vulnerable self and observing and revealing the broader context of that experience." Throughout the research process, the interviews – which often had a personal narrative to them as the experts and professionals (including the researcher) reflected on past experiences in practice and the patients reflected on how they would want to be approached about their spirituality – were recorded as true to original form as possible, as the narratives of the participants and also from the researcher's point of view as a participant.

2.5 Study setting

The study was based in Pretoria, South Africa. Data gathering was done at different locations to accommodate the different research participants, with the aim of having the research conducted in their natural environment wherever possible. The three health experts were individually interviewed in Pretoria at different locations, depending on what suited them at the time. Health expert 1 resided in the Western Cape and travelled to Pretoria, Gauteng for a conference where he was a speaker. An interview was scheduled with him the following day at a private residence. Health expert 2 resided in Pretoria and was scheduled for an interview at the same private residence. Health expert 3 was interviewed at her psychology practice in Pretoria.

The patients that participated in the study were interviewed individually at a health and fitness facility, the High Performance Centre in Pretoria. The High Performance Centre offers a range of health services. The programmes offered have a strong focus on enhancing sport performance and many users at this facility are athletes. At the time of the research, the facility also offered a chronic disease management programme to patients who were diagnosed with one or multiple chronic diseases, where an integrated health and fitness programme was deemed to be of benefit to the patient's health. Over 200 patients belonged to the chronic disease management programme that was sponsored by the patients' health insurance provider, Bestmed.

The inter-disciplinary focus group of health professionals all worked at Daspoort Community Clinic, which had been a service-learning facility of the University of Pretoria for over 50 years at the time. The health professionals were scheduled for the interview one afternoon on site at the clinic. Daspoort Clinic was a unique primary care clinic in that it hosted over 12 health

disciplines working together in a collaborative team to offer services to a multi-national community with socio-demographic statistics that indicated financial constraints, food insecurity and a high burden of social and medical problems.

2.6 Study population and sampling

The participants were sampled purposefully from various sites in South Africa. Three scholars participated based on their roles and experience as health practitioners (irrespective of whether they were for or against a framework). The views of ten users of health care services (i.e., patients) who belonged to a chronic disease management programme in Pretoria were purposefully sampled. For the third round of data collection, eight health professionals representative of various disciplines participated in a focus group at a clinic based in Pretoria.

Participants were invited to take part in the research with the specification that they had an interest in holistic care, and more specifically the inclusion of spiritual care in the health consultation and care plan. The specification of an "interest in the field" was purposeful as to ensure that people (health experts, professionals and patients) who are keen to gain from the integration of spirituality into health care were given a voice (irrespective of whether they were for or against a framework). Note that this selection was considered a strength in qualitative research (rather than an unwanted bias as would be the case in quantitative research), provided that claims and findings were explicitly limited to this selected population.

The three health experts were purposefully sampled with a common qualification criterion that they all had a post-graduate qualification and/or experience in the field of spiritual health care. Health practitioners were considered to be experts if they presented or published on the topic of spirituality in health care nationally or internationally. The scholars all met one or more of the following two criteria: They presented their research at a spiritual health conference (e.g. the National Spiritual Health Conference organised annually by Hospivision in South Africa) or attended an international conference (e.g. the Integral Health Conference in Vellore, India in 2014); and/or they have published on integrating spiritual components in a holistic health care approach or obtained a tertiary qualification in this field. Three scholars participated in the study based on their roles and experience as health practitioners (irrespective of whether they were for or against a framework). The three in-depth interviews were scheduled over the course of seven months, and after each interview the draft framework was updated. Each expert's verbatim opinions were highlighted in the document in a unique colour. The quotes were inserted anonymously and numbered respectively as *Health Expert 1, 2 or 3*. Each updated iteration of the framework received a subsequent new number.

Patients who attended sessions as part of a chronic disease management programme offered at the time at the High Performance Centre in Pretoria were purposefully recruited to participate on a voluntary basis. Patients were contacted via email and were selected to participate on a first-come, first-served basis, with those indicating an interest in participating being scheduled for an individual in-depth interview in order of their response to the

invitation. Patient interviews were held until data saturation was achieved. Patients who belonged to this programme had one or more chronic diseases or suffered a serious condition at that time. The selection of such patients was purposeful in that patients with a chronic disease often profess spiritual, emotional and social needs more than those who have an acute or less serious illness.

Health practitioners from any consulting health profession offering coordinated care as part of an inter-disciplinary team at Daspoort Clinic were invited to participate in a focus group. An invitation to participate in the research was sent out via email to all 12 health professionals working at the clinic. Ten participants indicated an interest in participating in the study. All interested participants were invited to attend a focus group session at the clinic on a date chosen by the inter-professional team. On the day of the focus group, eight health professionals attended the session as the two others that indicated an interest to participate withdrew from the study due to personal reasons and/or other professional obligations.

Participants under the age of 18 were excluded from participation in the study, mainly for ethical reasons. Participants for all categories were included irrespective of their faith and/or religious beliefs. Participants represented various faiths and religions (including Christian, agnostic, spiritual without a specific faith, beliefs in ancestors).

Three sources of data were purposefully selected for the research to triangulate the data (Carter et al, 2014) as a strategy to better understand the concepts questioned in the study and capture different dimensions for offering spiritual health care from various contributory roles and perspectives in the clinical setting – in this instance those of spiritual health expert, patient and professional. The three sources of data, as research participant groups, are described below.

2.6.1 Sample description - health experts group

The following is a short description of each of the health experts interviewed that were purposefully selected based on their contribution to the field (see more on their personal profiles in the field notes).

Health Expert 1 (HE_1): A medical doctor for over 20 years with experience in incorporating spiritual care into health consultations and practice. He is internationally known in this field and started his research initially through Duke University. He has presented on this topic at numerous conferences and at meetings around the globe, as well as online. The interview was done in Pretoria on 28 May 2017.

Health Expert 2 (HE_2): An experienced bio-kineticist with a postgraduate qualification in theology and a qualification as a counsellor. At the time of the interview she worked in her own practice as a Functional Medicine practitioner with a focus on pathology (disease) counselling. She was a published author of a book that incorporated spirituality into a wellness programme for patient self-care and managed a holistic spiritual counselling centre

for a Christian church at the time. She has presented on this topic at conferences and also for educational purposes online. The interview was done in Pretoria on 18 Aug 2017.

Health Expert 3 (HE_3): A psychologist with extensive experience in the psychiatric setting. At the time of the interview she was a PhD candidate and subsequently completed her studies in spirituality, religion and the impact on mental health from a Christian perspective. She has presented on an ethical approach to addressing spiritual needs of patients and has presented her own work at international and national conferences. The interview was done in Pretoria on 2 Nov 2017. For a detailed description of the content outcomes of the health expert interviews, refer to chapter 4.

2.6.2 Sample description - patient group

Patients interviewed had various diseases ranging from dyslipidaemia, hypertension and diabetes to breast cancer, chronic lung disease and another debilitating chronic conditions. The age spectrum of patients interviewed ranged from 40 to 70 years old. The interviews were scheduled individually between 28 June and 5 July 2018. For a detailed description of the individual patient cases, refer to chapter 5.

2.6.3 Sample descriptor – inter-disciplinary health group

The third source of data was an inter-professional team working at a University of Pretoria service-learning clinic. The health disciplines that worked at Daspoort Clinic at the time included medicine, nursing, occupational and speech and language pathology, social health work, clinical associates and community health work. The health professionals who indicated an interest were sent an email with the draft framework prepared as a Health Professional Guide. Ten health professionals indicated an interest in participating initially. On the day of the data recording, only eight were present to participate. The interview was held at Daspoort Clinic on 12 March 2019. The participants were familiar with each other as they worked together as an inter-disciplinary team offering coordinated clinical care at primary care level at the facility and through home visits in the area. The research participants represented the following health disciplines as described in table 2.1 below.

Table 2.1 Focus group participants representing the inter-disciplinary team in the research

1. Patient case manager
2. Community dietician
3. Professional nurse
4. Professional nurse
5. Environmental health officer, CHW team manager
6. Community health worker (CHW)
7. Community health worker (CHW)
8. Clinical associate & clinical counsellor

2.7 Data sources

Data were collected by means of individual interviews and a focus group. The three health experts were individually interviewed at three consecutive events between May and Nov

2017. Open-ended questions that reflect the objectives of the study served as semi-structured prompts throughout the data collection in facilitating qualitative exploration. The interview schedule contained a number of questions that served as a conversation starter to explore how spirituality in health care can best be approached during a consultation. Participants were asked to define their own spiritual beliefs and how they would want to be approached by a health professional if this were to be incorporated into clinical care during a consultation. Participants were asked about personal experiences, principles were recommended for practice and recommendations were made to implement the principles in a quality manner, amongst other things.

The draft framework that was constructed as an outcome of the first cycle of data collection was summarised as a *Patient Booklet* that served as a practical interview guide for patients during the individual interviews. The interview schedule was also updated. An example of this was that the definition of spirituality and its application within the health context were identified during the interviews with the health experts as something that needed to be explored from the patients' perspectives. For the next round of data collection, the patients were first asked to give their own opinion on the definition and value of spirituality in health care and examples or cases of their preferred approach, before being asked to comment and give inputs on the draft framework. The interviews were scheduled individually over two weeks.

As an outcome of the second round of data collection, the draft version at that time was summarised as a Health Professional Guide that served as an interview guide for the inter-disciplinary focus group for the third phase of data collection. The Health Professional Guide and interview schedule were emailed to the participants beforehand to help them prepare for the interviews and reflect on past professional experiences about spiritual care in practice. The inter-professional focus group from various health disciplines was the third source of data collected during the research.

2.8 Procedures and data collection

El Hussein et al (2017) and Gibson (2007) encourage researchers applying grounded theory to harness their own experience as professionals in combination with literature in the research process to enlighten the perspective of how the researcher views the research situation and to serve as a stimulus for new theory development. This is described in the literature as 'theoretical sensitivity', and becoming familiar with the literature before data collection commences is considered an important component. In line with this research approach, the study first extracted from relevant literature practical guidance items that were included in a draft framework that was subjected to views of participants on:

- exploring their views on spirituality and spiritual health care;
- unpacking their unique views and personal experiences on how spiritual care is best approached within the clinical setting;

- evaluating the potential items of the initial framework and refining it continuously until the final document presented in this thesis;
- exploring and articulating additional items that were raised as considered conducive to the integration of spirituality as included in the framework;
- exploring impediments to the integration of spiritual aspects and how these were addressed in the framework;
- exploring how practically useful the framework was and how it was refined accordingly;
- exploring the ethical acceptability of the guidance items and how the framework was refined accordingly;
- exploring and articulating an ethically sound attitude towards diverse spiritualties and how these were incorporated explicitly in the framework;
- exploring reservations and concerns about the framework and how these were refined or accommodated in the framework; and
- evaluation of the potential practical worth of the framework.

2.9 Fieldwork and memos

Field notes of all data gathering sessions were maintained. The purpose of this was twofold: to describe the data gathering process at each point in time and to reflect on the research process, the context and the content that emerged during the research. Emotions and words were interpreted within the experiences relayed by the participants and the nonverbal communication was recorded. The field notes were recorded on a template titled with the date and name of the person/group interviewed, a description of the activity that would serve later on as a verbal snapshot and my reflections on the interview with questions that emerged during the data gathering process. This was repeated after each interview throughout the data collection process. The purpose of keeping a personal research diary before and after data collection (El Hussein et al, 2017) is to intentionally document the researcher's connections and biases to the studied process and concept so that later one can later compare the interpretations of data with these diaries in an attempt to minimise prejudice.

Summaries of the major findings, together with the personal reflections on the data collection, were recorded as memos for each interview conducted throughout the research process. The Centre for Research and Evaluation (2012) describes the importance of memo-writing as "a critical aspect of effectively analysing qualitative data (e.g. key informant interviews; focus group interviews; observations; document reviews, etc.) and can help immensely in writing your results. Essentially, it provides the basis of your analyses that you will end up including in your final report." The ongoing memo writing that took place during the interviews, analysis and write-up helped to distil the connections made between the participants' data, the researcher's interpretation and the existing theory described in the literature. Throughout the process of data analysis and coding, new ideas and thoughts about relationships between codes identified were recorded in memos to include in the research later on. In this way the analytic yield fed back continually into the data collection process,

not only for verification but to aid in the further iterative refinement of the framework. These steps were repeated continuously throughout the research process until saturation of data was achieved.

Reflexivity (Stephen et al, 2014) was done throughout the research process and this was included in the background to the research as part of my personal motivation for conducting the research and also in the memos where I reflected not only on what the participants had said, but my own ideas and opinions. This helped in crystallising my own biases and preconceptions so that the data reflected not only my views, but that the individual voices as well as that of the collective were recorded as accurately as possible in the culmination of their ideas and concepts in a framework.

2.10 Recordings and transcription of data

All data collected with the health experts, patients and inter-disciplinary group were recorded and transcribed verbatim. Except for autobiographical responses, all interviews and the focus group were audio-recorded and transcribed verbatim for purposes of analyses. The researcher transcribed the three individual interviews held with the scholars in the field. The individual patient interviews and focus group with the inter-professional team were transcribed by a company that specialises in transcriptions for research purposes.

2.11 Process instruments for engagement with participants

The processing instruments for the first round of data collection were the initial draft framework and interview schedule for the individual interviews with the three health experts. The first version of a draft framework was compiled from an extensive literature review on spiritual health, the researcher's own personal experience and inputs from my supervisor. The draft framework and interview schedule were both revised and updated as an outcome of the first round of data collection to be suitable to enquire on the perspectives of patients on spiritual care during the ten individual interviews with health users (patients) during the second round of data collection. The processing instrument for the second round of data collection was the updated version of the framework that included the coding of the data generated during the health expert interviews. The updated framework was summarised as a patient tree booklet. The interview schedule was also updated for the individual patient interviews to explore questions asked regarding spiritual care from the point of view of a health service user. For the third round of data collection, the draft framework was updated again to include the codes identified during both the health expert and patient interviews. The updated draft framework was presented to the focus group as a health professional guide. The interview schedule was also updated to include extra questions that emerged during the previous round of interviews with the patients. The questions were reformulated to accommodate the views of the inter-disciplinary focus group from the perspective of both a health service provider and a user. Table 2.2 below is a summary of the instruments used for each round of data collection. The three rounds of data collection are depicted in different

colours: In-depth individual interviews with the health experts (yellow), individual in-depth interviews with patients (green) and focus group with an inter-professional team (blue).

Table 2.2 Instruments and tools for data collection as they were applied during data gathering with each participant group

Processing instruments	Description and use	Sources
Initial draft framework prepared for health experts interviews	The first version of a draft framework was compiled from a literature review on spiritual health, the researcher's own personal experience and inputs from my supervisor. Codes were identified that were used to compile a draft framework to explore the concepts with three health experts.	Literature review and researcher's personal experience with inputs from the research supervisor. This was also submitted beforehand for approval to the PhD and Ethics Committee at the University of Pretoria.
Interview schedule for health experts	Initial data collection sheet comprised of a draft in-depth interview schedule for the interviews with three scholars in the field of spiritual health care. The interview schedule contained possible questions to conduct the interview. Questions explored the personal approach of the experts and their recommendations for practice.	Literature review and researcher's personal experience with inputs from the research supervisor and the PhD and Ethics Committee at the University of Pretoria.
Revised draft framework summarised as a patient spiritual tree booklet	The revised draft framework was presented to patients as a patient spiritual tree booklet with the codes identified during the health expert interviews incorporated into the previous draft. This was summarised for patients in a booklet that was easy to read and give inputs to.	Initial draft framework presented to health experts was updated to include the codes identified during the analysis of the data generated during the health expert interviews.
Interview schedule for patients	The interview schedule explored similar questions to those asked of the health experts, but from the perspective of the patient. A question was added asking patients how they would define spirituality. Patients were asked how they would prefer to be approached and their	Interview schedule used during the health expert interviews was updated and questions were formulated from the perspective of the patient.

	recommendations to health professionals to address spirituality during a health consultation in a manner that is person-centric.	
Revised and updated framework summarised as a health professional guide	Updated draft framework for interviews with inter-disciplinary team during focus group summarised as a health professional guide that included the codes identified during the analysis of the health experts' and patients' interviews.	Updated draft framework with the codes identified during the health experts' and patients' data analysis of the interviews incorporated into the framework.
Interview schedule for inter-professional focus group	The interview schedule explored similar questions to those asked in the previous two rounds of data collection. The interview schedule was updated to enquire about the views of various health disciplines on implementing spiritual care in practice in a practical manner that is ethically acceptable.	Interview schedule used during the health expert and patient interviews was updated and questions were formulated from the perspective of the inter-professional team.

2.12 Data analysis procedure

The theoretical coding that was used to develop a draft framework was that of structural and pattern coding. The existing theories on spiritual health care included standards recommended for practice (Puchalski, Vitillo, Hull & Reller, 2014), models and tools for spiritual needs and care (Koenig, King & Carson, 2012; Puchalski & Romer, 2000; Monod et al, 2010). Structural coding "results in the identification of large segments of text on broad topics; these segments can then form the basis for an in-depth analysis within or across topics" (Saldana, 2009). Structural coding was used to identify various broad topics for spiritual care as described in current literature. Pattern coding was used to group similar codes into sub-sets for a draft framework and as part of preparing an interview schedule with the insights gained from the information available on spiritual health care. This included a good understanding of what the current international literature conveyed, and also what questions still need to be pursued to meet patients' needs in a health consultation with regard to their spirituality and incorporating of practices that could address this. There was also an approach and understanding from the start that there would be a certain category of openness for new codes that arose that were not previously identified in the other research, and therefore all the documents used during interviews were presented as draft frameworks.

The document constructed through this process was included as a draft Spiritual Care Framework in a protocol. The protocol was submitted for ethical clearance and approval by a research committee specifically convened to scrutinise and approve PhD studies at the

University of Pretoria, South Africa. The inputs received during two meetings with the PhD committee were also incorporated into the protocol, draft framework, the interview guide and the informed consent documents, as well as influencing the research approach. After approval was obtained from the PhD committee, the protocol and other research documents were submitted to a second committee focused on ensuring that the research content and approach were ethically sound. For this purpose, the interview guide was also prepared and submitted together with a protocol and a first draft of the ethical framework that would be presented to participants during the expert individual interviews (as the first round), then to individual patients, and lastly to the participants in a focus group interview with health professionals who indicated an interest in the field. The research ethics committee also gave comments and feedback twice, which was accommodated in the protocol and draft framework and submitted after alterations for final approval.

2.12.1 Coding strategy for the data from the research participants

Throughout the data analysis of each source of data, the framework was developed by identifying codes, as is practice for a qualitative inquiry. Saldana (2009:3) defines a code as a "word or short phrase that symbolically assigns a summative, salient, essence-capturing, and/or evocative attribute for a portion of language-based or visual data. The data can consist of interview transcripts, participant observation field notes, journals, documents, literature, artefacts, photographs, video, websites, e-mail correspondence, and so on. The portion of data to be coded during first cycle coding processes can range in magnitude from a single word to a full sentence to an entire page of text to a stream of moving images. In second cycle coding processes, the portions coded can be the exact same units, longer passages of text, and even a reconfiguration of the codes themselves developed thus far. Just as a title represents and captures a book or film or poem's primary content and essence, so does a code represent and capture a datum's primary content and essence." During the data analysis, similar codes were grouped together and categories emerged through analysis, sorting and reflection on the data. The researcher reflected on personal experience and bias throughout the data gathering and analysis and this is also included in the final write-up, as the research has a strong autoethnographical component.

First, during the open coding process, the data was broken down into substantive codes (in this research as *in vivo codes*). The written data and field notes were coded line by line for similarities and differences until a core category or code was identified for various sections of the codes. This process was repeated for each cycle of data collection until data saturation was achieved. The substantive codes were integrated and grouped together as theoretical codes. The coding processes throughout each cycle for both substantive and theoretical codes occurred simultaneously. The researcher "will focus relatively more on substantive coding when discovering codes within the data, and more on theoretical coding when theoretically sorting and integrating his memos. Without substantive codes, theoretical codes are empty abstractions" (Hernandez, 2009). The theoretical coding was used to describe relationships detected between various categories of codes identified. The value of theoretical codes in

grounded theory is that it can contribute to research that is relevant, as this type of coding can maximise making meaning of the data with greater scope (Glaser, 2005). The following recommended approaches to enhance the "researcher's ability to see the emergence of theoretical codes" were applied during the research:

- The researcher built an understanding of possible theoretical codes by reading existing literature on spiritual care to establish *theoretical sensitivity* (Hernandez, 2009*)*.
- *In vivo coding* was used as part of the open coding process as this can "point to possible theoretical codes" (Hernandez, 2009).
- Memoing and sorting of memos throughout the research process assisted the researcher in identifying possible connections between portions of data and codes assigned (Hernandez, 2009).
- The framework throughout its construction and in its final product presented in this thesis was developed by using the theoretical code to depict the "theory pictorially by either a linear model or a property space" (Glaser, 1978).

The first cycle of qualitative data analysis for each of the interviews entailed applying both open and then axial coding as well-known methods for data analysis in research where a grounded theory approach is used (Khandkar, n.d.). Open coding in this case included line-by-line coding and also grouping paragraphs of contents under similar codes that were not necessarily based on existing theory alone, but rather the emergence of codes from the interviews combined with the researcher's lens on the codes in the light of my exposure to spirituality in health care and preparation of the first draft framework and interview guide for the research. The codes were labelled in a draft document, and in certain cases an in-vivo code was assigned. Manning (2017) defines this type of coding as such: "In vivo coding is a form of qualitative data analysis that places emphasis on the actual spoken words of the participants. This form of coding can be especially helpful when researchers interact with participants from a particular culture or micro-culture to help highlight how those participants use specific words or phrases in their interactions that might not otherwise be understood when using other forms of coding."

The open codes were either words or sentences, and in some cases entire paragraphs (more so in cases where an in vivo code was used), in which the participants described concepts and gave examples. The open and in vivo codes were grouped into similar categories under the headings as identified in the interview guide. The headings included concepts such as principles, catalysts or impediments or patient examples. One new code that emerged after the first interview was recommendations from participants on the research process. As this was seen as an important theme, it was incorporated as a heading and not as a sub-set of previously identified codes. This was incorporated into the draft framework for the rest of the first research cycle and the ones to follow. All three of the health experts' interviews were incorporated and all new concepts that arose were either grouped under existing codes or as a code under a new heading.

The initial versions of a draft framework had large portions of in vivo coding. The portions of in vivo coding that contained specific words or phrases that were seen as significant in its original context were each assigned a different colour. Thus, HE_1; 2 and 3's original words, when used in a subsequent draft, were each assigned a specific colour. This was also done in a specific colour for the in vivo coding for the patients as a data source and for the inter-disciplinary focus group as the third data source. This assisted greatly in highlighting the similarities in what the various experts interviewed had revealed and identifying similar codes throughout all three data sources. In many cases, similar codes emerged from the coding and these were visibly highlighted in the data analysis of the three rounds of data collection. All the words and codes, line by line as in open coding, were scrutinised to ensure that no important message was missed and that the various perspectives on similar codes were accommodated.

After each interview and coding cycle, the content was discussed and analysed with my supervisor to ensure that it was clear and representative of the data and that the structure followed a logical order. At the end of the first research cycle I embarked on a second cycle of coding where the longer passages of text and the in vivo codes were coded by the means of axial coding into condensed codes under specific principles that emerged throughout the research process. Gallicano (2013) describes this type of coding as follows: "Axial coding consists of identifying relationships among the open codes". The links between the open and in vivo codes were summarised for each subsequent round of data collection as part of the latest draft version of the framework. This was presented in a format that was easily understood to the next source of data, which for the second round was the patient group. For the second round, this draft framework was presented as Patient Spiritual Tree Booklet, as the original document with all the in vivo codes and open codes became too lengthy in its format at that stage to present to patients and have a meaningful conversation about their views and opinions. The axial codes were grouped into headings similar to what the first draft framework started out as. The pages of open codes and in vivo codes were however summarised under similar codes as sentences that could be presented to patients. The Patient Spiritual Tree Booklet also served as a data collection instrument together with the in-depth interview guide for the next cycle of data collection. The data analysis method entailed extractions made by 'copying and pasting' the codes into a second document, where they were also numbered to reference to original participant numbering of the transcriptions. During the second cycle of coding, *in vivo coding* (Manning, 2017*)* was done in a similar manner to the interviews with the health experts. The verbatim words of the participants highlighted during the first cycle of coding were extracted and numbered as individual documents for the second cycle coding, with the researcher's own side-notes that expanded on the codes, or would help with axial coding (Gallicano, 2013) in the third cycle of coding where relationships between the various in-vivo codes would be made. The axial and substantive codes were grouped to construct the theoretical codes that were used in the synthesis of the various iterations of the framework.

With the analysis of the second source of data (the individual patient interviews), the initial 300 pages of patient transcriptions were summarised into 30 pages, each with a patient number as heading. The patient interviews were summarised by following the same data analysis approach described above and presented in a document titled Patient Spiritual Needs - Analytical Extracted Theoretical Codes.

During this phase of the research process, a second and parallel research document was created that contained the longer in vivo quotes of the patients together with the researcher's own comments. This was titled Thoughts on Patients Quotes. Both the Analytical Extracted Theoretical Codes and the Thoughts on Patients Quotes documents were first shared via email with my supervisor and subsequently discussed as part of ensuring that rigor is applied during the research process and analysis that adheres to transparency and maximal credibility, and that the data analysis follows a process of dependability, comparativeness, and reflexivity. As an outcome to this discussion, the codes identified in the Patients Analytical Theoretical Codes were grouped according to four types of theoretical codes captured as headings. These types were: principles, general guidelines, what to do, how to do. Through a subsequent cycle of coding the data were captured as Thoughts on Patients Quotes. Each new theoretical code was expressed as a heading, i.e. 21 headings. The patients' verbatim words were highlighted in a different colour than those of the researcher's own autoethnographical contributions to the analysis.

The final products, with the research data from both the Patients Analytical Theoretical Codes and the Thoughts on Patients Quotes, were incorporated into the latest version of the draft framework at that time. The data extraction from the focus group was approached in a similar manner as the health expert and patient interviews, with the data analysis following a process of comparison and reflexion on existing codes identified during the previous coding cycles and identification of new theoretical codes that were incorporated into the final framework. Throughout the coding process, each updated draft framework was saved with a subsequent number. New iterations of the framework were developed by identifying codes in various cycles of analysis until the final product as presented in this thesis.

2.12.2 Rules for in vivo (excerpt) coding in the write-up

As mentioned earlier, *in vivo coding,* as a form of qualitative data analysis, was used as part of the data analysis and final research write-up. The emphasis placed on the actual spoken words of the participants not only helps the reader get a better understanding of where principles or recommendations were extracted from, but it also enriches the construction of one's own practice and personal experience to reflect on own past experiences or plan for improved future patient-professional interactions. Constructing meaning through analysis of the contributions of the participants by taking the point of view of the other (Chilisa & Kawulich, 2012), in hearing and recording the actual spoken words of the participants, assisted the analysis process to unpack where new knowledge was generated by participants. Throughout the thesis document and final framework, the spoken words of participants were highlighted in individual colours to give recognition to the various individuals that contributed

to the final product. Table 2.3 below summarises the colours used for the in vivo citations of the different participants/groups, as will be used in the reporting of the results in the subsequent chapters.

Table 2.3 The in vivo citations referenced by colour and code

Participant/group	Code and colour
Health expert 1	HE_1
Health expert 2	HE_2
Health expert 3	HE_3
Patient (all ten grouped anonymous)	Patient
Inter-disciplinary health professional focus group	HP

In the next chapter, the framework for incorporating spirituality into a health consultation will be unpacked as the product of the research.

Chapter 3
The final research product: Framework for integrating spirituality into health care

3.1 Introduction to the framework

This chapter presents the framework as the product of the research. It is the distilled product derived from the participants' inputs, the details of which are presented in the subsequent chapters 4, 5 and 6. The framework describes an approach for integrating spirituality into health care. Presenting the framework in this chapter before the details of participants' perspectives in the subsequent chapters reflects a reverse of the traditional order, in which the various data sources are presented prior to the final outcome or product of the research. The intention of presenting the framework, as the product of the research, before the discussion of the details contributed by the various participants is to allow the reader to reflect on the components of the framework when reading the words spoken by the participants within the context of integrating spirituality into health care. The structure of the chapter is the structure of the framework. The framework consists of principles for practice, quality requirements to attain the principles, recommendations for implementation, catalysts and impediments for successful implementation and spiritual health tools. The framework components are listed in table 3.1 below.

Table 3.1 The six components of the framework for integrating spirituality into health care

1. Eight principles for spiritual care
2. Quality requirements for each principle
3. Recommendations on how to implement the principles
4. Catalysts to implement spiritual care
5. Impediments to implementing spiritual care
6. Spiritual health tools

The first component of the framework unpacks eight principles for incorporating spiritual health care during a consultation. The second component describes the quality requirements for each principle. The principles and quality requirements are followed by recommendations on how to implement the latter. There are certain catalysts that could enable the successful implementation of the principles or impediments that could achieve the opposite, which are also part of the framework. The final component of the framework includes connections to existing spiritual health tools. The spiritual health tools are summarised in three categories, viz. frameworks, screening and treatment tools. The synthesis of this framework is integrated into existing literature as presented in this chapter. The research participants, especially the health experts, referred continually to the works of others and how these influenced their practice. The value of an evidence-based approach founded on existing spiritual resources in

the health care context was an important component of the data yield and thus the framework construct.

The framework is presented as a visual metaphor depicting a spiritual health consultation tree. This is to serve as a visual image of the approach recommended through the research to incorporate spiritual care in practice. The sources of data and participants in the research represent the roots that ground the tree and not only offer support for the rest of structure, but are the life-source of the framework. These include the existing theory drawn from literature in combination with the experiences and thoughts of health experts, patients and an inter-disciplinary health group. The outcome of the research has, as the broad frame, eight guiding principles. These are depicted as the trunk of the spiritual health care tree; without them, no growth or fruit is possible. Each of the eight principles is unpacked and discussed with the personal narratives of the participants, as practical examples, running throughout the framework in threads represented by various colours. Recommendations are also made on how to implement this best practice based on the experiences of the participants. There are certain 'tricks of the trade' that could either be facilitators of barriers to a perceived quality spiritual health experience; these are discussed as catalysts (fertiliser for our spiritual health care tree) or impediments (weeds for our spiritual health care tree). The final component of the framework is the connection to existing spiritual health tools as spiritual health resources, as this tree is planted alongside current research and literature describing an approach with practical tools on spirituality in health care. Figure 3.1 below depicts the spiritual health care tree as a visual image of the framework presented in this research.

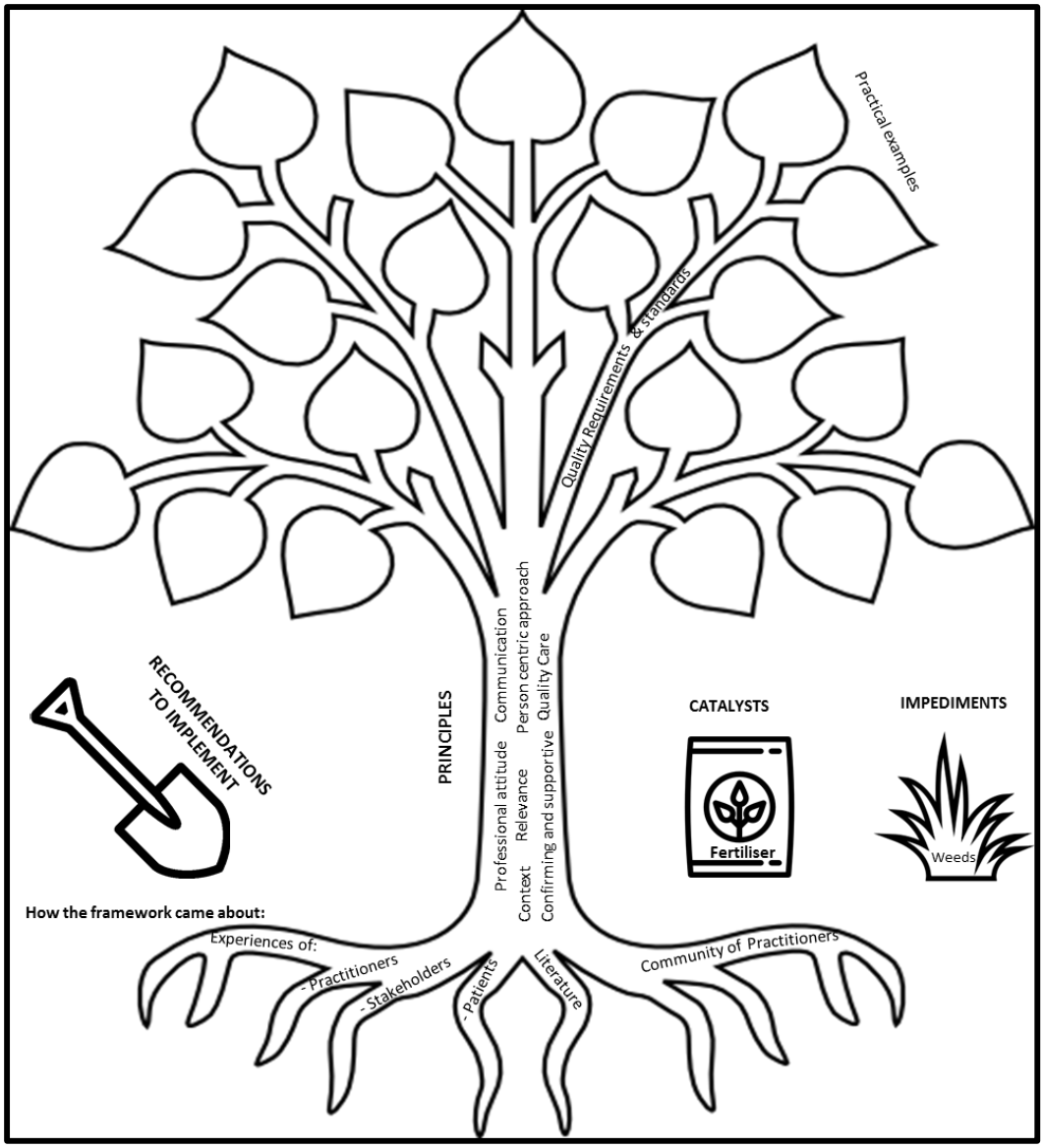


Figure 3.1 Spiritual health consultation framework depicted as a tree

As the first component of the framework, the eight principles for quality spiritual care serve as the foundation for an approach to incorporating spirituality into health care. The eight principles were identified as overarching codes throughout the participants' inputs, which form the basis for why spirituality in health care is important and how this should be addressed in an ethical and high-quality way. The principles to frame and guide practice during the health consultation are listed in table 3.2 below.

Table 3.2 The principles for incorporating spirituality in health care

1. Spirituality should be part of the health consultation.
2. An evidence-based approach that is ethically grounded should be followed.
3. The practitioner should attend to his/her attitude during a spiritual health consultation.
4. The practitioner should create a receptive environment that takes into account the spiritual needs of the patient within his/her personal context.
5. The practitioner should adopt a person-centric approach.

6. The practitioner should foster communication that suitably addresses spiritual health needs.
7. The practitioner should be sincerely interested in the patient and his/her spiritual needs.
8. The practitioner should co-mobilise spiritual resources that build resilience for the patient.

The codes that emerged in the analysis of the narratives describing the requirements for each principle are presented as the second component of the framework, as quality requirements for each principle. The principles derive meaning and purpose from the manner in which they are implemented. The quality requirements for each of the principles are discussed in detail in the framework and the following three chapters, with the inputs from the patients, practitioners and health experts. Implementing the principles successfully requires an understanding of how to practically apply them. The third component of the framework consists of a description of recommended guidelines that describe practically how spiritual care can be approached against the backdrop of the principles and quality requirements, and what a practitioner can do to facilitate this successfully in practice. The recommendations made to incorporate spirituality into health care are described according to four categories as seen in table 3.3 below.

Table 3.3 Categories of recommendations to incorporate spirituality into health care

1. 5 **W** questions for spiritual health care
2. General guidelines on applying the principles
3. 'How to do' from the perspective of the patient *and* practitioner
4. 'What to do' from the perspective of the patient *and* practitioner

There are systemic and individual factors that could either serve as catalysts to enable the successful adoption of spirituality in health care as part of holistic care or become barriers to offering such care. Certain factors could be influenced on an individual level and others are beyond the scope of the individual to change and should be addressed within a health practice or system set-up. In certain instances, adopting a different attitude or changing an approach to how services are organised could either be a catalyst or an impediment. As the fourth component of the framework, the catalysts are described to help one identify in which areas a health professional, health care practice, unit or institution is currently enabling a holistic approach to health care, and where changes could be made on micro or macro level to incorporate quality spirituality into health care. The categories of possible catalysts for implementing quality spiritual care in a consultation are listed in table 3.4 below.

Table 3.4 Categories of catalysts to incorporate spirituality into health care

Enabling conditions on a health systems level
Enabling conditions on a health implementation level
Health professional competence requirements
A holistic patient approach from screening to treatment

An incorrect approach could achieve the opposite and become a barrier to offering quality spiritual care. The fifth component of the framework describes practical examples of possible impediments to implementing quality spiritual care in a consultation.

The sixth and final component of the framework describes existing frameworks, spiritual screening and history taking tools, and recommends approaches for treatment available and how this links to the principles and approach recommended in this framework. The spiritual tools are unpacked in three categories, listed in table 3.5 below.

Table 3.5 Categories of spiritual health tools

Frameworks and/or spiritual care models
Spiritual screening tools and history taking
Treatment approaches

The discussion on different frameworks, models and spiritual care tools can assist the health professional in deciding on a tool that fits into his/her specific practice and area of health care. There might be differences in the approach to be followed, depending on whether spiritual care is being incorporated in an emergency health care unit, a general practice or an oncology care practice. The spiritual screening approach used could range from asking two questions to screen for and identify a spiritual need, to taking an in-depth spiritual history. Beyond the spiritual history, whether brief or thorough, lies the question of which member of the health professional team should address the spiritual needs and to what extent these should be addressed by a health professional before the patient is referred to a specialised spiritual carer. This is one of the reasons why a framework for addressing spirituality in health care is important.

The principles and recommended approach serve as a guide for both the practitioner and patient to agree on what falls within the ambit of the consultation and when the patient's needs would most ethically and efficiently be served by referral to another professional. Each of the components will be unpacked in greater detail in this chapter. Table 3.6 gives a short descriptive summary of the framework components that will be discussed throughout the chapter.

Table 3.6 Description of the six components of the spiritual health care framework

Framework components	Description
Eight principles for spiritual care	1. Spirituality should be part of the health consultation. 2. An evidence-based approach that is ethically grounded should be followed. 3. The practitioner should attend to his/her attitude during a spiritual health consultation. 4. The practitioner should create a receptive environment that takes

	into account the spiritual needs of the patient within his/her personal context. 5. A practitioner should adopt a person-centric approach. 6. The practitioner should foster communication that suitably addresses spiritual health needs. 7. The practitioner should be sincerely interested in the person and his/her spiritual needs (to achieve quality spiritual health care). 8. The practitioner should co-mobilise spiritual resources that build resilience for the patient.
Quality requirements for each principle	Described in the chapter
Recommendations on how to implement the principles	1. 5 **W** questions for spiritual health care 2. General guidelines on applying the principles 3. 'How to do' from the perspective of the patient *and* practitioner 4. 'What to do' from the perspective of the patient *and* practitioner
Catalysts to implementing spiritual care	1. Enabling conditions on a health systems level 2. Enabling conditions on a health implementation level 3. Health professional competence requirements 4. A holistic patient from screening to treatment
Impediments to implementing spiritual care	Described in the chapter
Spiritual health tools	1. Frameworks and/or spiritual care models 2. Spiritual screening tools and history taking 3. Treatment approaches

As the first component of the framework, the eight principles will be discussed with the inputs from the participants running throughout the discussion in different colours.

3.2 Principles to frame and guide practice

The eight principles are depicted as the tree trunk, as this is the main axis around which the other components of the framework are made relevant. This is depicted in figure 3.2 below.

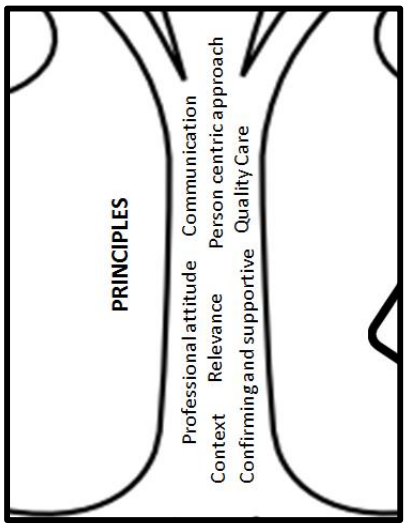


Figure 3.2 Principles of spiritual care

Principle 1: Spirituality should be part of the health consultation.

Spirituality plays a distinct role in offering holistic and compassionate care. With modern advances in medicine and medical care, the focus shifted towards pathology and the prevention thereof. In recent years the renewed focus on offering person-centric care that acknowledges and serves the whole of the person has included a focus on care that encompasses that which is considered spiritual (Puchalski, 2001). Ethical concerns for the well-being of the person when offering health care have existed for millennia. In Western medical writings, the concern with ethical and compassionate care can be traced back to a compilation of writings in the early fifth century that include the thoughts of the physician Hippocrates. This was known then as the Corpus Hippocraticum and has become known to health care professionals today, in a modern version, as the Hippocratic Oath (Loeb Classical Library, 1923). The authors of the Corpus Hippocraticum argue that the motivation for health care should be to diminish suffering associated with illness and disease (Taylor, n.d.). Puchalski (2001) argues similarly that including spirituality as part of holistic care could be likened to compassionate care, which by definition means to 'suffer with', describing that the goal of this is to alleviate suffering. Patients interviewed during this research expressed that without attention to the spiritual aspect a person cannot cope with the tragedies of life. One patient interviewed stated that the goal of incorporating spiritual care should be to assist the person to make meaning of illness within the context of living a life filled with hope and purpose: "Having a condition or diagnosis does not ultimately define who you are as a person. Framing a diagnosis as a smaller component of who the person is, what the significance of his/her life is and how to live a meaningful life despite this, is part of the goal of spirituality."

The first principle that emerged through the research underpins what so many others motivate – that spirituality should be included in all types of health care offered. Spirituality

could entail holding someone's hand (therapeutic touch) or talking to a patient about what is important to them (Puchalski, 2001). Spiritual care could include and/or be incorporated into everyday experiences (as emerged through the interviews and is affirmed in the literature), including mental imagery, prayer, traditional medicine and herbs, homeopathy, therapeutic touch, natural diet practices and exercise programmes, to name but a few. The question of how spirituality should be included is inevitably linked to worldview and the current experience of the individual within his/her context. It is also linked to what is achievable from the perspective of the health professional within his/her practice, context and health care system.

Boylan (2012) describes recent popular paradigms on health care that include an approach that values objectivism with a focus on function and/or dysfunction, and is linked to achieving a long lifespan. This is in contrast to a subjectivist approach that does not focus solely on pathology, but also includes well-being. Both of these approaches have advantages and shortcomings. A third approach that is person-centric and inclusive of the larger context is the self-fulfilment approach (Boylan, 2012), which is developed by having an approach to health and health care that is inherent to what we internally believe, but that is comprehensive in that it has taken into account the outside world. It should also be measurable and achievable. When offering spiritual care, one has to acknowledge that the order of importance of what is considered as good spiritual practice and care will inevitably be linked to a subjectivist and personal fulfilment approach. However, there are certain values that cut across culture and enable spiritual care to be measured in that they maximise self-actualisation by linking values such as peace and fulfilment or acceptance of what is experienced on a personal level within a clinical care context to what is offered as part of compassionate and comprehensive health care.

The coding of the interviews with the research participants highlighted the following practical points that serve as the basis for why, how and when spirituality should be included in a health consultation and clinical care:

- Spiritual care is part of values-based practice and a person-centred approach.
- Spiritual consultation and assessment should take place in all health settings and with every patient as part of a comprehensive history taking.
- The inclusion of the spiritual care in the health consultation and treatment cannot be done using a 'one size fits all approach'. It should be adjusted to meet the needs of both the patient and practitioner, taking various factors into consideration: e.g. time, clinical diagnosis and reason for consultation, health care setting, patient's openness and practitioner's competence.
- The inclusion of spirituality in the health consultation and treatment process requires three dimensions of enquiry, viz. spiritual screening, spiritual history taking and a spiritual assessment. The depth and application of how spirituality is addressed in the health consultation will vary. Depending on the unique patient situation, one or all of these dimensions could be applicable to the consultation. Spiritual screening is very

brief and usually takes place during a first consultation or could easily be concluded during the waiting period before consultation. Spiritual history taking can be brief or extensive, and done prior to and/or during the consultation. Spiritual assessment over time is usually part of continuous or follow up treatment.

- The inclusion of spirituality during the consultation should be approached from within an inter-disciplinary team. This team should include people from faith religions, people with traditional beliefs and counsellors or a person qualified to address the patient's needs. Initial screening from the health perspective is often done by a health professional. Working as an inter-disciplinary team and referring amongst team members to fully address the patient's spiritual needs should be considered as good practice, just as with any other clinical condition. One of the patients interviewed remarked: "I believe the medical health professionals body and these traditional leaders somewhere higher up, they need to try and form a coordinating body where they can work together."
- Practice-specific spiritual consultation tools should be available and implemented in hospitals and individual practice settings. Practitioners should be trained on this continuously as the field develops, and quality screening of patient management should incorporate assessment and the inclusion of spirituality in health consultation and care, with appropriate pathways for referral and management.
- The timing of introducing spiritual health questions is important. "I found there is sort-of a natural hiatus (opening) in the conversation between the evaluation of the tests and the first prescription." – HE_1 during an interview on 28 May 2017. During the focus group, the inter-disciplinary health professionals said the following: "First create rapport and a connection of trust; the approach is more important than the timing."
- All health practitioners need to have training and knowledge on how to address basic spiritual health needs during a consultation. Health professionals need to have both a framework and a practical approach (including communication skills) to address the emotional and spiritual needs. This requires that they be equipped with the necessary "soft skills to address the delicate situations", including knowing when to refer to a specialist spiritual counsellor as part of a multi-disciplinary team.
- Offering spiritual care and doing a spiritual assessment is done from a different place of enquiry than the rest of the health consultation. As the health practitioner is probably in a 'position of power' – due to the traditional role of the medical doctor and because the patient is seeking 'expert help' when it comes to the clinical care – there might be an imbalance when asking about spiritual questions. Humility and an attitude of equality should be the nexus from where the spiritual enquiry is facilitated. "To come sit next to your patient and see their life, see from their perspective, what you know might not be knowledge that your patient has. And how you treat and respond to them can further heal or harm, if you are judgemental or open minded." – HE_2 during an interview on 18 Aug 2017.

Puchalski (2001) asks whether patients want health professionals (physicians) to address their spirituality (spiritual needs). She notes that quantitative research indicates that most patients indeed want their health carers to discuss their spirituality with them, but less than 10% have had a health professional address the topic. The qualitative data from this research affirms that patients want to be spoken to as a whole, which includes their spirituality. All patients interviewed for this research indicated that they wanted to have spirituality included in their health care. Although the sample size is too small to quantitatively substantiate any of their claims, this has been established by previous research. The descriptions from the participants in this research describe in greater detail what previous research has begun to unpack. Compassionate care includes spiritual care; it can be approached in various manners to fit the needs and preferences of both the patient and the practitioner. However, the discourse and discomfort regarding how and when spiritual care is introduced should not let health professionals forsake this opportunity and duty to whole-person care.

Principle 2: An evidence-based approach that is ethically grounded should be followed.

Much attention has been given to the practical clinical context of medicine over the last decades. Thousands of scholarly articles citing empirical knowledge are published yearly on the latest surgical techniques or benefits of evolving medical treatments. Less attention has been given to the *softer* side of medicine, which includes addressing the patient's social, emotional and spiritual context – especially when it comes to research and the application of an evidenced-based approach to holistic care. Puchalski (2001) states that more active quantitative (and to some extent qualitative) research has been undertaken in recent years around the role of spirituality in health care – specifically on the its impact on recovery, mortality and coping.

In health education, more and more health and tertiary institutions are including spirituality to a greater or lesser extent into their curricula in response to the updated WHO definition that includes spirituality as the fourth dimension of the health of man (Yach, 2008). In the Unites States, only three medical schools included spirituality in health care as part of their learning outcomes in 1992. Within less than a decade, this number jumped to 75 schools offering courses on spirituality and health in America (Kumar-Sinha & Kumar, 2014). By the year 2019, international and local spiritual health conferences presenting the discourse and latest research in the field were all still in their teenage years.

The health experts interviewed emphasised the need for more research, specifically in describing an ethical framework for health professionals to adopt at the individual or practice level to enable the implementation of spiritual care as part of holistic health care. The focus of this framework is to describe an approach to individual care that is acceptable in quality and that suitably addresses the needs of the patient in an ethical manner. HE_3 voiced very strongly what other authors and researchers in the field of spirituality and health care have been saying in recent years: "We need an ethical framework. Not only for the patient, but for the practitioner. So I am not sure if it is really ethical for a psychologist or practitioner not to state their spiritual beliefs. I am also not sure if that is even constitutional as we are supposed

to have freedom of speech and religion? But, currently my profession does not allow for me to state my spiritual beliefs up-front. Knowledge has to be a principle. We should have knowledge about protocols and research and evidence-based medicine. It also has to be integrated into practice. I cannot do an intake interview or diagnostic assessment or protocol without understanding how spirituality and religion impacts on that person. To be able to implement this at end-point D, we need to go back to the A, B, C. We need an ethical framework and knowledge for A. We need research to support this. Also locally, South Africa as a country needs to do more research on what our local needs are and to under-good the international research. We need a practical framework that gives us not necessarily practical steps, but a guide to questions to ask. What are our guiding principles? And then, if it is practical, it should be feasible. We need a code of conduct. And we need legislation that supports this…And this is where the B, C and D lie. And here we need to develop the substance: ETHICAL, PRACTICAL, and KNOWLEDGE-FILLED AND RESEARCH BASED. This would put the principles in place." – HE_3 during an interview on 2 Nov 2017.

If spiritual care is offered as part of a health consultation, then introducing this care up-front as part of a holistic approach offers the patient the opportunity to accept or decline this as part of a consultation or therapeutic process. HE_2 and HE_3 both stressed the importance of obtaining informed consent, as well as inquiring about spirituality and offering this as part of the treatment plan. All three HEs interviewed referred to existing models and research as good screening tools that are evidence-based and useful. This underpinned what was proposed to them as a draft framework in certain instances, but also enriched and added more concepts that were included as they emerged throughout the research process and framework development. HE_3 commented on current spiritual screening, diagnostic and treatment tools available within the health field: "One for the South African context would be relevant. Another thing that is valuable is peer-group and inter-disciplinary discussions that supports how we are practically doing this. These discussions as professionals should then inform the legislation and codes of conduct."

The coding of the interviews with the research participants repeatedly emphasised the offering of spiritual care within the African context. The next principle emphasises the importance of the practitioner's attitude and unpacks the essence of being able to address spirituality in a multi-cultural and multi-religious context, such as that of South Africa and the African continent. An appropriate attitude remains relevant to other cultures and could be adapted to suit individual context of expression. During the discussion on the principles to follow, and in the interviews with the patients and inter-disciplinary health group, the theme of the African context and how this is linked to spirituality and acceptable spiritual care features as a golden thread.

Principle 3: The practitioner should attend to his/her attitude during a spiritual health consultation.

When working in a multi-cultural and multi-religious context, one has to recognise upfront that the health professional will be faced with beliefs that do not resonate with his/her own

views. Many patients in South Africa and Africa place a high value on traditional healers and practices that seemingly oppose care that might be recommended from a Westernised health approach. The health practitioner cannot meet his/her patients in their context and address their needs if there is not an open-minded approach and respect for different perspectives and ways of expressing spirituality. The attitude of the health professional, whether or not he/she agrees with the patient's beliefs, is pertinent in determining a meaningful spiritual engagement with the patient. It also requires of the health professional a certain level of maturity in that he/she is comfortable with his/her own beliefs and worldview to the extent that this does not have to be imposed on a patient, but allows for meaningful two-way communication and engagement on the health care process, such that both parties can be comfortable. If the focus remains on assisting the patient, then the attitude and approach would follow in a similar fashion to address the needs of the patient and offer care that is deemed as evidence-based and scientific, but also accommodating of personal and spiritual preference. The health professionals interviewed described complex patient case experiences where patients' beliefs had to be accommodated before achieving acceptance of a recommended health care regime. The theme of ancestral beliefs and the influence this might have on clinical care was evident in both the patient and the inter-disciplinary interviews. One of the health professionals interviewed described the complexities with the following patient case: "I encountered a patient who believes in ancestors. So, basically, according to that belief you cannot take blood before you speak to the ancestors if you go to the hospital. You should explain to the ancestors that you need to, they might take blood, so they (the ancestors) must allow you to do it. So, basically, the story is we struggled to take blood from the patient. We struggled. And it didn't makes sense, because, I mean, the event alone isn't necessarily hidden – it's quite strange. I don't know how it happened, but so he says, 'By the way guys, I didn't ask for my ancestors that I'm gonna take blood today, so that's why you are struggling.' I was confused, but it's only later then I realised that some of these things can affect you if you don't believe in them. I don't know, but it did happen. I can tell you, we couldn't get blood from the patient."

The starting point of incorporating spiritual care successfully is, to a great extent, determined by the attitude with which this is approached. Walker and Breitsameter (2017) formulated the importance of an appropriate attitude with the following: "Regarding spiritual conversations and spiritual practices, the content of the discussions and the practices are less important than the forms these practices take, which, in the final instance, are in the hands of the speaker or the person carrying out the spiritual practice." Health practitioners should be prepared to comfortably engage beliefs that are different from their own when endeavouring in the domain of spirituality in health care. One of the health experts interviewed unpacked this with the following: "I have found (at least for myself) that when it comes to addressing spirituality in the health consultation, I first have to be comfortable with my own spirituality and worldview. I was at first very uncomfortable about my own spirituality and addressing patient needs in this context. I felt that it was as if I was having some sort of agenda. I was very defensive and felt as if I, in some vague way, I was going to impose my own

opinions and worldview and intrude on someone else if I addressed this in the health consultation, as I want to bring about some change to the person. Then I realised that *spirituality is a physiological feature* of mankind. With that concept in mind, it is far easier to have just a human-to-human conversation with the safe assumption that spirituality is a physiological feature and that the conversation and language we use and have (towards) spirituality may either be facilitating of the conversation or raise unnecessary objections. The realisation and perspective that this (spirituality) is an attribute of man, rather than a tool of therapy, is what I want to explore." – HE_1 on 28 May 2017.

HE_1 highlighted that one should understand *why* one is engaging a patient in a spiritual health conversation. He noted that the difficulty is that health professionals could pursue the spiritual exploration during the health consultation, but their attitude towards the health care they are offering may be flawed in that they want to arrive at a diagnosis as quickly as possible and prescribe the right treatment. Every patient may need spiritual care, but one's attitude should be one of assisting the patient, and understanding the setting and relevance of addressing the spiritual needs and care in that specific context to meets the patient's needs.

If the health professional does not value the importance of spirituality in the health consultation and management plan, then often the meaning is lost. HE_2 put it the following way: "Spirituality is at the core of healing and health. I think if the profession could just understand this. If someone is spiritually connected, then they have already put healing in motion. Our bodies were created by God to function from homeostasis. So if the sympathetic nervous system takes over then health cannot be restored, and therefore patients need to be educated on their thoughts and emotions and its impact."

The inter-disciplinary health focus group confirmed the view that integrating spirituality into care is of importance: "Spiritual history taking is important." Another health professional stated: "Spirituality has to be addressed because we are mind, body and soul. The health needs of the patient have not been addressed until all components have been addressed." The focus group also discussed the interlinkage between culture and spirituality, that specifically in the African context, patients often practice spiritual rituals as part of their healing remedies and processes. This could be a resource to a patient if embraced during the clinical health consultation: "Beliefs deriving from culture can strengthen one's spirituality." This is only possible, however, if the health professional is equipped to approach this with the necessary skills and knowledge: "The health professional needs to understand different cultures, beliefs and have knowledge on how to integrate this successfully into the clinical care."

HE_3, during an interview on 2 Nov 2017, summarised her ideas on professional attitude and the importance of spirituality in the health consultation by saying: "My mind fires in a million different directions with that question as it is a passion of mine, but it is also a major concern for me in psychology practice. I have a few thoughts: The first is that it is integral to the treatment of the patient. I cannot imagine not addressing the spiritual component as part of

a holistic approach to a patient. But this is not only with regards to treatment, it is also about the assessment and diagnosis and everything that leads up to the treatment plan. My concern with this is that, specifically in my field, people have been nervous about the difference and intersection of spirituality and religion and how to address this in practice. For me, it is a devastating place for psychology as a field to be: If we are working in a 'sacred' space of the patient every day as a practitioner working with a person that is vulnerable and in pain; if we are not open to incorporating spirituality into our therapeutic model, then I feel that we are managing that patient unethically. So while I am passionate about incorporating spirituality into our practice, I know that we are not doing it. And there is a whole myriad of reasons why we are not. And I am passionate about that. We need to do it, but we are not, and the question is how do we bridge that?" If the health professional adopts the attitude that spirituality and its expression are unique to the individual and is able to adopt a respectful approach that wants to meet the patient at the point of need when enquiring about this during the consultation, then the patient's needs will be met successfully.

Principle 4: The practitioner should create a receptive environment that takes into account the spiritual needs of the patient within his/her personal context.

Various acronyms have been developed to assist health practitioners to remember how to take a spiritual history. This includes the **FICA** spiritual history tool (Puchalski & Romer, 2000), which stands for F: **f**aith and beliefs, I: **i**mportance of spirituality to the person, C: spiritual **c**ommunity of support, and A: preferred way to have this **a**ddressed. The **CSI MEMO** (Koenig, 2007) consists of four questions: Do religious or spiritual beliefs provide you **c**omfort or **s**tress? Do they **I**nfluence medical decisions? Are you a **mem**ber of a religious or spiritual community? Do you have **o**ther religious or spiritual needs? There are also other spiritual tools available, including the **SPIRIT** tool (Maugans, 1996), which enquires about **s**piritual belief system, **p**ersonal spirituality, **i**ntegration in a spiritual community, **r**itualised practices and **r**estrictions, **i**mplications for medical care and terminal events planning; and the **FACT** spiritual tool (LaRocca-Pitts, 2012) that contains questions on **f**aith, how **a**ctively this is expressed, **c**oping or concerns regarding spirituality and the **t**reatment plan. Another spiritual screening tool known as the **HOPE** tool (Anandarajah & Hight, 2001) looks at sources of **h**ope and meaning, **o**rganised religion, **p**ersonal spiritual **p**ractices and **e**ffects on medical care.

These tools are all valuable in that they assist the practitioner to easily remember what to ask when enquiring about spirituality in the health care context. It does not, however, guarantee that a meaningful discussion will be conducted. Before attempting to ask questions that are an important component of who the person sees him/herself to be and the implications of these beliefs on the health care experience and the patient's journey, it is important to establish a rapport and trust that will enable an open and genuine conversation. The research participants also reflected on the delicate balance between ticking off a list of questions asked versus having an unfolding discussion that enables better care and a person's needs being met in a manner that acknowledges his/her personhood. "One of the biggest challenges is the way in which the topic of spirituality is introduced into the health consultation. There are

active and passive approaches to this. The active way is to specifically solicit the patient by asking whether they have any particular spiritual needs during the consultation process. The danger of that type of approach is that it can seem so profound that you can get a very evasive or limited response. In the passive, if the consultation is of an appropriate length, the approach of the practitioner is to respond to a verbal cue of the patient and then to weave this into the conversation about the outcome of her diagnosis or the therapeutic process. An example of this: 'Ms Jones says: "Doctor, I realise that I am very ill, but I have faith that I will get better." Then the doctor says to Ms Jones that "I hear you mentioned the word faith, can you elaborate what that means to you in your health context currently."' The patient will give you openings that you can pursue then quite legitimately: Important to note that the doctor is not asking this question out of curiosity on the person's worldview. The practitioner wishes to assess the needs that the patient has, and to how far their spirituality is either an asset or liability to their health goal and health care process: To *understand* that their spirituality could either be a health resource or a liability. I think that emergencies and intractable or life-threatening conditions are the extremes of context in which spirituality is very relevant, but the approach might be very different. In an emergency the person is still processing what happened. In a chronic situation they have to navigate the issue of hope and just what the rest of life would look like, and even end-of-life issues. The context is critical. The difficulty is navigating the range and for the clinician to calibrate the approach to a person's spiritual needs based on those frameworks. So again, context is critical, but how this is communicated and assessed in each situation needs to be fleshed out." – HE_1, 28 May 2017.

The words spoken by the research participant sketch the complexities of incorporating spirituality successfully. The importance of listening to the patients' stories and allowing them to direct the text in terms of the value of spirituality to them within their health context was highlighted repeatedly during the interviews. Picking up on patient cues and using these as a starting point to ask spiritual questions was reported by the interviewees as critical to creating the right context during the interview. It is in the approach that a context is created which enables quality spiritual enquiry and care. In this context, the saying that medicine is both a science and an art rings true, as it is with the correct scientific screening tool and the appropriate approach and attitude that an environment is established which enables a story to unfold in a meaningful manner. It is in this context that health practitioners can assist patients towards wholeness, with or without a continued disease.

Sulmasy (2001) underscores the potential value that can be created in the interaction between the health practitioner and patient: "Research should pay attention to the importance of the relationship between the health professional and the patient as a possible context for the patient to work out and express spiritual concerns and struggles." In her description of a biopsychosocial-spiritual model, Sulmasy (2001) illustrates the narrative of a patient diagnosed with cancer who admitted that he wanted to stop the chemotherapy regime, but continued for the soul reason that he enjoyed his oncologist's support so much that he feared he would lose the relationship if he discontinued the therapy. Spirituality is

inevitably linked to our experiences and emotions – whether this is with what is experienced in the consultation room at a certain point in time or with what has been experienced outside of the room in everyday life. It is important to note that spirituality may be linked for the patient to an experience, emotion and/or illness and that the doctor can assist the patient in making connections between experiences, emotions and his/her health and health care plan: "Well, I happen to go to a doctor who wouldn't say to me, *what's wrong with you*. He said *who's wrong with you*; because somebody might be causing you grief. And to me that is a holistic view of not only looking at your sore toe, or your sore stomach, because there's a reason why you have that. Is it necessarily something physical or is it something else, are you upset about people, is that making you sick?" This comment was made by a patient during the interviews conducted. Another patient stated: "I know it's not the medicine that gets my blood pressure up and down. The reason it's low today is I had an hour-and-a-half conversation with one of my best friends last night and I touched reality that most of the time I'm working in an area somewhat removed and isolated."

In creating a relevant context, the health professional should be aware that when the topic of spirituality is addressed (especially if there was no prior context created), patients will want to understand what is meant by this. Many patients interviewed first wanted to define what is meant by spirituality. They had their own ideas and perceptions of what is meant by spirituality and also its importance in relation to health. It was, however, voiced throughout all the patient interviews that the health professional should create a context for the patient where both the practitioner and patient feel comfortable about what is meant by spirituality and why this is relevant during a health consultation. "If you want to approach this (spirituality and health) with a patient, one first has to define what is meant by spirituality. It's such a wide thing and to me spirituality means being aware, respectfully, of the whole creation. So I think from a health perspective yes, of course, you're not little compartments. You know, it's part of your being. I think it is relevant, but it has to be, be handled very carefully so people don't take offence. I see spirituality as being aware of a higher being and having great respect for other people's point of views." – comments made by one of the patients interviewed. This was affirmed in another patient interview: "It will depend to me on the time that we have available. I believe mindfulness and looking at spiritual abilities or inner strength and developing these components, that can impact on your health. I also think it is important for the health professional then, if she wants to discuss it with me, to define the concept of spirituality because people, not me, but people will sometimes think only in terms of it as their straightforward religion."

Patients are often more open to discussing spirituality than the health professional might anticipate: "I am open-minded about life and thoughts and things, so, to me, really there would be no issue. I don't even know if there's anything that I would not be able to talk about." It is, however, important to create context that is patient-specific: "I think most people, especially the older generation maybe, were still looking at the doctor or the medical practitioner from a medical point of view. And if you waste my time by talking about other

things...now, then you're not doing your job. And I don't want to pay you for that. So I really think it's important to...let the patient understand. And then, of course, you will then find all the aches and pains that is there psychologically and not only medically. And you know the reasons why you become overweight and the reasons why you don't want to gym, and so forth..." -

Kumar-Sinha and Kumar (2014) define spiritual health with concepts that include peacefulness, simplicity, empathy and compassion: "It is said, a spiritually healthy person is very much in tune with the present moment and doesn't live in the past or in the future, but instead fully accepts the current moment as the only *real* moment in which to experience and enjoy life in totality." Using these spiritual and emotional concepts to guage whether a patient is experiencing spiritual distress due to a current medical condition or experience could be helpful. This could be approached by asking whether the patient is at peace with his/her diagnosis, has enough knowledge and skills to simplify and manage the complexity of his/her disease without experiencing daily distress, and feels cared for and supported by professionals and loved ones to cope with his/her disease. These are all possible questions that could assist the health professional to indirectly introduce spirituality in the health consultation.

During interviews with the various health experts (HEs), the issue of when and how to address spirituality within a health consultation were noted as being important. The various experts had similar notions on the importance of recording the health history; however, how and where a screening could be done was viewed differently. HE_2 mentioned including spiritual screening questions in the history document that a patient could complete before seeing a health professional. For patients seen on a more regular basis for a consultation or who are known to have a chronic disease, exploring within an inter-disciplinary team the role of the patient's spirituality in his/her health and illness management could be of value. "One can complete a form in the waiting room, and this screening could guide the questions in the consultation. A pre-screen can be done by a health coach or bio-kineticist. This information is then packed into various categories and this could assist the doctor in how to address the needs of the patient better. If I can give an example: let's say a patient comes in with type II diabetics, but on the pre-screen you also realise that he has lost his job and going through financial problems, and this had an impact on his health. And maybe earlier this patient had another trauma and this is causing anxiety. He might have underlying anger still, even developed perhaps a disease such as high blood pressure because of unresolved underlying emotions. This allows the doctor to manage the patient differently/better and also consider which medication to prescribe. Also, referring to the inter-disciplinary team for the management of his chronic disease and underlying spiritual-emotional triggers and needs, one can empower the patient on how he can do things that could assist him, and this is not necessarily only using medication." – HE_2, 18 Aug 2017.

Creating the context for the consultation to probe deeper into the social context of the patient and unpack his/her spiritual and emotional and social resources requires finesse.

Depending on the patient's context and reason for consultation, the use of a metaphor or descriptive information of the usefulness of understanding the greater context could alleviate underlying fear that the patient might experience when sharing his/her personal information. HE_3, during an interview on 2 Nov 2017, related a metaphor that she often used in practice: "One of the images I use when a patient sit in front of me is to say: 'You are sitting here, but all I can see is a black and white image in a colouring-book and for me to really know and understand you and join you in your suffering, I need as much colour as possible. And the more colour I have, the more I can understand you.' Part of the colouring in is having a space where the patient can also discuss the spiritual and religious beliefs and faith tradition. I also use the FICA tool (Puchalski & Romer, 2000) and often ask the introductory question: Is religion or faith important for you in your life? This enables me to explore further with them. The importance to which they emphasise spirituality and religion in their life is also critical for the consultation process. We can get so caught up in saying someone is Christian, but what that means for different people is not the same thing. That is not a homogenous class. Especially in the South African context, we have to understand what being Christian means for this specific patient. We have to create a vulnerable space for someone to be honest and open. So for me as a practitioner, one would be exploring the patient's worldview, the extent to which spirituality and religion infiltrates their lives and the degree to which they live their life from that point of departure."

Patients interviewed indicated that creating the correct moment and space requires competencies in the *softer skills* (such as communication, approach and values) portrayed by the doctor. Some patients indicated that this would strongly influence whether they are open to discussing their spirituality with a health professional or consider this beneficial: "I would prefer a directness, honesty, some basis for having created some level of trust. There should be a demonstration of competency in this domain from the health professional." Another patient remarked: "Wait for the correct moment. I would definitely not do it if I do not know or haven't built up a good rapport with the patient or a good relationship yet. But later, when there is more trust in the relationship, I think I would then be able to talk to the patient, you know, taking that the time and the context is correct – like the space, the physical space that we are in and privacy and that kind of thing." – during an interview in June/July 2018.

A conducive context is critical for a meaningful spiritual enquiry. The context starts by creating a physical space that allows for privacy and a moment to engage with the professional on a human level. It is enabled by creating an understanding from the patient regarding what is meant by spirituality and what its relevance is. Meaningful enquiry goes beyond asking appropriate questions. It is important that both verbal and non-verbal communication are responsive to the patient's needs and honour the patient's beliefs. In many instances, the spiritual questions could be weaved naturally into the clinical care context if the practitioner is skilful in identifying opportune moments for such enquiry.

Principle 5: The practitioner should adopt a person-centric approach.

'The fundamental basis for a holistic approach is a person-centric approach' (Demirsoy, 2017). Patient care should be a *patient-driven* rather than a therapeutically driven process. The nexus of a person-centric approach is that a patient is seen within the whole of his/her context. This includes values and preferences, beliefs, current challenges and assets within his/her environment. The person-centric approach also includes the value and role of the practitioner as a participant. Hippocrates summarised the role of the practitioner in adopting such an approach by stating: "It is more important to know what type of person has a disease, then what type of disease a person has" (Freeman, 2005). The value of being seen and recognised as a person emerged as a need cited by patients during the research: "The main thing for me would be is that the practitioner must be able to think themselves into my place, into my position."

A person-centric approach also allows patients to list the order of importance of the care plan, as well as the order of importance that spirituality plays and how they live that out. "To give you an example, if you become a quadriplegic through a car accident or something, or a spinal injury, I might, as the occupational therapist, I might think that it would be best for you to learn first, if possible, how to brush your own teeth... or how to manage yourself at the toilet or whatever, which are the more personal care type of activities. Whereas if you, if I am your patient and you're the OT (occupational therapist), and you ask me what would I want to learn first, I would probably say something to switch on my CD player to listen to Maria Callas. That is more important to me than brushing my own teeth. And I think that is in my job, in my interaction with clients, the most important thing is to take them where they are and not where you want them to be or where you think they must be at this stage, but to really take them where they are" – said by a patient during an interview.

Spirituality as part of a treatment plan requires more than following a step-by-step approach. Without meaningful engagement and application on a personal level, to the patient, it is an empty ritual: "In occupational therapy, where we use activities to reinstate the patient back into his life and his level of functioning as high as possible, I can have 1 000 activities which are all applicable to the patient...But if I cannot meet the patient, look him in the eye and say to him, I'm not going anywhere, OK. Because then the patient, sometimes the patients get very angry with you. If you say to them, 'but we have got to start doing this and this,' and they get very angry. And then to say to them, 'I'm not going anywhere. You'd better get over it. I'm coming back tomorrow morning!'" A person-centric approach is that one allows the patient to decide not only what is considered as spiritual or important, but how this is applied in the therapeutic process. The previous comment was from a patient who was also an occupational therapist for many years. She recounted various personal stories and patient accounts of suffering, death and dying, as well as how meaning-making and applying spiritual significance to the daily treatment plan of her patients assisted them amidst suffering to foster positive attributes that made life worthwhile. The spiritual care plan is a dance with your patient, where he/she takes the lead.

One of the health experts interviewed described a person-centric approach as follows: "We have to identify and address the spiritual needs of the person rather than us trying to treat a specific spiritual health problem…The controversies related to spirituality and health care really fall away when one sees this as a patient-centred, patient-driven, patient-ethical-driven mandate, rather than us abusing a situation to influence people with our worldview. This is a welcome shift in an approach to health care that makes the climate more conducive to address spirituality in health care. Bear in mind that people have different expectations of what they want from a medical professional. Some expect information providers, some want a parent in a white coat, so they want the health professional to make decisions for them, and others are there in the health consultation very reluctantly and might refuse whatever is offered to them. So the patient-centrism may not only influence the need to address spiritual concerns/issues; it may also have to do with the style that the therapeutic relationship to begin with, and within which the spiritual aspects then need to be framed. Being patient-centric is very dynamic and one cannot assume because the physical medical discussion follows a particular slant of avenue or level, that the spiritual health discussion will follow a similar trend. And therefore it is really focused on the patient and non-judgemental. Therefore, patient-centeredness is not a homogenous aspect when it comes to the different areas or domains of existence. Confirming, supportive – absolutely! Non-judgemental… Graceful opportunities to bow out. Statements such as: 'Many patients welcome the opportunity to discuss their spiritual needs in cases such as this, but in no means am I imposing this on you. Please do, however, feel free to discuss anything with me should you want to.' In opposition to direct accusatory questions like: 'Do you smoke?'" – HE_1, 28 May 2017.

HE_3 confirmed what HE_1 said regarding a person-centric approach, she also noted the importance of creating an opportunity for the patient to discuss his/her spirituality: "I agree with a person-centred, or client focused approach. So my difficulty with this is that we can be person-focused and wait for the patients to bring the spirituality in the room, but I had a patient that tempered her responses regarding this in the past, and then after a long period of therapy and having to sign my newer informed consent documents that included spirituality, she started opening up about this and she said it was because I never discussed this (spirituality and its role and impact on her health and illness). Once she saw that I was comfortable to have discussions regarding this, our therapeutic sessions ventured to a much deeper and more meaningful level. The reason is not only professionals are reluctant to talk about spiritual issues; patients are also scared to open up to practitioners, scared of how they will be received." Both patients and practitioners had much to say about a person-centric approach during the interviews – the complexities of balancing professional opinion with personal preference. A patient interviewed said: "We must be very aware that other people may have a different truth. The health professional should be sensitive and be aware that he or she doesn't necessarily have the right answers. And the other person may have answers that the health practitioner thinks are totally wrong but that person may have taken a long

time to arrive at. It's not the health practitioner's duty or even place to try to convince a person to, you know, to be aware of, of the greater picture."

HE_3 reiterated the importance of an attitude that is *non-judgemental* and *safe*, and summarised it as a *respect for the patient's worldview*. She related this through a personal story of when she was in a clinical consultation, not as a professional, but as a patient, and she experienced the absence of these values: "I am going to draw from my own personal experience. We suffered a loss a few years ago, and in that loss I realised that it was not my profession and what they could offer that brought me through that loss. They (the psychology profession colleagues) ignored my spiritual beliefs and needs completely in the therapeutic process. So looking from interactions drawn from that period of my life, I think I would like to be understood and treated holistically and integrated as a whole person. To be understood for what my core value and driving force is, how I live and understand my life. So often we call that worldview, and yes, it is that, but it is also respect for another person's worldview. I would want a respectful exploration of who I am and why I am who I am, and a keen interest in what the core area of need is for my 'healing' to take place." - 2 Nov 2017, extracts from the interview. HE_3 also related this to a clinical case experience: "I had a patient say to me that in a previous process with a psychologist, when she said to the psychologist that she will pray about something, the psychologist asked her whether this was her unfulfilled need for a father or authoritarian figure that made her want to do that? So my concern is with patient-centeredness is that we also sometimes do not allow our spirituality of our patients to be part of the process. This is an example of a patient-centred spiritual approach gone wrong. The patient or client should feel safe and comfortable enough to be a person."

Demirsoy (2017) states that no health professional can be expected to understand every detail and application of personal spirituality for a patient within his/her environment. What is, however, expected – ethically and professionally – is that the health carer adopt a sensitivity when approaching patients about their spirituality and beliefs. One of the patients interviewed remarked: "If you're dealing with people, you have to, you can't come with preconceived ideas of what the questions are. The questions must actually come from them, so, because you know, if you have a net with big holes and you are going to see what fish are in the dam, you, the little ones are going to slip through. But if your net is too small, the big ones are going to break them." The difficulty that health practitioners might face is what questions to ask initially to have the patient feel safe, but still achieve relevant communication that enables patients to share about their spirituality. HE_2 contributed to this with practical questions that she used in her own practice after establishing a context of trust and openness: "You have to accommodate all spiritualties. But there are safe questions that you can ask to anyone:

1. Is there a higher being that you involve in your spiritual thinking?
2. How do you feel about your spiritual life?
3. Do you think your spirituality has an impact on your health currently?
4. Do you attend a place of worship regularly?

5. Do you make time to be quiet and connect to the spiritual?"

This also relates to the FICA spiritual history tool (Puchalski & Romer, 2000) that all three HEs were familiar with and had used in their professional context in the past. It also has much overlap to the Religious Struggle Screening Protocol (Fitchett & Risk, 2009). The following words from one of the patients interviewed crystallises a valuable discussion on the role of the inter-disciplinary team, which includes traditional healers and making sure that patients are counselled about their medical choices and given time to process emotionally and spiritually what the best personal choice would be: "Start with the patient. Is the patient inclined or does he like traditional healers, or is he for the health practitioners as we know them? And once he knows himself, which way is he inclined, he can start with the health practitioner, and if in two or three months there is no progress, then there should be some consultation between the health practitioner and a very genuine traditional healer. Now there is a body of traditional healers I believe, and there are also leaders of those organisations that maybe if, if it is possible at all, that contact details of these be made available and there should be some consultation between the health professionals body, that's the medical health professional body as well as those traditional, they can meet at the top on the higher structures, but they need to try and identify the best so that you shouldn't be letting, or giving a patient over, the health practitioner should not give the patient over to a bogus traditional healer. I believe then the medical health professionals body and these traditional leaders somewhere up they need to try and form a coordinating body where they can work together"

The importance of being honouring and accommodating to create an atmosphere where patients and professionals can relax and express their beliefs without hindering another's emerged throughout the interviews. I (Ellenore, the researcher) am reminded of how, as a Christian, I also thought early on in my career that if someone's beliefs were different than my own I had the obligation to speak up and try and 'convert' them. When one brings these beliefs into a profession such as medicine, it becomes a source of much internal conflict. Moving into a position of love and genuine care for another and being concerned for the well-being of your patient (which is all still in line with the Christian belief and most other religions) has released me from this earlier 'obligation' I believed I had. The interviews with all the health experts and patients highlighted that a person-centric approach underpins a correct professional attitude, which includes the health professional displaying an openness that generates trust and enables the patient to feel safe to share beliefs with the assurance that they will not only be respected, but incorporated into the care plan. A person-centric approach is also facilitated by the timing of the discussion during the consultation process. A spiritual sensitivity is required towards the preferences of the patient for a holistic health experience not only to take place, but to be a positive patient experience contributing towards quality health care. If a practitioner does not *go there* – to that sacred space – as part of a holistic approach, then the fullness of the patient's needs, and a person-centric approach, is not possible.

Principle 6: The practitioner should foster communication that suitably addresses spiritual health needs

Communication that is meaningful and relevant to the holistic context of the patient requires competence and emotional intelligence from the health professional. Effective communication is about using appropriate words as much as it is about the non-verbal communication. The development and approach to spiritual health care has been influenced a great deal by palliative health care because patients with a terminal illness profess a need for spiritual care more readily than patients presenting with a non-serious complaint. This is not to say that patients with an acute or less threatening chronic illness do not have a similar need for spiritual care. A relationship that is established over time between a health professional and patient creates a context for trust and a sense of connectedness. This is often part of the palliative care approach before the health professional will discuss end-of-life concerns. The palliative care approach to creating a context of trust for open sharing and expressing of emotions and spiritual experiences offers valuable insights for the rest of the health professional team. Barnard (2011) describes five principles of quality communication in palliative medicine (when having a difficult conversation) that are relevant to spiritual care: *listening*, not only to hear the patient, but to understand; *silence* as a tool to allow the patient to discuss matters freely; *attending* to the conversation, as part of a person-centred approach; *acknowledging* the legitimacy of the emotions described; and lastly containment of emotions by the use of *metaphors* to create a distance between the patient experience and the emotion. Acknowledgement of the legitimacy of emotions or an experience starts by acknowledgement of the person within his/her context, culture, belief and worldview. It is a respect for who the person is that reflects in an attitude that is honouring of the story that the patient brings to the conversation. "Communication, especially when it comes to spiritual matters, should always be accompanied with the assurance that it will not compromise on the treatment and that there will be no judgement or rejection and that there is a sensitivity regarding the person's spirituality and worldview, irrespective of your own worldview. In a nutshell, I found that if you have an honouring attitude of the person's worldview then issues of spirituality and religious differences become far less a problem." – HE_1, 28 May 2017.

HE_3 summarised a personal experience related to communication and the detrimental impact of negative non-verbal cues by saying: "Our body language often speaks much louder than our words. I have had conversations with my colleagues and said that I am a Christian and I could see from their body language that they are not in agreement with the importance that I place on that faith. And when I see their reaction, I would immediately steer away from that direction, but then the rapport is lost, the trust is lost and the connection is lost. And I actually would not entrust my healing process with that practitioner and would put up an emotional defence with that practitioner, whether that is a psychologist or a doctor or another member from the inter-professional team." The importance of good rapport with the patient came up during subsequent interviews with the other health experts. HE_2 said: "I first have to establish a relationship with my patient if I want to achieve anything." – during an interview on 18 Aug 2017.

HE_1 described a practical approach to quality communication using the four Cs: "An approach for good communication include: non-imposing, offering rather than demanding care, extending an invitation rather than imposing a probing conversation. The basic principles used in establishing rapport with patients: confidence, confidentiality, character and competence. All of those features should make part of what is communicated. This includes verbal and non-verbal cues of what needs to be communicated. Rapport will be the basis on which the communication of spiritual health issues will be built. If I don't like you or trust you then I will not open up to you. If you have my best interest at heart, then I will be forthcoming." The patient interviews emphasised what the health experts reflected on during the interviews. Three patients described the following as an end goal to foster relevant spiritual health communication between patient and practitioner:

"Create an opportunity for the patient that enables self-exploration and self-awareness."

"Assist the patient to move to a level of re-centering and peace."

"Enable skills and awareness for a better feedback system between me and me (my physical and spiritual health)."

Principle 7: The practitioner should be sincerely interested in the person and his/her spiritual needs (to achieve quality spiritual health care).

The genesis of spiritual care is not nested in the *how* or the *when*, but the *why*. The concern with the well-being of the patient. At the core of asking questions related to a patient's spirituality should be a genuine interest in helping the person and seeing the person for who he/she is. If you are not going to care about the response, perhaps you should rather not ask.

The foremost question asked by all patients interviewed was: "Tell me what *you* mean by spirituality, doctor?" Patient interviews indicated that although health users would like to discuss this with their health carer, they were unsure what exactly the health professional expected to hear and why. It is therefore recommended that when structuring the health consultation to include spirituality as part of the history screening and treatment plan, the professional be open and ready to give a definition of spirituality and explain why he/she is asking the question. Health professionals interviewed within an inter-disciplinary team made the following suggestions on how to introduce spirituality during a discussion in a clinical context:

"Are you spiritual? Describe to me how you live this out and link it to your illness?"

"Are you religious, which church do you attend?"

"How can I help you with questions around your health/illness and spirituality?"

"How do you live out your spirituality: Tell me more about who you are, where do you come from, your family and upbringing?" – HPs during a focus group interview in March 2019.

Although it is the recommendation that quality and ethical medical care should include a spiritual screening, possibly included in the treatment modality, the context and timing is important (which includes not only when to ask this, but which member of the health team addresses this and that the health professional will make adequate time to address the points raised). All of this should be taken into account before enquiring about spirituality in a health care setting. The presenting complaint and clinical context of the patient may also influence whether this is the most opportune time to enquire about spirituality: "A person that comes for a trivial medical procedure probably would not be the candidate where one would introduce the issue of spirituality: such as a flu-shot, you are probably not going to ask what her transcendental worldview is. So again, is spirituality a resource or liability within this health context? Unless the vaccination includes other concerns that may allude to spiritual issues or connotations, it may not be necessary to go to such a level of definition of spiritual history taking." – HE_1, 28 May 2017.

HE_2 does 'pathology counselling', which entails that patients are referred to her within the inter-disciplinary team with a specific disease or diagnosis to explore the spiritual and emotional connections to their disease and design a holistic treatment plan. She explained her approach to structuring spirituality within the health counselling context as follows: "Firstly, I would determine which side of this person is more affected: The physical, emotional or spiritual side. I use the Functional Medicine Timeline (Institute of Functional Medicine, 2017) to determine where this person is in their lifespan. I try to find out what the antecedents are, the mediators and the triggers that cause these symptoms to emerge, why they are there and when this started. I usually see my patients for two hours during a first consultation. Then I use the Functional Medicine Model to tell their story back to the patients and tell them what I see/observe. Then the patient would guide me where their needs are: either more spiritual or symptomatic. Then we would move forward, either with lifestyle modulators or prayer."

The usefulness of the Functional Medicine Timeline is that it allows the patient to 'tell his story'. The timeline focuses on major events, from a holistic perspective, that have had an impact on a patient from birth up to the present. HE_2 discussed how the Functional Medicine Timeline is a resource to guiding her during the consultation: "The Timeline notes or records all the significant events in a person's history from birth up to now. One would put down any traumas or difficulties that they went through. It has a space for noting triggers or triggering events. It also has a line for mediators/perpetuators, what circumstances would mediate their experiences, or what would make it worse. With each of these events, one also would record any signs, symptoms or diseases that the patient reported. One also looks at antecedents. Family history or significant things that happened before conception or before birth are also recorded. I also look at their exercise, nutrition and stress, emotional, mental and spiritual status. Sometimes people's minds are so busy, they never make time to rest internally. I also link this to pathology tests, special investigations such as an X ray, and link the symptoms and disease to the spiritual. To understand this person and where he is now, I need to understand

how the health that is represented in the body is linking to the spirit and soul, as this is interlinked. We are one complex being that functions systematically. So is this body moving from homeostasis or survival mode?"

If a health professional is not really interested in *hearing* and *understanding*, he/she might miss out on the subtle nuances where patients link spiritual concerns with health concerns. If an approach is followed where a health professional uses one of the screening tools available and asks a short set of questions only by following the acronym, then an opportunity might be missed to attend to spiritual needs. HE_3, a psychologist, related having quality communication that is clinically relevant to asking the *right* questions coupled with *hearing* the response and picking up on the cues that are related in the discussion: "So the initial question is whether their (the patients and/or their families') religion and spirituality is important to them. In no way does this, however, become indicative of the importance that this plays in the patient's current emotional crisis. So later on during the assessment, if the patient for instance makes a statement of negative religious coping such as 'I am depressed and want to sleep late, but am afraid that God will punish me,' then that becomes something that I want to explore further clinically and spiritually. So spirituality needs to be woven in and throughout the clinical tapestry of the consultation. I have to understand at which point we are in the tapestry."

Patients that suffer from a chronic illness or pain may struggle with internal conflict about why this 'happened to them' or how God and their religion and spirituality is tied to this experience. Health practitioners can help patients to voice these struggles and questions and to resolve them for themselves, not only for improved mental and spiritual health, but also in adherence to treatment. One patient interviewed during this study underwent orthopaedic surgery for an arthritic condition. He still had unresolved conflict about whether he should have had the operation despite the good surgical outcome many years after the surgery. His spiritual and religious beliefs challenged him if he should not have trusted God longer to heal him without surgery. Patients need to be counselled with regard to this when making big medical decisions. A quality health outcome is not only a good surgical result, but also a good result in terms of the long-term emotional and spiritual well-being of the patient in relation to the medical care received.

One of the patients interviewed recounted how she, as a health professional (an occupational therapist), incorporated spirituality to assist a patient with a chronic illness and also in his pathway to accept his own death and process of dying: accepting that you are not your diagnosis, that having a disease does not have to mean you are 'handicapped'. This patient's views are a practical application of transcendence as a spiritual tool to accept certain limitations, illnesses and present suffering. She felt so strongly about the usefulness of this in her experience as both patient and practitioner that she stated that without it one becomes 'empty', stripped of purpose: "I've worked with a gentleman who had ALS (amyotrophic lateral sclerosis, a progressive neurodegenerative disease that affects nerve cells in the brain and the spinal cord) and he became extremely rigid. He could not move his eyes later, he

could not speak, we could not open his mouth to clean his, you know, his mouth and...there was really nothing else except the fact that I could say to him there's something bigger in life. Because our bodies didn't work anymore. And the fact that he didn't die, the fact that he kept on living, which was very difficult for him, for me, I would have let him die much earlier than he did. And for his family, for his wife. I just had to say it to him, that there's something bigger out there that we, that we must still do, that we must still achieve, that we must still help other people with. However, he could not accept with the expression in his eyes, and towards the end he even lost that. He could not, he was just a rigid frame. Because I've worked with progressive long-term conditions, where people don't die easily. And, and you have to go *there* then, to say, 'But we've got to look at life differently now.' To still make it meaningful. I think that for every human being there's got to be a bigger source of energy, whether it's God, or Buddha, or Muhammad or whoever. I think every person has to have something bigger. If you don't have that, you become what I call a 'sonsitter' (Afrikaans – literally someone who sits in the sun doing nothing all day). OK. And I've seen patients like that. I've seen patients who were highly functional and then they would have a car accident or something and they become a spinal quadriplegic. And that there is really nothing, and that is over a period of time, it's not as if it's a reactive depression type thing, you know, I'm now paralysed and whatever else. It continues for the rest of that person's life where you can visit him and he sits on the stoep (porch in Afrikaans) and his mother, who is now caring for this 48-year-old man, because his wife divorced him after the accident, whatever else, she decides what he will wear today, when he will have his tea, and things like that. And when you talk to him or try to converse with him there's really nothing, he can talk about nothing. Not even about his own feelings, because he's totally shut off." The words of the patient contain much reflection on *why* health professionals engage with the spiritual – because of a sincere interest in a person and to help the person, to assist the patient to attain peace, acceptance or fulfilment. Patients know when physicians genuinely care. Health professionals with a good patient relationship are often described as being good at their clinical work by patients, whether this is the case or not, because they are perceived to care. In recent years, patients have started to seek out health practitioners who address the spiritual component within the consultation and care plan more intentionally. This has created an opportunity for some to 'specialise' in this area and become known for offering such services. HE_2 commented that patients come see her specifically for this reason, knowing that the consultation and counselling will be done from a spiritual, and more specifically a Christian perspective. She commented that if she is certain and has 'screened' the patient's general spiritual needs and expectations, she often moves to more focused questions: "I ask different questions in such a case, such as: When did they get to know God? What kind of relationship do they have with God? I am trying to find out whether they are legalistic, as this puts them in a different paradigm. Also, to establish if they have some sort of silent routine that they follow to connect with God. I also want to know what their belief systems are about God. If they believe God is out to punish them then one could assist them to move from a punishment (condemning)

perspective to one of love – a God that accepts them and loves them. To move from a love perspective instead of a law perspective."

HE_2 discussed a practical approach to integrating clinical care with the other areas of a patient's life. She initiated history-taking by including a spiritual screening, then moved into an in-depth spiritual history and lastly constructed a holistic treatment plan in collaboration with the patient. She used the Functional Medicine Timeline to map out the spiritual and health areas of overlap. The management plan focused on establishing resilience, harnessing positive spiritual practices and making quality lifestyle changes.

"Yes, and the final component, when we have to change their lifestyle, this is also new to me. I came across a book by Watchmen Nee called *Sit, walk, stand*. God gave me certain entities that go with sit, walk, stand. I take people first to the spiritual discipline of sit - walk - stand, which is your different relationship components with God in a silence type of setting, in walking out your life and in your response to adversities coming across your life. So there are circumstances that actually bring your life to a halt. And the question is: How do you respond to this? It is important to change your lifestyle and choose better habits. But more importantly, it is to first develop a spiritual discipline and from that perspective make healthy choices."

Patients living with a chronic disease (life-threatening or not) who were interviewed described the pain and debilitating impact that their disease had on their overall health and well-being. They struggled with spiritual questions, yet most were never asked about this during previous health consultations. They asked questions such as: "Why did God allow me to become ill? What is the point of my suffering? What will my quality of life be like as I age?" Most patients voiced that having been diagnosed with any condition (e.g. hypertension) that required them to take daily medicine made them question spiritual and religious aspects too. The more serious the condition or the more detrimental the impact on quality of life, the more patients voiced a need for a health professional to discuss this component with them in greater detail and on a more regular basis. Concepts that were raised as important values that patients wanted to explore in a health context included: what to expect from their disease and the impact thereof on their functioning as the disease progresses; questions around end of life – facing death and dying as they age; and meaning-making and not living with guilt, but experiencing peace. "I think many people pray to God when they're in trouble. When they think they're going to die, they make promises to be good, and so I think, I think a lot of people think that they, towards, they think life is going to continue and suddenly when there's a threat and they think their life is going to end, then they think about how the universe works, what their place is in it. So I suppose for some, for people who are scared of death, I think it will play a bigger role being aware of this is how the world works. How, how, how everything functions, where this God is, who this God is, is this God is going to punish me because I cheated in primary school or I had affairs and all sorts of things, you know?" – patient interviewed.

Another patient discussed the role of spirituality in her life and the need to discuss this: "I haven't got a chronic illness but I've got chronic disability, so I think it is important to me. Spirituality is playing more a role in my life than before. I want to tell you that when I was diagnosed with breast cancer, 17 years ago now, I was not at all phased by it. I said thank goodness, I'm so glad I wasn't diagnosed with multiple sclerosis. I'd rather have cancer than multiple sclerosis. And at that stage I managed to go through the mastectomies, and four days after my first mastectomy I was mowing my lawn with two drip... two drainage tubes in my pockets. You know, things like that. I just went on with life. However, afterwards, because of the chemotherapy, I had some very severe side effects, permanent side effects which started to disable me a little bit, and then my knee packed up also because of the chemo, etc. So I became more dis... I really don't see myself as disabled but, what's the word now, *ingeperk* (translates into English as constrained) ...incapacitated in some aspects of my life... I couldn't run. I loved running. I can't run anymore. I can't walk fast. I can't do things fast anymore. In order to live with that, you have to have a bigger picture at life than, you know, otherwise you, I think will become, I will become very frustrated. So I think in the bigger picture to, to really stay in contact with your feelings..." Practitioners have an important role to play in helping the patient see his/her life in context and to make meaning of the care process. If the words of Hippocrates stay the focus, then a health professional will establish a genuine relationship of care: 'It is more important to know what type of person has a disease, than what type of disease a person has' (Freeman, 2005).

Principle 8: The practitioner should co-mobilise spiritual resources that build resilience for the patient.

The end goal of spiritual enquiry is not only to suffer with the patient, but rather to alleviate suffering. Victor Frankl, a psychiatrist that survived Auschwitz, founded Logotherapy as an existential therapeutic tool to assist people to make meaning of suffering: "When we are no longer able to change a situation, we are challenged to change ourselves" (Frankl, 1959).

Patients want to be equipped to harness their spiritual resources to help them transcend their health challenges, even if only mentally: "A hopeful expression of life: Despite my illness. Despite my condition. Despite my past experiences. Despite my current challenges." – researcher's reflections during a patient interview based on a conversation with the patient. "I understand now that I've become incapacitated to some extent. I walk behind people that walk quickly, like you did this morning. I was in the foyer when you came past there. I was too slow to stop you and to say wait for me. And get me up the steps. But I walk behind people and I think, gee, I hate it that you walk so fast, don't have to even think about walking. And I have to watch my right foot every time. And you have to get over that. And that is why the patient has to get that, he's got to be bigger than life if he wants to get over his medical challenges." – patient.

How should a health practitioner approach such a conversation that could enable patients to identify these inner resources and derive hope and meaning? One could argue that this is the domain of specialist spiritual care. It is, however, something that should be enquired about in

the consultation and addressed to the level of competence that the health professional has on the one hand, and the level of comfort the patient has on the other. This is not to replace referral for specialised spiritual therapeutic intervention, but to ensure that the whole is alluded to, if not addressed during the consultation. "There are established models that screen whether a patient's spirituality is a resource to him within his health context, either because of himself, or his community of faith that are a practical extension of his spirituality. So it could be an asset to him or a liability, such as with negative religious coping or when a person feels punished. An example of this is the tool by Harold Koenig: CSI memo – Do you have concerns? Does it cause you stress? Is there anything spiritual that will influence the care that you want? Are you a member of a spiritual community? Do they support you? Are there any other spiritual considerations?" – HE_1.

Practitioners interviewed during the focus group made the following recommendations on how to address the spiritual resources and concerns of patients:

- "Support the patient emotionally, relate to the patient's illness and distress."
- "Ask the patient if he considers this appropriate to discuss."
- "Offer to pray with the patient if you know that this would be appropriate within his religion and beliefs."
- "Explore possible spiritual distress including: Do you feel guilty? Are you angry at God? Do you feel God is punishing you?"
- "Unpack positives and spiritual resources and emotions and values that link to transcendence and instil hope and value despite the challenges or illness faced."

The positive influence of spirituality, when appropriately harnessed, in coping with a chronic disease or life-threatening events has been documented in various studies (Monod et al, 2010). The opposite has also been documented in research: that negative spiritual manifestations, also defined as spiritual distress, are associated with poorer health outcomes. When assessing a patient's spirituality (especially when time is limited) and one wants to do a quick spiritual assessment, it would be helpful to screen for two specific things: a spiritual need (which could be addressed by referring or scheduling a follow-up if there are time constraints) and/or screening for spiritual distress (which could also be referred to a specialised team member if the health practitioner is not able to address the need at that point in time). Patients interviewed during this study indicated signs of spiritual distress that were never assessed or identified by a health practitioner in the past. This included one patient's feelings of guilt about a past surgical intervention and whether God agreed with the patient's choice to have surgery. Another patient described how his emotions, and specifically feelings of anger, influenced his blood pressure and glucose control. A number of patients described how spirituality had been a resource to them in times of illness and suffering, whether it be their own illness or that of a loved one.

Monod et al (2010) define spiritual distress as "a state in which the individual is at risk of experiencing a disturbance in his/her system of belief or value that provides strength, hope,

and meaning to life." Monod et al (2010) developed a screening tool for spiritual distress that unpacks specific spiritual needs that patients might display whilst hospitalised. Patients seen for ongoing care in practice, or going for a significant medical intervention such as surgery, could possibly also benefit from being screened with this tool. The spiritual needs model (Monod et al, 2010) describes four dimensions of spirituality with a specific need attached to each dimension as identified by patients that were hospitalised for a serious condition or medical intervention. The four dimensions of spirituality include: meaning, transcendence, values and psycho-social identity. The needs model offers a practical approach to assess a possible spiritual need and which domain to give more attention to when addressing the need. The needs associated with each dimension can be explored by the health professional or referred to a spiritual carer. Addressing this within an inter-disciplinary team would possibly yield the best outcome, depending on the specific patient case and illness or disability that the patient has to come to terms with. For instance, the spiritual dimension of making meaning is associated with a need for life balance, which practically entails assisting the patient to rebuild a new life balance and better cope with an illness or disability (Monod et al, 2010). Health practitioners can work alongside spiritual carers to optimally address these needs. The collaborative work of an inter-disciplinary team of, for instance, occupational therapists, physiotherapists and the social sciences and psychology, working alongside the medical doctor and spiritual carer, would best address the spiritual and practical needs of the patient to make meaning and find a new life balance in cases of a diagnosis that entails a long-term functional limitation. A full description of the spiritual needs model is included later in this chapter as part of the discussion on spiritual tools available. Table 3.7 below summarises the four dimensions of spirituality with the need associated to each domain.

Table 3.7 Spiritual needs model: Dimensions of spirituality and corresponding needs in elderly hospitalised patients (Monod et al, 2010)

Dimension of spirituality	Need associated with the dimension
Meaning	The need for life balance: To become equipped to adopt an approach to daily life that enables the patient to cope with a diagnosis or disability.
Transcendence	The need for connection: The need to connect with the patient's existential foundation and find beauty.
Values	The need to have values acknowledged and autonomy (control) maximised: This includes that the health practitioner enquires about, understands and respects the patient's beliefs. The patient is also included in making decisions about the treatment plan throughout.
Psycho-social identity	The need to have the patient's environment and loved ones engage with the patient in such a way that he/she feels

	heard and recognised and forgiven, to be in touch, to touch and to have a positive experience in feeling connected.

These spiritual domains enable the health practitioner to enquire and plan how to address a specific need relating to functionality, connecting to the spiritual within the health process, maximising opportunity for patients to express their values during the treatment plan and care process and involve their community in a meaningful way. The health professionals interviewed during the focus group also related their own experiences regarding integrating spirituality with patient care, noting that they had at times discussed their 'own stories' to enable patients to relate their current experience to specific spiritual needs. The focus group mentioned prayer with patients who were open to this as a way to connect with existential beliefs during the care process. The team also described how they would work inter-disciplinarily to optimise meaning-making and psycho-social identity by involving the family members in the care plan or calling on a colleague during a consultation to give an opinion from another discipline's perspective at the community clinic. This approach seemed to help some patients accept their disease and transcend beyond an overwhelming illness with a focus on the whole. Some health professionals shared that they started a morning's work with singing and worship before patients were seen at the clinic. Patients were invited to join in on this voluntarily. This built relationships on a deeper level with patients and also amongst staff. One participant remarked that although she enjoys this, care has to be taken that someone with a different belief does not feel excluded. Creating 'spiritual space' for different beliefs amongst colleagues and patients was raised as important to foster an environment that is conducive to sharing spirituality in a meaningful but respectful manner.

When it comes to addressing the spiritual and possible spiritual resources during the consultation, the practitioner needs to develop an approach that is suited to his/her practice. The amount of time available to consult with a patient, the possibility of scheduling a follow-up consultation and the establishment of a long-term professional relationship all need to be taken into account. "There are a number of ways in which those two aspects of asset and liability and influence are essentially poled. Core distinctions would be made firstly on the time that the health practitioner has and the manner in which it is approached to create a conducive environment for the patient to respond to the questions. So the instrument used could be 'wrong' if the person using it is not competent in this or at the level of the patient that the questions are addressed to." – HE_1, 28 May 2017.

When enquiring about spiritual resources or possible distress, the aim would be to assess how a patient is coping in the larger context of acceptance of a diagnosis, daily management of his/her acute or chronic illness, possible resources that could be tapped into within his/her environment, or questions and concerns that are making it less likely for the patient to cope spiritually. Patients indicated during the interviews that they would want to explore these concepts with a health professional. Patients also voiced that they wanted their concerns about death and dying, and possible suffering, answered in a context of supportive care that

enabled them to make the most of the remainder of their lives: "I had a very good friend who was in fact my partner, who passed away four years ago with suicide. And I found it extremely difficult to continue living. OK. Even my straight religion couldn't get me up again. And still, many days I'm still there that I get up and I really don't feel like, what am I going to do, there's no meaning, there's no meaning. And then after my friend said to me, you know this is an active decision that you have to make to continue with life and to start enjoying things again. It's a decision. I actually thought that she is very correct."

"My approach to this is mindfulness about yourself and life. And I actually found that that helps me a lot. I can remember one morning since then that I got up and I wondered what I was going to do that day that was really meaningful…If your husband becomes chronically ill and he's got a condition and you know he's going to die you would be, you would want to be there when he passes away."

These are a patient's reflections on coping with her partner's illness and then also sudden death by suicide, as well as having to deal with her own chronic illness, meaning-making and living a life with the experience of peace and hope despite the difficulties. The spiritual needs model enables the practitioner to assist the patient to voice specific needs and then decide on a treatment plan or intervention together to unpack spiritual resources. The enquiry, if linked to appropriate spiritual care, could enable patients to reframe the context of their illness in such a way that they can still continue with life in a meaningful way.

Creating a supportive spiritual environment requires a team approach. Understanding which team member should take the lead to address the spiritual needs of the patient is important. Timely referral to a spiritual specialist for more complex spiritual needs is key. One of the health experts interviewed commented on how to decide on the right team member for a specific patient case: "There are obviously people that will have a more conducive communication style to have a conversation about spirituality, as with any other emotional discussion. It will be unlikely to have the 'over busy' cardiovascular surgeon to have a sit down and have extensive discussion about the spirituality of a patient. Practically, the contact time here will be short, where under the care of the nursing staff there would be more extensive contact time. Therefore, perhaps within a team approach the person that will have the longer contact time would be the most suitable. Then one is more likely to have a meaningful conversation." – HE_1; 28 May 2017.

HE_1 reiterated Puchalski's notion that all patients should at least receive a spiritual screening regardless of what they present for during a consultation. He was, however, concerned that if spiritual screening is approached in an automated fashion by just ticking off the questions asked, if would not be meaningful. On the practical application of spiritual screening, he made the following comment: "I have to agree with the principle. And the need is valid. But my work in hyperbaric and aviation medicine and working with a list of questions to solicit a relevant medical history from patients; my experience is that there is a tendency of understating things, to expedience things, to get to what you have come for or what the patient considers

relevant. Therefore, I think the nature of the instrument is very dependent on relevance to what the patient has come for and what the health care team wants to achieve. If it is just ticking a box, it is unlikely to give you a meaningful assessment. A tool like this could serve as a reminder of what the health practitioner needs to remember to ask. The way that it is asked and communicated is more important. I think it is necessary and a good idea, but a spanner in the wrong hand stays a tool, but may be useless to that person."

HE_2 commented on the fact that lifestyle and chronic diseases are rapidly increasing worldwide and that the link between spirituality and diseases related to lifestyle should be further explored and utilised when counselling patients. She felt this has not been successfully addressed with the current clinical and educational management programmes for chronic diseases. The spiritual beliefs and resources of the patient and community could and should be harnessed to assist patients to make healthier choices and live more fulfilled lives. This reiterates what was found through the extensive research of Cloninger (2013) on the question, "What makes people healthy, happy and fulfilled despite current world challenges?" His research resulted in the conclusion that "spiritual development of greater self-transcendence is the key to the future survival of the human species" (Cloninger, 2013:18). "The time is now to intervene differently in how we manage chronic diseases. It is on our doorstep on a daily basis and is a result of a certain lifestyle. The fast-paced society that we are living in…we cannot treat the disease without counselling and equipping patients to alter their lifestyle, and this includes using spiritual resources." – HE_2, during an interview on 18 Aug 2017.

To assist a patient to alter his/her lifestyle requires of the health professional to see the patient within his/her larger context. The Functional Medicine Matrix (Institute of Functional Medicine, 2014) assists the health practitioner to actively discuss a personalised approach to lifestyle factors. This includes looking at: 1) Sleep and relaxation, 2) Exercise and movement, 3) Nutrition and hydration, 4) Stress and resilience, and 5) Relationships and networks. The Functional Medicine Matrix, in combination with the spiritual needs model, is a practical way to address spiritual needs identified and map out a treatment plan that optimises patient autonomy. During the patient interviews the connection between relationships and nutrition amongst others, as described in the Functional Medicine Matrix (Institute of Functional Medicine, 2014) and the spiritual needs model (Monod et al, 2010), emerged in conversations either as a positive, where patients applied good practices in an area that had a good impact on their health or disease control, or as a negative which impacted detrimentally on their health. Nutritional psychiatry explores the link between mental health and nutrition. During the patient interviews the value of nutrition in spiritual expression emerged as a theme that was important to patients. Health professionals could and should play a role in linking food and mental-spiritual health for patients. This includes looking at what patients eat, but also their thoughts and social interactions when they eat. Practising mindfulness during a time of ingesting food can strengthen neurological pathway development and assist with overall emotional well-being (Leaf, 2016). The inter-professional team also discussed the high value

that is placed by patients on the practices of eating and ingesting herbs and remedies as part of the traditional health approach within the African context. This should not be ignored during the spiritual care plan, but engaged with to optimise patient integration of what is considered spiritual and also what is recommended from a health care perspective with day-to-day routine in which nutrition and the social engagement around food plays an important role. "I grew up in a family that has had high blood pressure and both my parents have had blood pressure problems and also cancer. I don't want it to be a trend that repeats in my life; and when you hear people say it starts with your genes, it just reminds me that we are what we eat." – Patient. Another patient stated: "I'm on chronic medication for sugar diabetes and hypertension. Now I pray a lot for healing but we are told that no: this is for life. Once you are on this medication this is for life. Now I've been trying some herbs, reading a lot of books on herbs. There are two herbs that I found that I've actually grown in my yard. Rosemary and basil. Rosemary – the leaves I prepare them in a teapot, pour hot water. I clean them first in water and then I take half a cup to a cup on a daily basis. That's what I did for a week and within a week my sugar level had dropped from 6 to 4.2." – Patient during an interview in June/July 2018.

Culture and context should be taken into consideration when a patient is approached about his/her spirituality: Some of the patients mentioned the role of ancestors as part of their traditional upbringing, others believed that crystals have healing power. This was not linked to level of education. Health professionals should be equipped to deal with the interlinking of various cultures, beliefs and religions to a spiritual care plan that is integrated with the health care plan. Patients interviewed described the importance of an honouring attitude to meet their needs and harness their psycho-social identity and context to be able to transcend and make meaning of a diagnosis: "My aunt believes in God and also prays to ancestors, and you have to be very sensitive when you talk about those types of beliefs. Because we Christians, we could be very judgemental. We don't have any other God and then we want to shut them out, so we need to find a way of incorporating different cultures, for instance also a Muslim's spirituality." - Patient

"I had taken my daughter to a traditional healer. My daughter suffers from Lupus and the family then believed the aunt had some relationship with some spiritual people that's traditional black people. And they said this young girl has spiritual gifts but she has to go and we say "ukotwasa", to go and defend for her cause, so that she can be a healer also in future. Then we had to travel to Venda with a friend who had some people that he knew might be able to help us in that regard." - Patient

"I don't have a problem. Actually, I have an article here from the *City Press* of this past Sunday that a friend gave me. The letter that I received from you inviting us to participate in the research also relates to this article of the concept of body, mind and soul, which is in relation to God the Father, the Son and the Holy Spirit. Similarly, what the traditional healers are actually doing is to find the problem that this person has. There obviously is something that is worrisome to the patient. Either the patient is fearful or the patient has some guilt or the

patient is feeling shameful for something that he or she has done. Now what they do is to find out what the problem is. And they will then listen to the patient telling them their problem. They will then prescribe something and assure the patient that this is going to help you, but it's a question of faith. Do you believe in that or don't you believe in that? So it's a faith. In the article they, they mentioned that most people – I don't know what percentage they are quoting – prefer going to traditional healers than going to modern medical experts. Or some actually combine the two. Right, they will go to a specialist, medical specialist and they will still go to the traditional healers. Because they get some sort of encouragement from the other side. They listen to them. I seem to understand the psychology behind the whole healing and prescription thing, that it actually the question of faith. I seem to have an idea that this man is going to say you are sick, so and so has bewitched you, I'll give you this in order to remove that and you take that, and because the man has promised you that this is what's going to be happening to you, indeed sometimes you get healed in a way." - Patient reflecting on the transcendental impact of traditional medicine on his family and the role it has played in his spiritual and overall health, during an interview in June/July 2018.

"Traditional healers want the patient to talk: What is your problem? And then from that problem they are then able to use their minds to try and assist the patient. Now if I come in and say I have a problem and the physician asks, what is it? Headache. Now to him headache could be this or that or that. They don't delve too much into my history, into how I feel, into how I perceive this thing. Whether it affects any other aspects of my life or not. Whereas the traditional healer is more interested in that that you should talk, that he should understand you better before coming to a prescription or what. But the specialist, the general practitioners, just go there, tell him it's this, okay it could be that, what else? And then from that little information they immediately prescribe without letting the patient say more about themselves." – Patient on what doctors can learn from traditional healers.

Incorporating spiritual care in practice begins with the acknowledgement of the person, which includes honouring his/her own beliefs, values and identity. A perceived threat such as a disease can lead to a spiritual need or distress. To successfully address spiritual distress, the health professional must identify the core components of this need. This should be followed by a management plan that enables these needs to be addressed in such a way that the patient develops resilience and utilises his/her individual psycho-social resources to foster qualities of meaning-making and transcendence of the health challenges faced.

3.3 Core elements of the eight principles

3.3.1 Spirituality should be part of the health consultation.

To successfully incorporate spirituality within a holistic care approach requires acknowledgement that:

- The spiritual consultation is a holistic way of exploring the connections the patient and his/her community make between spirituality and a health or illness experience. It is an explorative discussion that helps to unpack the personal meaning of health or

disease and the patient's perceived benefit or burden that spirituality places on him/her within his/her health context. It can be used as a tool to assist in the healing process if utilised correctly. It offers an opportunity to explore feelings such as guilt or fear or other emotions, and also spiritual beliefs that are impacting on or linked to the health or disease of the patient and in some cases assure a remedy.

- All patients can and should get a spiritual history or screening where needs are identified and addressed in the best manner possible within a team approach.
- The spiritual health consultation is not an opportunity for the practitioner to be an evangelist, per se, nor to convince the patient that his/her belief is inferior or incorrect. It is not an opportunity to correct/discipline behaviour or belief, but an opportunity to allow for personal beliefs to be expressed and accommodated to facilitate the best overall health outcome. It is not prescriptive of the answer, but explores possible alternatives that are acceptable to the patient and that can incorporate the patient's spiritual believes into the health care experience and treatment plan to the greatest extent possible.
- Culture and context should be taken into consideration when a patient is approached about his/her spirituality. Health practitioners need to be sensitive and equipped to deal with the interlinking of various cultures, beliefs and religions and their impact on health and the health care process.
- The limitations of spiritual practices should be discussed with the patient: Spiritual care should not be offered to the patient as a 'quick fix' for health problems.
- The value of spiritual practices should be discussed with the patient: If spiritual care is framed within the context of holistic management of the patient's needs and acknowledgement of his/her beliefs, then it could also improve the management of disease outcomes (such as pain control and attainment of feelings such as peace, a life worth living and improved functioning).
- Spiritual care should allow and make space for the supernatural and faith and belief in the miraculous, but does not in any way promise this or dampen the patient's personal spiritual approach.

3.3.2 An evidence-based approach that is ethically grounded should be followed.

This is measured against both the patient's perceived benefit and in the utilising of an approach that reflects value-based care that is grounded in clinical research. It includes that:

- Patient experience and expectation should be matched or even exceeded.
- Both the contents and the manner of conducting the spiritual health screening, history and treatment should reflect quality and be linked to existing research on how to identify and address spiritual needs in health care.
- The practitioner should be knowledgeable and competent to apply various spiritual tools available and understand the differences between a spiritual screening tool, in-depth history taking and making a spiritual diagnosis, in order to offer spiritual care in practice. The health practitioner should be equipped to apply the right tool for the specific context and also know when to refer for specialised spiritual care.

- The approach adopted should be supported by best practice, evidence-based medicine and continuous professional development of the health professional and the medical body at large, to offer quality spiritual care as part of a holistic approach that is up to date with current health trends and underpinned by spiritual care principles.
- An ethical approach includes informed consent. Patients should be asked if they are open to discussing their beliefs before a health carer dares to broach the topic – similar to asking beforehand one examines a patient or does a side-room investigation.

3.3.3. The practitioner should attend to his/her attitude during a spiritual health consultation.

Adopting a correct professional attitude during the consultation includes:

- Acknowledgement that spirituality is integral to any patient-centred healthcare system.
- Being empathetic (in pursuit of the patient's interest).
- A position of openness, acceptance and affirmation.
- A non-judgemental approach to the patient's spirituality.
- Active listening, which includes finding the balance between being directive and allowing for a spontaneous patient response. The health carer should facilitate the spiritual health interview to enable the patient to freely express spiritual beliefs and needs and preferences regarding how this should be addressed within the care plan.
- Acknowledging and accommodating the patient's dignity, preferences and opinions.
- Being respectful of the person's beliefs.
- Establishing a connection with the patient, including his/her spiritual beliefs and needs.

3.3.4 The practitioner should create a receptive environment that takes into account the spiritual needs of the patient within his/her personal context.

Creating a context within which one should have the spiritual health consultation includes:

- Discussing and agreeing on spirituality and the applicability and approach thereof between practitioner and patient.
- Creating an atmosphere that is relaxed (not rushed) and caring.
- Creating a space that is safe, free from power, prejudice, correction or ridicule.
- The view that spiritual distress is seen as a valid health complaint, similar to any other medical problem.
- Being willing and competent to perform a spiritual screen (in-depth spiritual health interview) with inclusion into the treatment plan. This includes appropriate referral for specialised spiritual care.
- Practitioners work as an inter-disciplinary team to address spiritual needs identified.
- Patients are engaged in a manner that allows them to bring their personal context and worldview to the discussion. This includes perceived links between health, emotional and physical experiences, relationships and social circumstances.

3.3.5 The practitioner should adopt a person-centric approach.

A person-centric approach entails the acknowledgement that:

- A dynamic process should take place, and not a 'one size fits all' approach.
- The patient is more important than the process: It is not about meeting specific outcomes, but supporting the patient and meeting his/her needs.
- The depth of the discussion and approach to the spiritual health consultation should be directed by the patient, handled as is best suited to the patient and to his/her benefit, and directed, as with a dance, with the patient taking the lead.
- Person-centrism is impossible without having an attitude that is non-judgemental, supportive and accommodating of how (or even if at all) the patient prefers to be met on the incorporation and addressing of his/her spiritual needs.
- Being respectful of the patient's worldview on spirituality and religion includes the willingness to create a context where this could be expressed in the health care setting as part of the care plan.
- Individual patient preferences and biases should be explored to meet the patient where his/her needs are.

3.3.6 The practitioner should foster communication that suitably addresses spiritual health needs.

Principles of communication during a spiritual health consultation include:

- Establishing two-way communication that builds trust, rapport, openness and a confidence to share.
- Exploring common ground and that which is uncommon (not agreed upon) with practical ways that this could be accommodated/incorporated into care.
- Communicating care that is non-imposing, offering rather than demanding a care approach to be adopted, extending an invitation rather than imposing a probing conversation.
- Establishing rapport with patients by displaying qualities of the 6 Cs: confidence, confidentiality, character and competence, confirming and conveying care (6 Cs as given by HE_1 and HE_2 independently and combined during interviews in 2017.) All of those features should make up part of what is communicated. This includes verbal and non-verbal cues of what needs to be communicated.
- Connecting with the patient on his/her level of being, need and understanding of spirituality.
- Communicating support of the patient's environment and psycho-social resources, and exploring how these could be incorporated into a treatment plan and overall health approach.

3.3.7 The practitioner should be sincerely interested in the person and his/her spiritual needs.

The relevance of spirituality within the holistic health care of the patient should be kept as an end goal when exploring the patient's needs. This includes:

- Exploring patients' spirituality and beliefs, which should be a process where the patient is given an opportunity to take the lead, make the call on the value and importance of spirituality within his/her health context and how he/she prefers to have this addressed.
- The practitioner creating a space for an open discussion in a relational way, where there is a relinquishment of power. It allows for the following areas to be explored in relation to health and spirituality (personally and within the family and community): emotions about health/illness, values and beliefs, spiritual needs or distress, preferences on how to address spiritual needs, enabling of meaning-making of the health and illness experience.

3.3.8 The practitioner should co-mobilise spiritual resources that build resilience for the patient.

Co-ordination and mobilisation of resources includes:

- Creating a supportive spiritual environment within a team approach: Understanding which team member should take the lead to address the spiritual needs of the patient is important.
- Development of a care plan that is relational and is in pursuit of fostering psycho-social resources, including the inter-disciplinary team, family members and loved ones, and the patient's spiritual community.
- Spirituality as a resource is explored and resilience or vulnerability identified and addressed to the benefit of the patient.
- Resilience, spiritual discipline and lifestyle choices are linked to the benefit of the patient in a manner and in a communication style that is comfortable for the patient to hear, understand and respond to practically in a daily care plan.
- Spiritual needs are identified on specific domains and addressed in a suitable manner to foster values of transcendence and meaning-making that is relevant to the patient and improves perceived fulfilment, functioning and overall well-being.

3.4 Recommendations on how to implement the principles

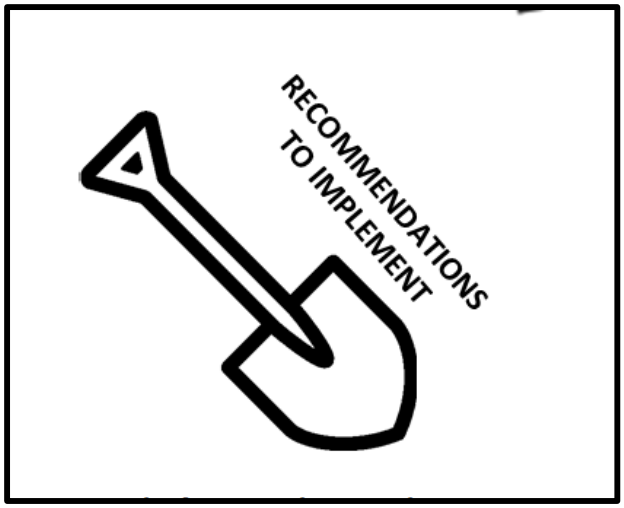


Figure 3.3 Recommendations on how to implement the principles

3.4.1 5 W questions for spiritual health care

The research participants often initiated the discussion on spiritual health care by asking questions rather than making statements. The coding of the data indicated that the reflections of the participants on the value and need for incorporating spiritual care during the interviews centred on five general questions. If a health professional or an inter-disciplinary team wants to adopt a holistic approach that incorporates spirituality when offering care, then these questions serve as a practical outline of what to consider when deciding on an approach that would fit individual practice. These five questions ask: Why? What? How? Who? When? Table 3.8 below lists the five questions.

Table 3.8 The 5 **W** questions to plan for implementing spirituality in health care

Why include spirituality in health care?
What are we screening for?
Ho**w** should spiritual screening and history taking be conducted?
Who should offer the spiritual care for a need identified?
When should one refer for specialised care and to whom?

The successful implementation of the principles for quality spiritual care takes planning and the adoption of an approach that is relevant to the individual health context. In deciding on the best approach, the health practitioner needs to start with the acknowledgement of the value that spirituality holds as part of a holistic care approach. This is the answer to the question: **W**hy? **W**hy should spirituality be included in health care? The second component for successful implementation is an understanding of the various spiritual needs that a patient might have. The answer to the question: **W**hat? What to screen for spiritually? The third question relates to the how. Ho**w** should a health professional conduct a spiritual screen, history taking or construct a care plan that addresses spiritual needs. This requires that the health practitioner have knowledge on various screening tools available and adopt an approach that is specific to the individual patient's needs and attainable within the practice

setting. The fourth and fifth questions centre on timing and the identification of the health team member most suited to addressing needs identified? **W**ho and **W**hen? What member of the team should see the patient and when should he/she be referred for specialised care? Table 3.9 describes possible answers to the 5 **W** questions for spiritual health care as they emerged during this research.

Table 3.9 Answers to the 5 **W** questions for spiritual health care

5 questions to plan for successful implementation of spirituality in health care	Possible answers to the questions to plan for successful implementation of spirituality in health care
1. Why include spirituality in health care?	Patients report a need for spiritual care (Ruder, 2013; Taylor, 2012). The spiritual care of patients is considered a fundamental component of quality, compassionate health care (Puchalski, Vitillo, Hull & Reller 2014:11). Culture and spirituality both have a significant impact on health-seeking behaviour and how patients want to receive health care when it is offered to them (Young & Koopsen, 2005). The health practitioner has an opportunity to tend to the patient holistically by bringing into account the resources and issues in the patient's social, environmental and spiritual life.
2. What are we screening for?	Monod et al (2010) developed a tool that can assess the spiritual state of a patient by assessing four spiritual domains with a specific need linked to each domain. The spiritual domains include: transcendence, psycho-social identity, values and meaning. Spirituality can either be an asset or liability in the overall health of the patient and is not a homeostatic process as life-events also influence one's spiritual state (Pargament et al, 2001; Koenig, Larson & Larson, 2001). The goal of the spiritual enquiry is to identify a spiritual need that could be addressed, enquire about possible spiritual distress and its relation to the overall health of the patient, and identify possible resources that could improve well-being.
3. How should spiritual screening and history taking be conducted?	Various spiritual screening tools are available. Spiritual screening or history taking should be customised according to the needs of the patient in balance with the practitioner's competence and clinical

	context that he/she offers services in. Fitchett and Risk (2009) describe a brief spiritual/religious tool for health practitioners that are too busy for a narrative enquiry, or are unable to do an in-depth spiritual assessment. This is a practical tool recommended by all three health experts interviewed. It asks a few simple questions that prompt one of three actions: 1. Is there a current spiritual distress: Refer for spiritual assessment if the answers indicate possible religious/spiritual struggle. 2. Is there a need for spiritual care: Refer if spiritual care is requested by the patient on questioning. 3. No action if there is no indication of spiritual struggle or no interest for spiritual care. Various acronyms have been developed to assist health practitioners to remember how to take a spiritual history. These include: The **FICA** spiritual history tool (Puchalski & Romer, 2000) that stands for F: **f**aith and beliefs, I: **i**mportance of spirituality to the person, C: spiritual **c**ommunity of support and A: preferred way to have this **a**ddressed. The **CSI MEMO** (Koenig, 2007) consists of four questions: Do religious or spiritual beliefs provide you **c**omfort or **s**tress? Do they **i**nfluence medical decisions? Are you a **mem**ber of a religious or spiritual community? Do you have any **o**ther religious or spiritual needs? The **SPIRIT** tool (Maugans, 1996) that enquires about **s**piritual belief system, **p**ersonal spirituality, **i**ntegration in a spiritual community, **r**itualised practices and **r**estrictions, **i**mplications for medical care and terminal event planning. The **FACT** spiritual tool (LaRocca-Pitts, 2012) that contains questions on **f**aith, how **a**ctively this is expressed, **c**oping or concerns

	regarding spirituality and the **t**reatment plan. The **HOPE** tool (Anandarajah & Hight, 2001) looks at sources of **h**ope and meaning, **o**rganised religion, **p**ersonal spiritual **p**ractices and **e**ffects on medical care.
4. Who should offer the spiritual care for a need identified?	Spiritual care should be addressed within an inter-disciplinary team by the member most suited to do so. This is dependent on whether specialised spiritual care is readily available or not, whether one of the inter-disciplinary team members has established an ongoing and trusting relationship with the patient and the competence and skill of the health practitioner. All practitioners should be trained to address spiritual needs on a primary/essential care level, but also be comfortable enough about their own limitations and know when to refer. The spiritual care provider could be anyone of the following (Koopsen & Young, 2009:21): • Physician • Nurse • Traditional healer • Chaplain • Psychologist or another mental health provider • Spiritual mentor • Social worker • Friends and family

5. When should one refer for specialised care and to whom?	The spiritual care should be coordinated by the health carer taking the lead on the patient's case. This does not, however, indicate that the health case manager should offer the spiritual care. Spiritual care is best addressed when included as part of the overall health care plan. Holistic care requires a team approach where members of the health care team discuss the spiritual care plan as part of the treatment plan and incorporate this for both the patient and family in such a manner that it enables meaning-making, finding hope and peace and transcendence with a sense of connectedness. Quality spiritual care includes timely referral to a spiritual counsellor or spiritual leader when appropriate. It also includes incorporating the patient's spiritual network and support system into the care plan. Referral for care is dependent on patient preference, practitioner competence and the availability of specialised spiritual care.

The interviews with the research participants revealed various practical tools that were recommended by both the practitioners and patients. These recommendations can assist a health carer to adopt an approach that will increase the success of implementing the spiritual care principles. The recommendations are described according to three categories as listed in table 3.10 below.

Table 3.10 Three categories of recommendations for implementing the spiritual care principles

1. General guidelines on applying the principles
2. 'How to do' from the perspective of the patient *and* practitioner
3. 'What to do' from the perspective of the patient *and* practitioner

3.4.2 General guidelines on implementing the principles

The following points should serve as overall guidelines to assess whether a principle is upheld in practice:

- Spiritual care should also be described for what 'it is not': Spirituality as part of a holistic care approach should not be offered as 'the quick fix' to all health problems.
- Incorporating spiritual care is person-centric when its focus is on the beliefs and preferences of the patient, whether or not the health professional agrees with it.
- Spiritual practices preferred by a patient should not be discouraged or dismissed by the health professional unless there is a clear medical indication that this could be to the detriment of the patient's health.

- The patient should also be aware that he has the right to not discuss spirituality as part of a consultation and care plan.
- The motivation for including a discussion on spirituality should be clearly communicated to the patient: To assess possible resources/strengths and spiritual-emotional impediments to health, and to offer alternative treatment to be included as part of a holistic care plan.
- Exploring patients' spirituality and beliefs should be a process where the patient is given an opportunity to take the lead, make the call on how in-depth they want to discuss this and also its importance to them personally, including the relevance and application thereof in the health context.
- The patient's personal narrative is just as important as the clinical history, and patients should be given the opportunity to explore this in a health context as part of history taking.
- Ethical principles to be adhered to include being non-judgemental and sympathetic, honest, congruent, genuine, respectful and sensitive to the patient's current needs and preferences with regard to expressing and addressing these needs.
- Patients might be concerned about what the boundaries and limitations are when addressing their spiritual needs during a health consultation and treatment plan, and this should be discussed as part of spiritual care.
- Practitioner worldview or spiritual stance should not interfere with patient preference and should be dealt with carefully if ever shared.
- Respect for the patient's autonomy includes obtaining informed consent, honouring confidentiality and establishing a relationship of trust. These are important principles to adhere to as part of establishing a context for a meaningful discussion relating to spiritual needs and care
- Non-religious patients or patients that profess to be unsure about whether they consider themselves as spiritual, still profess a need to be cared for from an emotional and spiritual perspective that is supportive.

3.4.3 'How to do' from the perspective of the patient *and* practitioner

The following points are meant to serve as practical pointers for the health practitioner when incorporating spiritual care in practice:

- Patients want to have both a professional and a personal experience: For a patient to engage meaningfully on a spiritual level requires that the practitioner meet the patient as a human, allowing for vulnerability, connection and open sharing. Patients want to feel that the health practitioner is genuine and honest.
- The health professional should be knowledgeable and skilled in his/her approach to offering spiritual care that is generalisable to various cultures, religions and spiritual beliefs, and should be able to offer such care in a professional manner that is of relevance to the specific patient and clinical context.

- Health professionals should be sensitive about patients' concerns that the health carer's spiritual views and preferences are not imposed on the patient.
- Practitioners should be open to varied patient responses and be sensitive to the patient's preference.
- A person-centric approach includes being sensitive and open to exploring the patient's beliefs, at a pace that is comfortable for the patient and in a framework that is acceptable to him/her, underscored by an attitude that comforts and supports the patient.
- The doctor must make enough time to listen to the patient and create an environment that feels safe and generates trust.
- The health professional should relate and integrate the spiritual component in a meaningful way to the patient assessment and treatment plan.
- Seeing the patient in his/her context includes seeing his/her abilities, family, dreams and goals, current needs and challenges and how this health issue is influenced by his/her life story.
- A compassionate approach with good communication skills that enables the patient to explore his/her own spiritual-social resources that could improve his/her health and disease management should be sought and made part of a quality health consultation. During the patient interviews, this was stated to be preferred by many patients above asking direct questions related to their spirituality as an initial approach.
- The health professional and the patient do not have to share the same faith to share similar values or have a meaningful discussion on the value of spiritual care. Spirituality and adhering to principles that reflect quality care is still attainable. If practitioners keep the end goal in mind of assisting the patient to improved overall well-being within his/her system of belief and context, then this is readily achievable.
- End-of-life issues and fears relating to functionality when faced with a serious illness are often reported by patients as a definite need, although they will not necessarily voice this until it is enquired about. Conversations about death, dying, making peace with one's own mortality and having a care plan that enables the patient to feel in control as much as possible should be part of a spiritual care plan for patients that have a chronic condition.
- Spiritual resources that should be explored and utilised include meaning-making, self-acceptance and peace. Practices that include mindfulness and self-awareness should be discussed as part of a treatment plan within an inter-disciplinary team approach to addressing patient needs. For patients living with a chronic illness this should be included in the treatment regime as part of fostering transcendence and 'life beyond a diagnosis'
- The value of a focus on nutrition and other social practices and their link to mental and spiritual health should be explored as part of a holistic health approach for patients. Within the African context, traditional medical practices should also be

discussed and how this could be incorporated into a care plan to accommodate the patient's needs and address the health problems effectively in a holistic manner.

3.4.4 'What to do' from the perspective of the patient *and* practitioner

The coding of the recommendations made by the research participants revealed practical insights that can assist the practitioner to adopt an approach best suited to his/her individual practice. These could serve as points for discussion within an inter-disciplinary team or individual tips for practical implementation. They are intended to make the health carer aware of how to identify spiritual resources and support the establishment of positive spiritual and psychological features such as transcendence. The following points are practical recommendations on what to do in practice:

- Find a method of taking the spiritual history that fits your time, practice, personality and discipline.
- Combine a spiritual screening tool with an in-depth enquiry about the patient's narrative (this could entail using a short spiritual screening tool as part of your history whilst the patient is waiting, and spending more time during the consultation on needs that were identified beforehand).
- Work and refer according to an inter-disciplinary structure, and know which health team member to refer to when you have identified a need for specialist spiritual care. Spiritual health concerns or resources that could be unpacked to assist the patient cope during the treatment plan and future management should be addressed within a team and with the professional that is most competent and comfortable to address this.
- Health practitioners from all disciplines should be trained on how to screen, take a spiritual history and integrate spiritual care into the treatment plan of patients from different spiritual beliefs and backgrounds. This should be part of undergraduate and ongoing professional training. Identify health team members in your practice or area of service that offer specialised spiritual care, with whom a collaborative patient management approach can be established.
- Foster a person-centric, collaborative relationship with your patient that maximises patient autonomy and participation when it comes to addressing the needs of the patients and incorporating spiritual care in the health process.
- The identifying of spiritual health concerns and addressing them is not necessarily the responsibility of the same health professional. Finding the right tool to address the spiritual health needs is also patient-specific and could include prayer, cognitive behavioural therapy, lifestyle education, therapeutic touch and traditional practices.
- Incorporating spirituality into holistic health care should be practical and achievable for a patient. This should be linked to daily living in a natural way that is easily understood. Spirituality and the expression of this component in a meaningful way should be linked to one's lifestyle. Altering one's lifestyle requires of the health professional to see the patient within a bigger context. This includes linking spirituality to daily rituals including sleep and relaxation, exercise and movement, nutrition and hydration and how the patient manages

his/her stress and fosters resilience, as well as how the patient expresses his/her spirituality within his/her relationships and networks.

3.5 Catalysts for the realisation of the principles

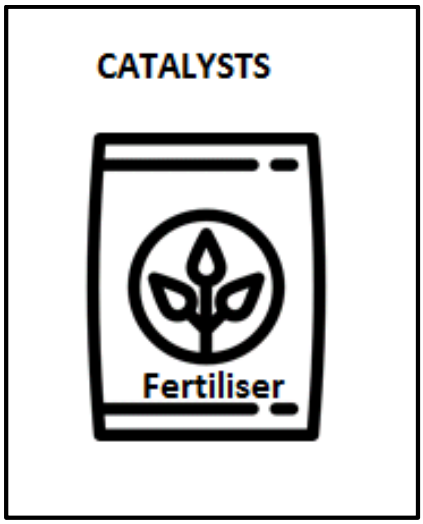


Figure 3.4 Catalysts to enhance implementation

"It would be a serious mistake to think any spiritual intervention could give a dying patient either a sense of hope or a sense of dignity. Rather, the health professional must understand that the value and the meaning are already present…waiting to be grasped by the patient. The health professional's role is to facilitate the spiritual stirring, not to administer it" (Sulmasy, 2002). How the conversation about spirituality is approached in terms of what is communicated in the appropriate setting at an opportune moment can all contribute to the value of the spiritual health experience. The ability to create a conducive context for a 'stirring' could be enhanced, serving thus as a catalyst, if the process is approached in a manner that is conducive for the patient to perceive this in a positive light. HE_1 described a catalyst as an approach that: "Facilitates reconciliation between the spiritual, intellectual and psychological worldview of the patients and their physical health circumstances."

The elements that could serve as a catalyst for a well-perceived professional spiritual health experience are linked to systemic and environmental factors, professional approach and the extent to which the health professional includes the psycho-social and community resources of the patient. There are certain 'tricks of the trade' or competencies that are necessary for a patient to be able to experience a 'spiritual stirring' as Sulmasy (2002) refers to. The inputs from the research participants in combination with existing literature identified the following four conditions, approaches and attributes that are required to create an environment conducive to a quality and relevant spiritual health consultation and experience as listed in table 3.11 below.

Table 3.11 Four categories of catalysts to incorporate spirituality in health care

1. Enabling conditions on a health systems level
2. Enabling conditions on a health implementation level

3. Health professional competence requirements
4. A holistic patient approach from screening to treatment

The catalysts described below are intended to enable the health professional to determine what can be done at various levels of care to assist in the attainment of the principles and enable a perceived patient experience of quality spiritual care.

3.5.1 Enabling conditions on a health systems level

Health policy and how health services are organised within a health system can have a major impact on whether spirituality in health care is addressed effectively and perceived to be of good quality and value for patients utilising the services offered. Health policy should acknowledge the importance of spiritual health and legislation should support the offering of such services within clinical settings. "Health professionals should have knowledge about protocols and research and evidence-based medicine. It also has to be integrated into practice. I cannot do an intake interview or diagnostic assessment or protocol without understanding how spirituality and religion impacts on that person. To be able to implement this at end-point D, we need to go back to the A, B, C. We need an ethical framework and knowledge for A. We need research to support this. Also locally, South Africa as a country needs to do more research on what our local needs are and to under-good the international research. We need a practical framework that gives us not necessarily practical steps, but a guide to questions to ask. What are our guiding principles? And then if it is practical, it should be feasible. We need a code of conduct. And we need legislation that supports this…And this is where the B, C and D lie. And here we need to develop the substance: ETHICAL, PRACTICAL, and KNOWLEDGE-FILLED AND RESEARCH BASED. This would put the principles in place." – HE_3 during an interview on 2 Nov 2017.

Health care systems should adopt a wellness approach to patient care that accounts for the spiritual. This should filter down to how health services are offered at different levels of care. Traditionally the disease-based approach to health care focused primarily on the patient's presenting complaint. A welcome shift in health care to a wellness approach has been adopted, at least at policy level, by many countries. The wellness screening in resource-constrained settings currently focuses mostly on prevention of the most prevalent chronic conditions. The spiritual influence on wellness and adherence to care should be accounted for at both policy and service delivery level. One of the community health workers interviewed described a patient on diabetic treatment who also had a problem with food insecurity at the household level. He could get his medicine at no cost at the primary care clinic, but still preferred going to a traditional healer for herbal remedies despite this costing him money, which caused him to go hungry more often. He thus often defaulted on his medical care. The wellness approach that ultimately influenced his adherence to the treatment prescribed by the doctor was when the health professional engaged with the traditional healer on a collaborative care plan. This is also recommended as a standard for attaining quality spiritual care by Puchalski, Vitillo, Hull and Reller (2014) "Health care systems and settings provide opportunities to develop and sustain a sense of connectedness with the

community they serve; healthcare providers work to create healing environments in their workplace and community." In the South African and African context, one has to take the individual patient preferences and community context into consideration and incorporate these role-players as stakeholders into a care plan that is best suited to addressing the patient needs.

3.5.2 Enabling conditions at a health implementation level

Spiritual care should be organised to meet the needs of the community. In South Africa, different communities have different spiritual beliefs and often people of a similar faith/religion choose to stay amongst people that share their beliefs. In Johannesburg in South Africa, a Jewish community is funding their own community clinic known as the Chevrah Kadisha (Internet: http://www.jhbchev.co.za/pages/content_Healthcare-Services.aspx). The services offered for Jewish believers focus on mental health and special needs of their community members, which are services that are limited within the public sector for health users in the country. The spiritual and mental health support offered by the Chevrah Kadisha strengthen the clinic services offered by the health professional team not only for the patients that are treated at the facility, but for the larger Jewish religious community. The organisation and integration of clinical services within spiritual and cultural contexts such as within this Jewish community are practical examples of what could be offered within clinical care settings to accommodate various religions and beliefs. Health services offered at clinical level can be organised to include partnerships with faith traditions and belief groups. Health services should also be offered within a collaborative care approach, where certain health professionals become 'experts' or specialists in spiritual health care and a holistic approach to care that can support the rest of the health team. Working within an inter-disciplinary team, health professionals should know to whom they can refer complex patient cases that require specialised spiritual services. This being said, it is still important that all health providers are trained on the various options and tools available to both identify and address essential spiritual needs of patients.

3.5.3 Health professional competence requirements

Health professional training at undergraduate level and as part of continuous professional development should include training on how to conduct a spiritual screen and/or history taking and how to incorporate the needs identified into a care plan. Health professionals should also be taught how spiritual care relates to their scope of practice within the specific care model that they are functioning in to accommodate the specific context of the communities they serve. The competencies required include:

- Acceptance of the relevance of spiritual care by the health team and professional
- Health professionals need to become comfortable with their own mortality, worldview and spirituality
- Acquiring of skills and knowledge that fit into the specific health team/practice or field and are based on standardised assessments and tools that are rigorous and meet evidence-based criteria to support spirituality in the clinical context

3.5.4 A holistic patient approach from screening to treatment

A holistic approach to care starts at policy level and should filter down to the consultation where the health professional is skilled in addressing the bio-psycho-spiritual needs of the patient within the context of the patient's community, including his/her spiritual needs and relevant religious support group as required. A holistic approach in practice includes:

- Creating a space for conducting a spiritual health history during the consultation and recording the spiritual health history into the electronic or written notes
- A sensitivity to the patient's needs, beliefs and current overall health (including spirituality) and how he/she prefers this to be addressed
- Establishing a relationship of trust and openness with the patient to allow for the patient to comfortably share his/her beliefs, fears and emotions
- The nature of the spiritual health instrument used or approach followed should reflect respect for the patient and allow the patient to recognise and utilise spiritual strengths and to deal with negative spiritual behaviour that could impact on his/her health
- Working as an inter-disciplinary team and knowing when to refer to a spiritual counsellor or other health team member
- Adopting a spiritual triage approach for individual practice that is able to address essential spiritual needs and appropriately refer to a specialist spiritual carer (e.g. health professional, counsellor or pastoral worker)

3.6 Impediments to the realisation of the principles

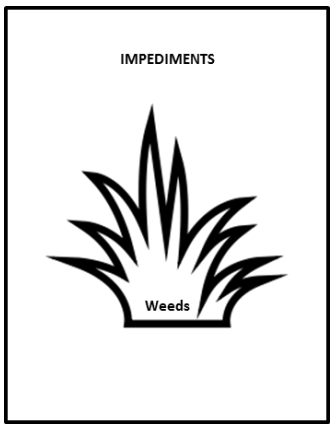


Figure 3.5 Impediments to quality spiritual care

It is possible for physicians and health carers to overstep an ethical boundary when offering spiritual care (King, 2012). The negative impact of inappropriate spiritual health practices on the health of patients could lead to various barriers that could impede offering quality spiritual care. These are captured in the questions asked below (King, 2012):

"Will physicians impose their own religious beliefs on vulnerable patients?

Will patients' religious and spiritual beliefs be honoured, even if different from those of the physician?

Will doctors prescribe religious practices such as going to church or praying to nonreligious patients, just as they encourage patients to exercise and stop smoking?

Will such prescriptions induce guilt over moral failures if patients refuse such advice and then become ill or fail to recover?

Should boundaries be drawn on how far physicians go in addressing these issues?

What are those boundaries?

Where does the chaplain—the true professional with years of training in this area—fit into the picture?"

Patients interviewed for the research raised concerns that professional attitude, skill or approach could become barriers to a patient having a positive experience during the health consultation, should spirituality be incorporated: "The health professional might not feel equipped, or fear that they will harm a patient or perhaps offend someone" – Patient. The health experts shared similar concerns: **"**In the medical field one should not enforce your spiritual beliefs on a patient, but meet them were they are" HE_2.

The following points are possible obstacles that should be taken into account by the health professional as cited by the participants during the research:

- Opposing worldviews and beliefs regarding spirituality between the patient and practitioner can hamper openness and trust and a willingness to address the patient's spiritual needs during the consultation. Meet patients where they are and in their belief context, not where you expect them to be because of your own background.
- Lack of knowledge, competence and confidence regarding the various options and tools to approach spirituality as part of the health consultation can cause practitioners to avoid spiritual needs.
- Limited time and high patient volumes can cause practitioners not to address spiritual needs adequately.
- Patients' perceptions on the role of the practitioner and separation of their illness experience or reluctance to explore spirituality can impede the integration of spirituality into the health consultation.
- Clinical institutional ignorance, disease-based and speciality-directed approaches, and fear of offence or litigation can hamper patient-practitioner knowledge and freedom to incorporate spiritual care in health consultations in an acceptable way for the patient.
- Practitioner inability to distance his/her own worldview from that of the patient can cause counter-transference or misuse of a clinical situation to morally correct perceived incorrect patient behaviour or belief or to 'convert' a patient to one's own spiritual beliefs.
- The role of cultural and traditional health practices in combination with expression of one's spirituality in opposition to a more Westernised approach to care can be complex for the health team to manage and discuss with their patients, but this does not mean it should be ignored or excluded from a holistic care approach.

- When a patient believes that the root cause of his/her illness is spiritual, this needs to be engaged with just as any other emotional or social contributing factor to disease. However, this can be uncomfortable for the health practitioner to address.
- The spiritual state of the practitioner and/or angst about addressing spiritual issues within a health care context can cause avoidance of the subject or an incorrect approach.
- If a patient has a spiritual believe or practice that will not harm the patient's health, it is not the role of the health practitioner to try and convince the patient otherwise, whether the health professional agrees with the beliefs or not.
- If patients were not informed and had not consented to a spiritual history or interview as part of a holistic approach, this can cause discomfort, stress and achieve the opposite of what was intended.

The interviews with the participants unpacked the possible impediments to offering quality spiritual care. "That the person doing the approaching is frankly inadequate for the job. That my requirements and my expectations exceed the ephemeral and fluffy, if you will. The health professional should be dealing with achievement and performance beyond the physical level. Frankly think it should occur at the level of psychiatry. I think it also has to be tied to some measures of feedback. I think they have to do it in a way where the expectations are largely on the patient, more so than on the doctor." – A concern raised by a patient that spirituality and its relevance to medicine lies in a specialised field such as psychiatry. Contrary to this, patients strongly expressed that if the health professional did not include spirituality as part of the therapeutic process or consultation, then they would not dare venture *there* either with the professional: "The doctor has to put it on the table as a part of the therapeutic process."

"I think that is one of the most important things that I would do for patients, is to really have a good description of spirituality and explain because you're not always going to talk to people that are academics." Patients indicated the importance of creating a context to frame the discussion, as the lack thereof could impede a quality experience. Barriers to care that could hold back patients from being open about their spirituality included the health professional being perceived as judgmental or insensitive. Patient barriers that came out in conversations included:

- The patient being a very private, closed person
- The patient not being religious
- Lack of capacity or openness to look at care within a broader context and discuss this comfortably (from both the perspective of the patient and/or health professional)
- Apprehension patients might have to spiritual care due to unfamiliarity; not being used to it being introduced into a clinical setting

HE_3 gave a personal and practical example of a clinical consultation and the practitioner's approach becoming an obstacle to addressing the spiritual component within the care process: "One obstacle would be the professional's own angst or spiritual confusion. The

practitioner's own spiritual state can become an obstacle. If they do not first explore their own spirituality and become comfortable with this, it can be an obstacle. Proselytisation can be an obstacle. So lack of spiritual maturity where the practitioner is not mature enough to explore the patient's issues within a context that might go against the values of the practitioner for e.g. a patient having sex before marriage, but confessing to be Christian and then the practitioner says but you are doing a sin and this is the cause of your problems. I have patients that come to me because this has happened to them in other clinical settings. The comfort within your own spirituality should be such that I am not threatened by the patient's situation or what he brings. Otherwise countertransference becomes an obstruction. Another one would be lack of knowledge on the area: so the health professional goes there, but does not know how to go through on it."

The interviews also highlighted that patients' own hurts or fears of opening up towards a health carer about spiritual beliefs can become an obstacle to care. Health professionals should be attentive to their approach and wording when addressing the spiritual care, as words that are meant to comfort can be mistaken for judgement, such as: "I am Christian, but I can also work with patients from other beliefs. It might sound initially like an ethically sound remark, but if this is said without the patient asking this type of question, it may be interpreted as a judgement on the patient's chosen religion or spiritual belief."

It is often said that medicine is both a science and an art. This is where the balancing act between these two field comes into play: the ability to switch between clinical judgement and freedom for the patient to express his/her needs, beliefs and fears. HE_3 voiced her own fears as a patient about spirituality being addressed in a clinical context: "Unless I have been very well prepped, I would question the relevance of being approached regarding my spirituality and would wonder if this will have an impact on the treatment I am going to receive. I think there would be a vulnerability that potentially could make me uncomfortable. I have had a few experiences with patients coming to me because of a practitioner or a well-intended person in their lives that linked a disease like cancer to sin in that person's life and this caused distress. I had a patient with a diagnosis of cancer this year that we had to work for weeks through someone placing this burden on her life. And for me as a practitioner I know there is research that links certain diseases to certain emotions and sins and although I can see the link, for patients that is often not helpful as it causes more distress. This can cause a spiritual crisis. So something that was intended for help became harmful. And first and foremost, we are to do no harm."

Health professionals should be aware that although they might have the best intention of incorporating spiritual care in a quality manner, there might be systemic or individual factors that become a barrier to offering such care and that these will have to be taken into account. They could include having too little time to offer spiritual care beyond an initial screen or having limited privacy. The successful addressing of the possible barriers to care will lie in how not only the individual, but the inter-professional team and the health system respond and adapt to the spiritual needs of patients.

3.7 Connections to existing spiritual health tools

This framework is the construct of the inputs from the research participants, the researcher's own experience and existing literature on spiritual care. In many instances the research affirms what others have written on the subject. To assist the reader in finding out more about existing tools and how they relate to this framework, the connections to other frameworks, spiritual diagnostic tools and care plans are briefly described below. This is also intended to enable the reader to adopt an approach that is best suited for individual professional practice and personal preference within the framework recommended. Figure 3.6 below depicts the recommended framework as a spiritual care tree planted alongside existing resources and spiritual care tools.

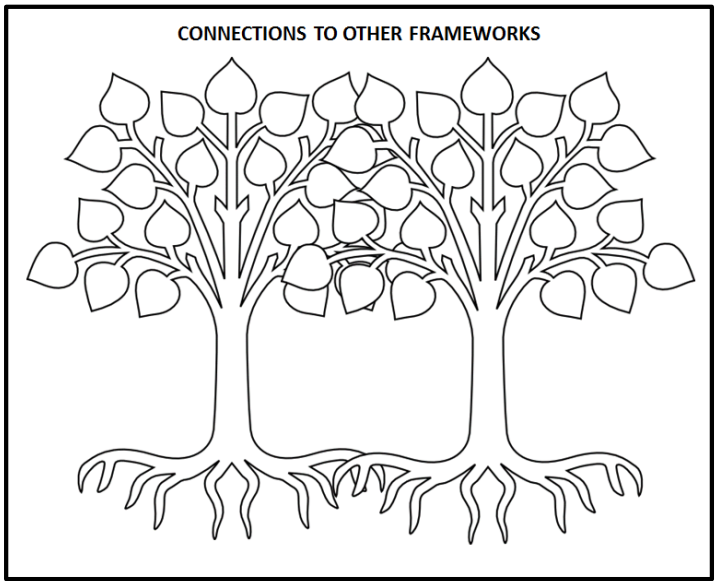


Figure 3.6 Spiritual care tree approach complimenting other spiritual care resources

The spiritual health tools in literature that were drawn from for this research are summarised into three categories, viz. frameworks, screening and treatment tools. These will be discussed below.

3.7.1 Spiritual care models and frameworks

The model for compassionate and spiritual care below (Puchalski, Vitillo, Hull & Reller, 2014) depicts what was argued in this framework: that spirituality should be included in health care because it is what compassionate and quality health care requires. Spirituality could be the balm to alleviate suffering, especially where medical care has reached its limitations.

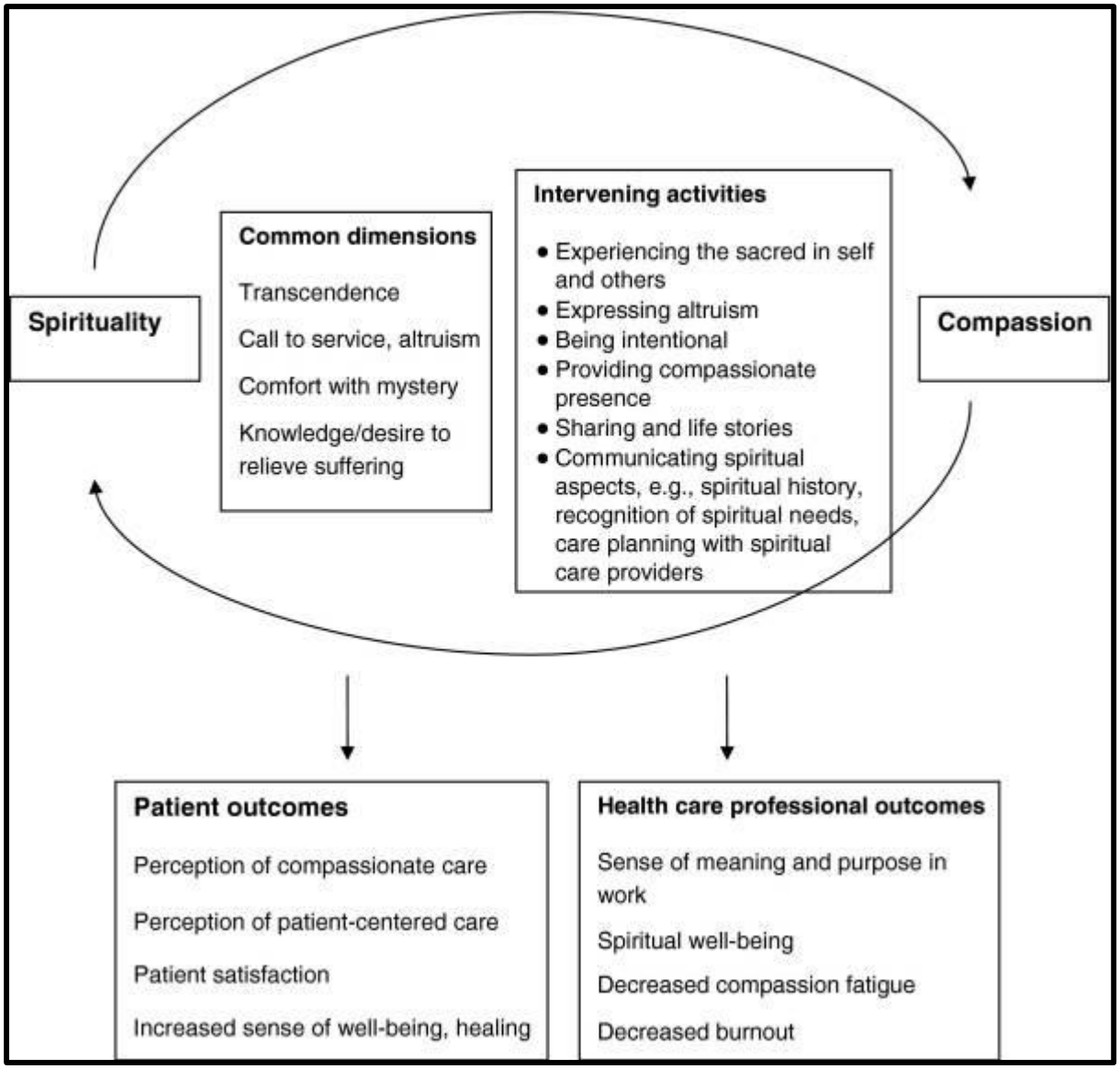


Figure 3.7 Model of spirituality and compassion (Puchalski, Vitillo, Hull & Reller, 2014)

In 2009 the George Washington Institute for Spiritual Health (GWish), in collaboration with the City of Hope, convened a national consensus conference entitled 'Improving Quality Spiritual Care as a Domain of Palliative Care'. The focus of this conference was to develop guidelines that could enable spiritual care as a component of high-quality health care. As an outcome of this conference, Puchalski, Vitillo, Hull and Reller (2014) defined spirituality as: "The aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred." Participants noted the importance of spirituality in a person-centric approach that portrays compassionate care. The sacredness of the practitioner-patient relationship as a potentially transforming encounter for either party emerged as a key point. This was described as having the possibility to become a 'healing relationship' where, despite having a specific diagnosis, patients could find healing/inner peace in the midst of suffering in their interactions with a compassionate carer. In this context, spirituality was directly linked to compassion, as displayed in the model of spirituality

and compassion above. Concepts that were used to describe health carers as being spiritual included: transcendence, meaning-making and sense of purpose or call to service, being able to connect to others, and inspiring transformation. These attributes also enabled compassionate care. They affirm the foundation of the principles described in the research framework and relate to what came out during the interviews with both patients and health practitioners during this research. Patients interviewed described a perceived quality when there was a strong relationship of trust and an openness to sharing life stories. Compassion and the role of the practitioner in enabling transcendence and fostering hope for patients, despite their condition, to life a live filled with hope were codes that emerged in the analysis of the interviews that are supported by this model (Puchalski, Vitillo, Hull & Reller, 2014), as described in the framework presented in this research.

Another outcome of the 2009 conference was 'recommended standards for spiritual care' as part of a focus on addressing the spiritual dimension of whole-person care: reaching national and international consensus. Table 3.12 below describes the top 12 standards listed. These standards confirm what surfaced during the interviews with health experts, patients and practitioners during the research process. The research described in this thesis included an extensive review of existing literature on incorporating spirituality in health care. Puchalski, Vitillo, Hull and Reller (2014) list the top 12 recommended standards for spiritual care as part of creating a compassionate health care system. The standards were derived by expanding on an inter-professional spiritual and palliative care model developed during such a conference in 2009. The follow-up conferences of 2012 and 2013 produced as an outcome a set of standards and recommended strategies for integrating spiritual care across health care. These recommendations were also echoed by the experts and health professionals interviewed for this research.

The first recommendations made by the authors (Puchalski, Vitillo, Hull & Reller, 2014) state that spiritual care is integral to compassionate, person-centred health care and is a standard for all health settings, which should be part of both policies and routine care. Principle one described in this research argues that spiritual care should be part of the health consultation, taking the conversation from policy level to bedside approach and strengthening the findings of others (Louw 2014; De la Porte, 2016) that in the African context spirituality is seen as a vital component of whole-person care.

The fourth standard for care recommended by Puchalski, Vitillo, Hull and Reller (2014) describes something that also emerged in the interviews with the health experts in this research: that spiritual care should be supported by evidence-based research. This is considered a key principle in the research described in this thesis. It is only in combination with existing research and literature on local and international context that an appropriate spiritual care model tailored to the African context can be developed and continue to be relevant as the cultures and medicine develop and evolve over time.

The next few recommendations made by Puchalski, Vitillo, Hull and Reller (2014) focus on two distinct areas: firstly, health care education and the incorporation of spiritual care education in health training, and secondly, health system design. The principles described in this research compliment the recommendations made by the authors of the standards for spiritual care as they describe at the health professional level what is listed at the health educational and systemic level in detail, as well as referencing the African context for both the patient and the professional. Table 3.12 lists the eight principles for offering spiritual care in a health consultation described in this research, in comparison to the top 12 recommended standards for care by Puchalski, Vitillo, Hull and Reller (2014).

Table 3.12 Top 12 recommended standards for care by Puchalski, Vitillo, Hull and Reller (2014) in comparison to the eight principles for offering spiritual care

Eight principles for offering spiritual care in a health consultation	12 recommended standards for spiritual care
1. Spirituality should be part of the health consultation 2. An evidence-based approach that is ethically grounded should be followed 3. The practitioner should attend to his/her attitude during a spiritual health consultation 4. The practitioner should create a receptive context that takes into account the spiritual needs of the patient within his/her personal context 5. The practitioner should adopt a person-centric approach 6. The practitioner should foster communication that suitably addresses spiritual health needs 7. The practitioner should be sincerely interested in the person and his/her spiritual needs (to achieve quality spiritual health care) 8. The practitioner should co-mobilise spiritual resources that build resilience for the patient	1. Spiritual care is integral to compassionate, person-centred health care and is a standard for all health settings. 2. Spiritual care is a part of routine care and integrated into policies for intake and ongoing assessment of spiritual distress and spiritual well-being. 3. All health care providers are knowledgeable about the options for addressing patients' spiritual distress and needs, including spiritual resources and information. 4. Development of spiritual care is supported by evidence-based research. 5. Spirituality in health care is developed in partnership with faith traditions and belief groups. 6. Throughout their training, health care providers are educated on the spiritual aspects of health and how this relates to themselves, to others, and to the delivery of compassionate care. 7. Health care professionals are trained in conducting spiritual screening or spiritual history as part of routine patient assessment. 8. All health care providers are trained in compassionate presence, active listening, and cultural sensitivity, and practise these

	competencies as part of an inter-professional team. 9. All health care providers are trained in spiritual care commensurate with their scope of practice, with reference to a spiritual care model, and tailored to different contexts and settings. 10. Health care systems and settings provide opportunities to develop and sustain a sense of connectedness with the community they serve; healthcare providers work to create healing environments in their workplace and community. 11. Health care systems and settings support and encourage health care providers' attention to self-care, reflective practice, retreat, and attention to stress management. 12. Health care systems and settings focus on health and wellness and not just on disease.

Monod et al (2010) developed a tool that can assess the spiritual state of a patient. Spirituality can either be an asset or a liability in the overall health of the patient and is not a homeostatic process, as life-events also influence one's spiritual state (Pargament et al, 2001; Koenig et al, 2001). The screening tool to assess the spiritual state of the patient (Monod et al, 2010) can assist one to identify a specific spiritual need that can either be addressed by the health practitioner that has done the initial spiritual state screening, or, once identified, can be referred to another member of the health team. Monod et al (2010) identified through this research four specific dimensions to spirituality and linked these to specific patient needs described in figure 3.8 below. Patient needs were further analysed and described as specific patient cues or responses that could serve as an indication of a specific need that could then be addressed. During the patient interviews conducted with the research written up in this thesis, patients expressed similar needs as plotted out in the model depicted in figure 3.8 (Monod et al, 2010). During the interviews it was evident that patients felt that they had a strong need to be seen as an individual and recognised as having a unique identity. Patients also expressed their need to find balance and make sense of life events that had an influence on their health. Connecting to the health practitioner in a meaningful way and also to other people in relation to their illness was a strong theme during the interviews. It was evident that these spiritual needs often remained unmet in the current health context. The spiritual needs model (Monod et al, 2010) describes in a practical way which areas of needs health professionals need to be attentive to and screen for. Once the needs have been identified,

they can be addressed during the health consultation or referred to a specialist spiritual carer such as a chaplain, traditional healer or other health professional within the inter-disciplinary team.

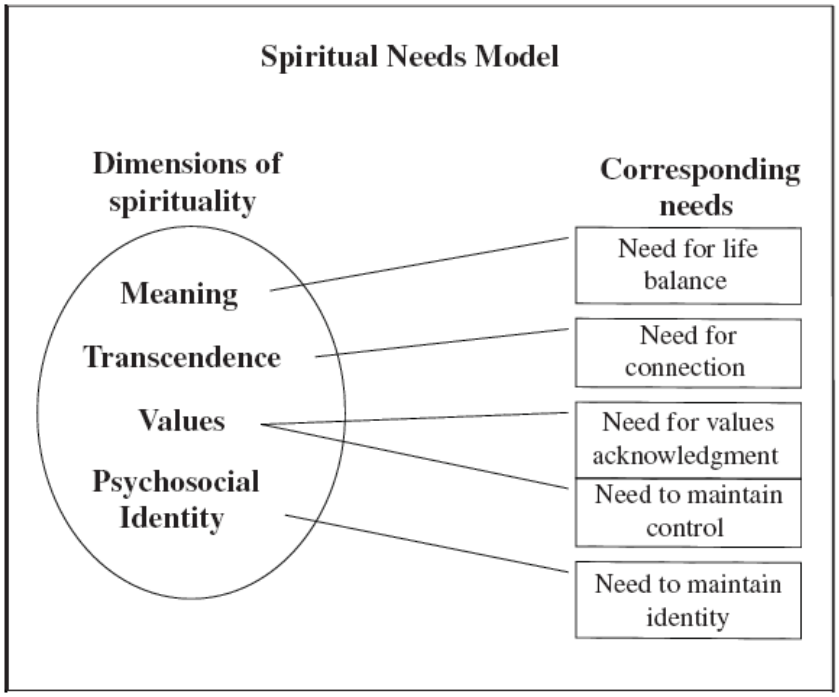


Figure 3.8 Spiritual needs model: Dimensions of spirituality and corresponding needs in elderly hospitalised patients (Monod et al, 2010)

Table 3.13 below is the expanded version of the spiritual needs model (Monod et al, 2010) where a definition is given for each dimension of spirituality and its corresponding need.

Table 3.13 Expanded version of the spiritual needs model with description of the dimensions of spirituality and corresponding needs in elderly hospitalised patients (Monod et al, 2010)

Table 2 Spiritual Needs Model: dimensions of spirituality and corresponding needs in hospitalized patients

Dimension of spirituality	Definition of dimension	Needs associated with dimension
Meaning	The dimension that provides orientation to an individual's life and promotes his or her overall life balance.	**The Need for life balance:** The need to rebuild a new life balance and the need to learn how to better cope with illness or disability.
Transcendence	An anchor point exterior to the person; the relationship with an external foundation that provides a sense of grounding. The group considered that everyone has an external foundation, even if different from God. For example, for some people, this transcendence might be found in nature, beauty, or art.	**The Need for connection**: The need for connection with his or her existential foundation and the need for Beauty (aesthetic sense).
Values	The system of values that determines goodness and trueness for the person; it is made apparent in the person's actions and life choices.	***The Need for values acknowledgement**: The need that health professionals know and respect one's values. ***The Need to maintain control:** The need to understand and to feel included in decision-making processes and to be associated with health professionals' decisions and actions.
Psycho-social Identity	The patient's environment; those elements, such as society, caregivers, family, and close relationships that together make up the person's singular identity.	**The Need to maintain identity**: The need to be loved, to be heard, to be recognized, to be in touch, to have a positive image of oneself and to feel forgiven.

*According to the hospital setting, two different needs were clearly distinguished to translate the values dimension.

When the health practitioner has orientated him/herself towards possible patient needs with regard to spiritual care, the next step is to decide on an approach to screen for or identify

these needs. The next component will describe existing spiritual screening tools that were mentioned by the research participants or relate to the coding of the data that emerged during the research.

3.7.2 Spiritual screening tools

Spiritual screening, in-depth interviewing/history taking and spiritual treatment/counselling were three distinct levels of engagement between health practitioner and patient that emerged from the research. Fitchett and Risk (2009) described this brief spiritual/religious tool for health practitioners who are too busy for a narrative enquiry, or are unable to do an in-depth spiritual assessment. This is a practical tool that was recommended by all three health experts during the research. All health practitioners should be able to do a brief spiritual screen and know when to refer. The spiritual screening tool (Fitchett & Risk, 2009) asks a few simple questions that prompt one of three actions:

1. Refer for spiritual assessment if the answers indicate possible religious/spiritual struggle.
2. Refer if spiritual care is requested by the patient on questioning.
3. Take no action if there is no indication of spiritual struggle or no interest in spiritual care.

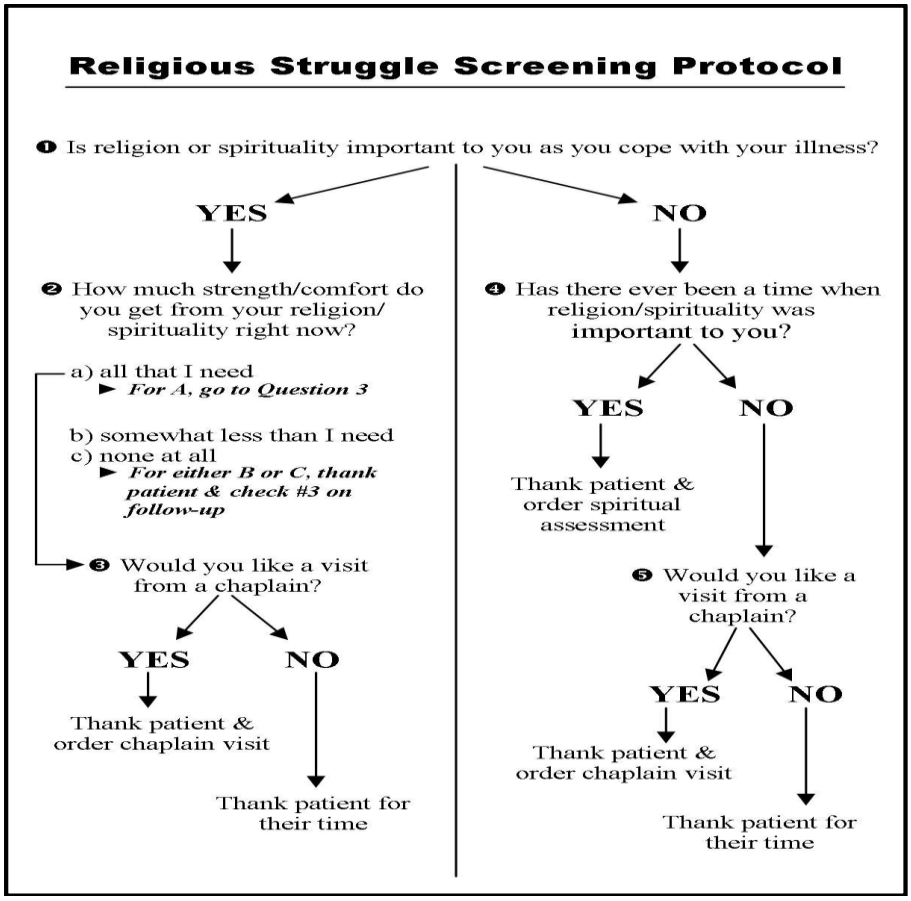


Figure 3.9 Religious struggle screening protocol (Fitchett & Risk, 2009)

During a health consultation, spirituality can be included in three ways: screening for spiritual distress, taking a spiritual history, and providing spiritual care by addressing specific spiritual

needs. The FICA model developed by Puchalski and Romer (2010) can be used as a guide to obtain a spiritual history of a patient. Table 3.14 below describes the four guiding questions of the FICA spiritual history tool. This tool is not intended to be used as a checklist, but rather as an interview guide that should be used to facilitate a patient-centric conversation that can open up a discussion.

Table 3.14 FICA spiritual history tool (Puchalski & Romer, 2000)

FICA—Taking a Spiritual History
F—Faith and Belief "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?"
I—Importance "What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness?
C—Community "Are you part of a spiritual or religious community? Is this of support to you and how?
A—Address in Care "How would you like me, your healthcare provider, to address these issues in your healthcare?"

Harold Koenig (2004; 2007) developed a spiritual history tool known as the CSI MEMO. The four questions asked during a patient consultation address similar concepts to the FICA spiritual history tool (Puchalski & Romer, 2000). The CSI MEMO is captured in Table 3.15 below.

Table 3.15 CSI MEMO (Koenig, 2007)

1. Do religious or spiritual beliefs provide you **C**omfort or **S**tress?
2. **I**nfluence medical decisions?
3, Are you a **MEM**ber of a religious or spiritual community?
4. **O**ther religious or spiritual needs?

Koenig also lists various reasons for obtaining a spiritual history from a patient that are described in table 3.16 below.

Table 3.16 Motivation behind obtaining a patient spiritual history (Koenig, 2007)

1) To understand the role of religion in a patient's life in coping with his illness or as a source of stress
2) To understand what possible influence religion or spirituality might have on a patient's decision with regard to his health or medical care
3) To identify possibly spiritual needs a patient might have that could adversely affect the patient's health if not addressed
4) To communicate to the patient that his/her views are recognised and respected
5) To gather information that could be useful in understanding what motivates certain lifestyle behaviours in a patient's life

6) To get an understanding of possible support systems and social resources that could assist the patient towards healing 7) To raise awareness to the patient that he/she can at any time in future discuss spiritual or religious concerns or needs with the health professional

HE_1 and HE_2 both referred to the Functional Medicine approach (Cole, n.d.) as one that they used in practice. Functional Medicine is a scientific health approach that has distinct differences from the current medical model. In recent years it has become increasingly popular amongst health practitioners. Table 3.17 describes the five basic principles that define Functional Medicine.

Table 3.17 The five basic principles of Functional Medicine (Cole, n.d.)

1) Functional Medicine acknowledges each person's unique genetic and biochemical makeup. Health care is personalised to treat a person and not a disease. Treatment is focused on restoring normal healing mechanisms of the body and not attacking the disease. 2) Functional Medicine is a scientific and evidence-based health programme focused on utilising the complex physiological processes of the body as it interacts to contribute to health or illness. 3) The human body is designed to self-regulate to bring about homeostasis. This dynamic balancing process is a key focus approach. 4) The human body has the ability to restore and prevent nearly all the diseases of aging. 5) Health is not merely the absence of disease, but a state of immense vitality.

Cole (n.d.) describes the distinctive approach of Functional Medicine in the following way: "Instead of asking what drug matches up with this disease? Functional Medicine asks the vital questions that very few conventional doctors ask: Why do you have this problem in the first place? Why has function been lost? What can we do to restore function? In other words, Functional Medicine looks to find the root cause or mechanism involved with any loss of function, which ultimately reveals why a set of symptoms is there in the first place, or why the patient has a particular disease label." The Institute for Functional Medicine has a number of practical sheets available for use in practice to complete during the interview and discussion as part of an appropriate holistic treatment plan. See, amongst others, the Functional Medicine Timeline and Functional Medicine Matrix in figures 3.10 and 3.11 below.

Figure 3.10 Functional Medicine Timeline (Institute of Functional Medicine, 2017)

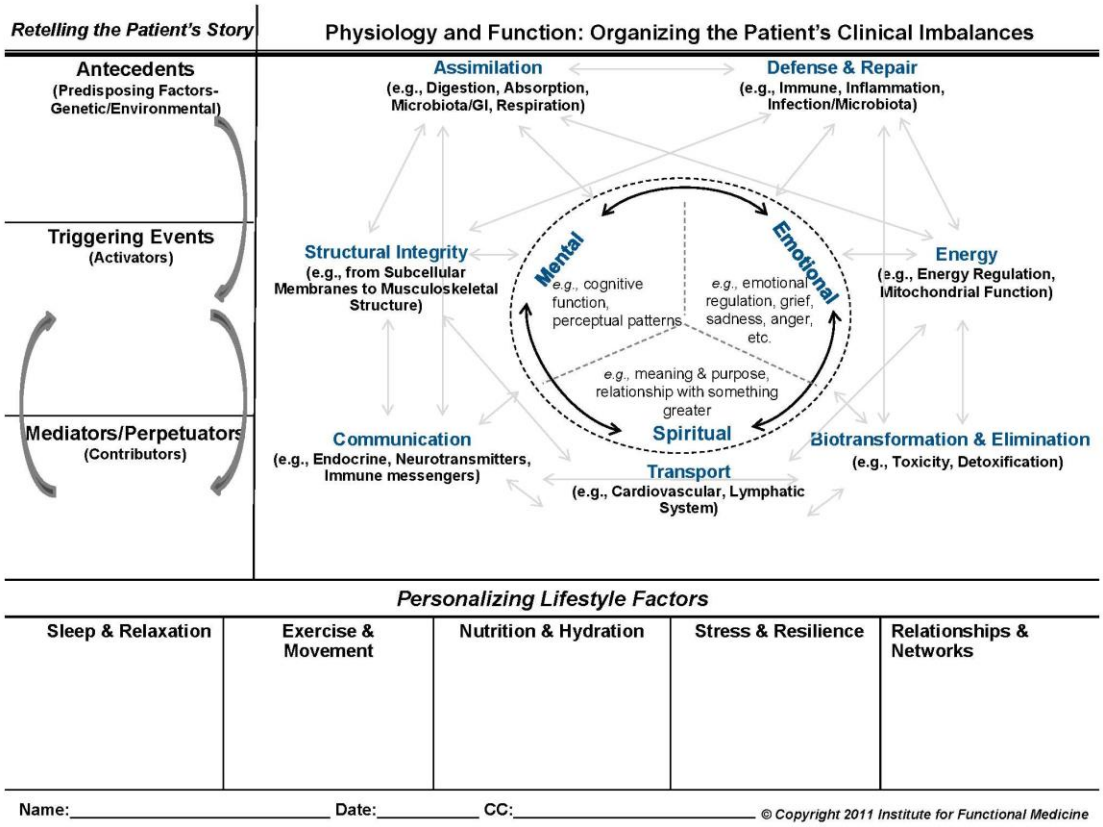


Figure 3.11 Functional Medicine Matrix (Institute of Functional Medicine, 2014)

Both the Functional Medicine Timeline (Institute of Functional Medicine, 2017) and Matrix (Institute of Functional Medicine, 2014) acknowledge the inter-relatedness of spirituality, life-events and socio-emotional circumstances with health status or bodily experiences. This integrative approach guides the health practitioner to map out triggering events that could have caused bodily symptoms or an illness or circumstances that contributed to the worsening of symptoms. Mental, emotional and spiritual health are seen as vital components to the definition of health; they are also prominently included in the holistic treatment plan of any disease. The personalised lifestyle factors focus on more than just following a diet plan or getting exercise. They include all the daily life experiences that contribute to overall well-being and homeostasis. Patients interviewed during the research noted the importance of these lifestyle factors in regulating their own symptoms and health. Despite lacking any background knowledge of Functional Medicine, patients voiced specific triggering events for symptomatic worsening of a disease. Nutrition was listed as a key component to spiritual, mental and bodily health by both health experts and patients interviewed during the research.

The various approaches and frameworks described in this chapter represent well recognised international evidence-based research on holistic care that is inclusive of acknowledging and leveraging spirituality as a resource for health. It is in no way meant to be an exhaustive list of what is available, but is intended to direct the reader towards other resources available.

The third component of spiritual enquiry entails mapping out a care plan. The Functional Medicine Matrix (Institute of Functional Medicine, 2014) has a dual purpose as it can be used both for enquiry and to map out a care plan. The third component of spiritual resources that will be described will explore spiritual care recommendations available.

3.7.3 Spiritual treatment tools

Koenig et al (2012) define a number of practical things that can be done to incorporate spirituality in patient care. The first is to document the spiritual findings or needs. The next step is to orchestrate spiritual resources. The health professional conducting the interview should assist the patient in identifying spiritual resources and, where needed, should schedule access to such resources. This could include participation in a spiritual ritual or service, an appointment with a spiritual carer or incorporating a specific spiritual need into the clinical care, e.g. prayer. This should be done in support of the patient's beliefs. A religious activity could also be prescribed as part of the treatment plan, such as keeping a journal that records spiritual distress and also positive spiritual experiences. An example of this is the therapist workbook by Ciarrocchi et al (2014) that describes religious cognitive behavioural therapy for patients who struggle with depression due to a chronic illness. This workbook entails a planner with a daily activity and self-monitoring logbook for clients/patients that can be used during discussions in follow-up care. The work of the inter-professional team, including spiritual carers, is important for patients to establish a relationship where they feel connected and are able to share their needs, distresses and journey with a professional on a path to wholeness.

Spiritual care could be incorporated into the daily treatment plan. The perceived value of this emerged in the patient interviews and is affirmed in the literature. Possible spiritual rituals that can be combined with the health plan include mental imagery, prayer, traditional medicine and herbs, homeopathy, therapeutic touch, natural diet practices and exercise programmes, to name but a few. The question of how spirituality should be included is inevitably linked to worldview and the current experience of the individual within his/her context. It is also linked to what is achievable from the perspective of the health professional within his/her practice, context and health care system.

Throughout the interviews, all three groups raised the importance of having the most appropriate team member address the spiritual care. Who the most appropriate team member is depends on the patient's need and the practitioner's skill; other health team members are available to address the need in the best possible way. This framework recommends that any member of the health team should be able to do a spiritual screen. Depending on circumstantial factors such as the time available, the relationship established, the nature of the distress and the skill of the health professional, a full spiritual history might be taken, spirituality might be incorporated in the care plan, or the patient might be referred for specialised care. The skill and art lies in matching the right spiritual care tool to the individual patient, facilitated by the appropriate team member. The spiritual care triad is the researcher's derived model as revealed through application of the discussions with the

various health experts. It depicts these three components that should be balanced to appropriately address the spiritual needs of patients, as seen in figure 3.12 below.

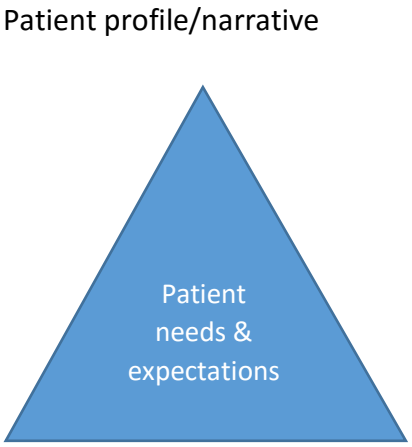


Figure 3.12 Spiritual care triad

This chapter presented the framework comprising eight principles, each with quality requirements to attain the principles. Recommendations were made on how to implement this in practice and catalysts or possible impediments to successful implementation were described. The framework also listed spiritual resources available to assist the health professional in practice.

In chapters 4, 5 and 6 that follow, the codes that underpin the framework at the lower levels will be described to gain deeper insight into the construction of the framework. Each of chapters 4, 5 and 6 will look at one participant group: the health experts, the patients and the inter-disciplinary focus group, respectively. The next chapter will describe the codes that emerged during the interviews with the health experts.

Chapter 4
Findings for the health experts: Harnessing the potential benefit of spiritual care for both patient and practitioner

This chapter unpacks the analytic yield from the three scholars that participated in the research. The crux of the health experts' findings described the potential benefit of incorporating spirituality in the health consultation and care plan. 'Spirituality is a physiological feature of mankind. With that concept in mind it is far easier to have just a human-to-human conversation with the safe assumption that spirituality is a physiological feature and that the conversation and language we use and have of spirituality may either be facilitating of the conversation or raise unnecessary objections. The realisation and perspective that this (spirituality) is an attribute of man, rather than a tool of therapy, is what I want to explore' – HE_1. An appropriate approach for spiritual care takes into account the value that is placed on spirituality and its exploration within the health care consultation. The analysis of the data yield from the three health expert interviews revealed six theoretical codes that are unpacked in this chapter. These mid-level codes were included in the final framework presented in chapter 3. The codes include: the ethical motivation for including spirituality in health care, spirituality as a possible resource to good health outcomes, various spiritual care interventions, the role of the inter-disciplinary team, possible limitations and pitfalls when offering spiritual care, and the need for spiritual care education and continuous professional development.

To give context to the codes identified during the analysis, the interviews with each health expert were summarised, with a brief background description of each of the health experts, followed by in vivo codes that capture the essence of each of the interviews.

4.1 Description of the individual interviews with the three health experts

The three participants were invited to take part in the research with the specification that they had an interest in holistic care, and more specifically the inclusion of spiritual care in the health consultation and care plan. The three health experts were purposefully sampled with a common qualification criterion that they all had a postgraduate qualification and/or experience in the field of spiritual health care. Health practitioners were considered to be experts if they presented or published on the topic of spirituality in health care nationally or

internationally. Three scholars participated in the study based on their roles and experience as health practitioners (irrespective of whether they were for or against a framework). The three in-depth interviews were scheduled over the course of seven months, and after each interview the draft framework was updated.

The three health experts interviewed each represented a different discipline. They also had different approaches to spiritual care. Despite their differences, there were theoretical commonalities in a spiritual care approach that emerged in the coding of the data generated during the three individual interviews. After each interview the codes were integrated into an updated draft framework that was presented in subsequent data sampling with the next health expert. The personal narratives and tools shared during the interviews with the individual experts became the scaffold on which the next health expert interview could elaborate and build. After the three individual interviews, as the first source of data, the draft framework was updated again and prepared for the second round of data collection with the patients. Below is a brief description of who the three experts that participated were in their professional capacity at the time, along with in vivo quotes of some of their thoughts. Throughout the rest of this chapter all the theoretical codes identified during the data analysis were described by including in vivo quotes from the experts.

Health Expert 1 (HE_1): A medical doctor for over twenty years with experience in incorporating spiritual care into health consultations and practice. He is internationally known in this field and was involved in spiritual care research initially through Duke University. He has presented on this topic at numerous conferences and meetings around the globe as well as online. The interview was done in Pretoria on 28 May 2017 and is briefly summarised in table 4.1 below. Although the write-up of the contributions of the various health experts in the framework was done anonymously, they did consent to having their names revealed in the research. This is the only research participant group where the names are stated. The intent of this is to enable the reader to have access to the resources and materials published by the authors on spiritual health care.

Table 4.1 Brief summary of interview with HE_1

Dr Frans Cronje described in great detail, with rich patient case experiences, principles that he viewed as important to offering quality spiritual care that is appropriate: "Perhaps one of the most important paradigms that I have come to appreciate is that patient care should be a *patient-driven* rather than a therapeutic-driven process. Identify and address the spiritual needs of the person/patient rather than us trying to treat a specific spiritual health problem. The concerns raised of the proselytising of patients and *the controversies related to spirituality and health care really fall away when one sees this as a patient-centred, patient-driven, patient-ethical-driven mandate, rather than us abusing a situation to influence people with our worldview.* This is a welcome shift in an approach to health care that makes the climate more conducive to address spirituality in health care." HE_1 considered the manner in which the topic of spirituality is introduced during the health consultation as one of the biggest challenges. He described two approaches to this

as an active and a passive approach in the following words: "The active way is to specifically solicit the patient by asking whether they have any particular spiritual needs during the consultation process. The danger of that type of approach is that it can seem so profound that you can get a very evasive or limited response. In the passive, if the consultation is of an appropriate length the approach of the practitioner responds to a verbal cue of the patient and weaves this into the conversation about the outcome of her diagnosis or the therapeutic process."

He also felt strongly that before the conversation between practitioner and patient could be addressed in a suitable manner, it was important that the health professional was comfortable with his/her own spirituality: "Spirituality is a physiological feature of mankind. With that concept in mind it is far easier to have just a human-to-human conversation with the safe assumption that spirituality is a physiological feature and that the conversation and language we use and have spirituality may either be facilitating of the conversation or raise unnecessary objections. The realisation and perspective that this *(spirituality) is an attribute of man,* rather than a tool of therapy, is what I want to explore."

Throughout the interview he interwove his own personal experiences in relation to international research and other scholars' models on the topic of spiritual health care. The interview, with is strong focus on the principle of being person-centric, also influenced the subsequent order of data collection. HE_1 expressed that in his opinion patients should be asked what their preferences and concerns were as a second source of data before a framework could be discussed with health professionals. His motivation for this being reflective of a patient-centric research approach influenced the order of data collection. Thus, for the second round, the order of participant groups was changed to patient interviews and the inter-disciplinary focus group was postponed to become the third source of data.

Health Expert 2 (HE_2): An experienced bio-kineticist with a postgraduate qualification in theology as well as a qualification as a counsellor. At the time of the interview she worked in her own practice as a Functional Medicine practitioner with a focus on pathology (disease) counselling. She had presented on the topic of spiritual health care at conferences and also for educational purposes online. The interview was done in Pretoria on 18 Aug 2017 and is briefly summarised in table 4.2 below.

Table 4.2 Brief summary of interview with HE_2

Elizabeth Myburgh described her approach to integrating spirituality and a holistic approach to care in the following manner: "Firstly, I would determine which side of this person is more affected: the physical, emotional or spiritual side. I use the Functional Medicine Timeline to determine where this person is in their lifespan. I try to find out what the antecedents are, the mediators and the triggers that cause these symptoms to emerge, why they are there and when this started. I usually see all patients for two hours with a first consultation. Then I use the *Functional Medicine Model* (Institute of Functional Medicine, 2014) to tell their story back to the patients and tell them what I see and observe. Then the patient would guide me where there needs are – either more spiritual or symptomatic. Then we would move forward, either with lifestyle modulators or prayer."

During this interview she recommended an approach that could be useful to accommodate different worldviews amongst patient and practitioner: "There are safe questions that you can ask to anyone:

1. Is there a higher being that you involve in your spiritual thinking?
2. How do you feel about your spiritual life?
3. Do you think your spirituality has an impact on your health currently?
4. Do you attend a place of worship regularly?
5. Do you make time to be quiet and connect to the spiritual?"

Health Expert 3 (HE_3): A psychologist with extensive experience in the psychiatric setting. At the time of the interview she was a PhD candidate and subsequently completed her studies in spirituality, religion and the impact on mental health from a Christian perspective. She had presented nationally and internationally on an ethical approach to addressing spiritual needs of patients, which included her own in the field. The interview was conducted in Pretoria on 2 Nov 2017 and is summarised below in table 4.3.

Table 4.3 Brief summary of interview with HE_3

Dr Wendy Greyvenstein viewed spirituality as an integral component to quality health care: "I cannot imagine not addressing the spiritual component as part of a holistic approach to a patient. But this is not only with regards to treatment, it is also about the assessment and diagnosis and everything that leads up to the treatment plan. My concern with this is that, specifically in my field (psychology), people have been nervous about the difference and intersection of spirituality and religion and how to address this in practice. For me it is a devastating place for psychology as a field to be. If we are working in a 'sacred' space of the patient every day as a practitioner working with a person that is vulnerable and in pain, if we are not open to incorporating spirituality into our therapeutic model, then I feel that we are managing that patient unethically."

HE_3 described her approach to introducing spiritual care in the following manner. She said she often initiated the conversation with a patient using the following metaphor: 'You are sitting here, but all I can see is a black and white image in a colouring-book and for me to really know and understand you and join you in your suffering, I need as much colour as possible. And the more colour I have, the more I can understand you. Part of the colouring-in is having a space where the patient can also discuss the spiritual and religious beliefs and faith tradition."

She also referred back to the FICA tool and said that she would often ask as an introductory question: "Is religion or faith important for you in your life?" The FICA Spiritual Screening questionnaire (Puchalski & Romer, 2000) for health professionals includes asking the following 4 questions:

F—Faith and Belief "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?"

I—Importance "What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness?

C—Community "Are you part of a spiritual or religious community? Is this of support to you and how?"

A—Address in Care "How would you like me, your healthcare provider, to address these issues in your healthcare?"

The three health experts each contributed unique components from their respective health backgrounds and professional experiences that contributed to the construct of the framework. Many of the screening tools recommended by the three health experts were similar and complemented what the other had said. The three disciplines represented by the individuals interviewed were that of a medical doctor, bio-kineticist and psychologist respectively. Each of the experts, from their professional experience, focused attention on spiritual care within their practice and also within health care in general. HE_1 was influenced by the experience of an over-burdened medical profession that is trained to come to a clinical diagnosis as quickly possible. He called for a renewed attention on a person-centric approach that is more concerned with the person than his/her disease. His practical examples for medical practice to incorporate practice specific screening tools were very valuable. HE_1 also voiced the need for further research on spiritual treatment (care) plans that could be incorporated into health (medical) practice. HE_2 described an integrated approach that focused on the details of a patient's lifestyle that could be modified to influence health and spiritual well-being. Her approach was very practical and described a treatment plan where a practitioner is able to assist a patient on a 'life plan' that incorporates the spiritual to achieve health goals. HE_3 with a background in psychology had concerns about spiritual care being incorporated within her discipline in an unethical manner. Despite these concerns, she also felt very strongly, that is should be included in health care and specifically psychology. Her experiences of 'good' and 'bad' spiritual care practices in psychology offered a lens through which spiritual care could be evaluated for being ethical, relevant and appropriate quality.

The rest of the chapter will unpack the various codes that emerged during the interviews with the health experts. These codes were refined through a second and third round of data analysis to identify theoretical codes that made up the various components of the framework.

4.2.1 Mid-level codes identified during the individual health expert interviews

Mid-level theoretical codes emerged through preceding coding cycles, but prior to the articulation in the framework. The following mid-level codes emerged in the interviews and subsequent data analysis with the three health experts, as seen in table 4.4 below.

Table 4.4 Theoretical codes emerging from preceding cycles of health experts' interviews

1. The ethical motivation for including spirituality as part of holistic health care
2. Spirituality as a resource or impediment to good health outcome
3. Various spiritual care interventions
4. The role of the inter-disciplinary team
5. Limitations and pitfalls of spiritual care

6. The need for spiritual care education in health professional training and continuous professional development

The first theoretical code identified underscores the importance of including spirituality in a health consultation and care plan. This was described by HE_3 as: "Spirituality is integral to the treatment of the patient. I cannot imagine not addressing the spiritual component as part of a holistic approach to a patient. But this is not only with regards to treatment, it is also about the assessment and diagnosis and everything that leads up to the treatment plan." The second code identified explores that spirituality could either be harnessed as a resource to improve a patient's health outcomes or, if misused, it could become an impediment to quality care and a patient's health, which could include causing mental and spiritual distress. HE_1 described this delicate balance of "using a patient's value system to guide them back to healthier living. But, this is delicate, as it can come across as accusatory or trying to convert someone to your value system. It is still something that needs to be explored." The third theoretical code describes various spiritual care interventions used by the health experts. HE_2 developed an approach to incorporate spirituality into the health consultation and specifically the spiritual-emotional needs of patients she calls *The Ride of Life* or the *Dynamic Cycling Method*: "I developed this model based on a bicycle and start the patient history looking at the two bicycle wheels. So the one wheel is my past and the other is what am I rolling out now, thus where am I going with my choices." The value of working as an inter-disciplinary team and knowing when to refer for specialist spiritual care was recorded as a code described by all the health experts as the fourth theoretical code. The fifth code describes limitations of spiritual care and possible pitfalls to incorporating spiritual care into the health consultation: "So sometimes we misuse the clinical context for spiritual reasons. And this can confuse and leave patients' in a religious crisis. This is a concern for me as sometimes practitioners can step outside of what is an ethical boundary. So if we are going to integrate spirituality in practice, it must have a rigid ethical framework, and part of that for me includes equipping people with the right knowledge" – HE_3. The importance of continuous professional development and incorporating spiritual care into health sciences curricula as a means to equip health professionals was coded as the sixth theoretical code that emerged during the data analysis. Each of the codes will be unpacked in further detail in the rest of the chapter to follow.

4.2.2 The ethical motivation for including spirituality as part of holistic health care

HE_1, during an interview, explained his own 'conversion' to believing in the importance of including spirituality in a health consultation and as part of holistic health care: "I have found (at least for myself) that when it comes to addressing spirituality in the health consultation, I first have to be comfortable with my own spirituality and worldview. I was at first very uncomfortable about my own spirituality and addressing patient needs in this context. I felt that it was as if I was having some sort of agenda. I was very defensive and felt as if I in some vague way I was going to impose my own opinions and worldview and intrude on someone else if I addressed this in the health consultation as I want to bring about some change to the

person. Then I realised that spirituality is a physiological feature of mankind. With that concept in mind, it is far easier to have just a human-to-human conversation with the safe assumption that spirituality is a physiological feature and that the conversation and language we use and have of spirituality may either be facilitating of the conversation or raise unnecessary objections. The realisation and perspective that this (spirituality) is an attribute of man, rather than a tool of therapy, is what I want to explore."

Narayanasamy (1999:123) affirms this belief of HE_1 that spirituality is part of the physiology of mankind: "Spirituality is rooted in an awareness which is part of the biological make up of human species. Spirituality is present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a transcendent God or an ultimate reality or whatever an individual values." The viewpoint of accepting spirituality as a physiological feature of mankind makes it easy to relate to health sciences and ultimately health care. Astrow, Puchalski and Sumasy (2001) ascribe the ethical motivation for offering spiritual care in health to its potential benefit to both practitioner and patient. Not only can it enrich the practitioner's professional experience, but it can improve the practitioner-patient relationship. Astrow et al (2001) argue that the crux of medicine is focused on the imperfections manifesting in the body – ultimately on life and death. These private matters are deeply entrenched in a patients' religious and spiritual concerns. Religion and medicine are therefore not in conflict with each other, but align to achieve similar therapeutic goals if addressed ethically and in a skilled manner. HE_1 stated that for him it is a therapeutic goal to have a human-to-human conversation when including spirituality in the consultation because by doing so he is better able to understand the patient's needs and how to address them. This person-centric approach is at the heart of the value of and ethical motivation for including spirituality in health care.

The WHO biopsychosocial-spiritual model of health (Yach, 2008) lists spirituality as the fourth dimension of health. Sulmasy (2002) defines a human person as: "A being in a relationship – biologically (physical), psychologically (mental and emotional), socially and transcendently (spiritual)." Whole-person care has to include all four dimensions as all of these have an impact on the physical (health or illness). HE_2 elaborated on the meaning that spiritual care will have, and the ethical motivation to include this, as dependant on the value that the practitioner places on its inclusion: "It is very important where the health professional stands in his own beliefs. You can talk about spirituality and not really believe in anything or you could talk about spirituality and have a deep, meaningful connection to it and sense of believing. If you just view spirituality as a modality similar to exercise or nutrition, then it becomes an add-on. To me, spirituality is the grounding. In practice, often a health practitioner will focus solely on addressing the physical symptoms and not take the spiritual and emotional dimensions into account. So I think the first attribute one should have is patience. One should be patient with your patient – give them time to talk and tell their story. Don't jump to conclusions too quickly and ask questions and have an open mind. Also create a safe environment for patients to share. Then they will."

HE_3 reiterated the importance of whole-person care, which includes the spiritual component during the consultation and treatment plan: "Spirituality is integral to the treatment of the patient. I cannot imagine not addressing the spiritual component as part of a holistic approach to a patient. But this is not only with regards to treatment, it is also about the assessment and diagnosis and everything that leads up to the treatment plan. My concern with this is that specifically in my field (psychology) people have been nervous about the difference and intersection of spirituality and religion and how to address this in practice. For me it is a devastating place for psychology as a field to be: If we are working in a 'sacred' space of the patient every day as a practitioner working with a person that is vulnerable and in pain; if we are not open to incorporating spirituality into our therapeutic model then I feel that we are managing that patient unethically. So while I am passionate about incorporating spirituality into our practice, I know that we are not doing it. And there is a whole myriad of reasons why we are not. And I am passionate about that. We need to do it, but we are not: and the question is how do we bridge that?" Quality spiritual care is rooted in the perceived value that health practitioners place on such care as part of a holistic approach. If health practitioners subscribe to the value that spiritual care adds to the clinical consultation, the best approach to offer such care can be explored.

4.2.2 Spirituality as a resource or impediment to good health outcome

Spiritual distress has been documented by various authors to be a contributing factor to negative health outcomes (Massey, Fitchett & Roberts, 2004; Pargament, 1997; Pargament et al, 1998; Fitchett et al, 1999). Religious struggle has been linked to poorer health outcomes, increased depressive symptoms, poorer quality of life (Fitchett et al, 1999) and increased mortality (Pargament et al, 2001), amongst others. The opposite is also true. The positive impact of religious/spiritual involvement (King, 2010) in patient well-being on mental and physical levels has also been documented. When experienced as a resource, not only does spirituality (King, 2010:5) contribute to fewer incidences of depression and suicidal ideation, but it has been linked in various studies to improved physical health outcomes such as blood pressure control. This was also reported by patients interviewed during this research to be the case both for spiritual distress as a negative impediment to blood pressure and glucose control, or as a resource. The health experts also discussed the perceived value of spirituality when included in the health consultation.

The question in health care at this point is thus not necessarily *if* we as health practitioners should offer spiritual care to our patients, but *how*. HE_1 discussed the types of spiritual support using a metaphor of styles of nurturing linked to gender: "There is both sort off a mothering and fathering aspect to offering spiritual support. The one being saying like: "I am here for your". Silence as the individual is expressing their hurts and frustrations…listening to the patient. This is very much the Hospivision (n.d.) approach. The other approach such as applied by Be-In-Health (Wright, 2005), is very 'fathering'; meaning that they deliberately instruct and give directions for recovering from illness. The one is thus very responsive and the other more initiating. Within a 'secular' health setting, the 'mothering' (if you would

excuse my use of these typologies) approach would probably more appropriate or patient-centric by definition. Where the 'fathering' approach would perhaps be seen as offensive. But, I think in ultimately of having their (patients') spirituality being shaped would be essential. Now whether addressing spiritual needs would ultimately go to the point of providing instruction on issues of correcting for instance negative religious coping is moving from the mothering to the fathering style of offering spiritual care and I think this is something ethically 'delicate' to transition. Because moving from the mothering to the fathering style; and if you are imposing your views of spirituality this would be considered a potential violation of patients in a vulnerable state. But not making use of dimensions that could alter a patient's lifestyle would also be negligent. And I would like to refer you to the structured equation models (Simpson, Hyner & Anderson, 2013) that look at the primary modifiers in the whole assessment of spiritual health outcomes: social support, mental health and risk taking behaviour. And so the ways in which those elements that are so vital to many health outcomes should also be framed are within spiritual health outcomes. And so not being able to respond to these modifiers could be considered negligent, because then you are not using a patient's value system to guide them back to healthier living. But, this is delicate, as it can come across as accusatory or trying to convert someone to your value system. It is still something that needs to be explored."

HE_2 also reiterated the importance of understanding the spiritual component as a contributor to disease, but also as a potential resource in managing health outcomes: "I would definitely like to understand the spiritual component and will probably ask questions such as: I would like to understand why I have this disease? Is this something in my lifestyle that is causing this? Is this God's way of telling me to slow down? Is it something in my surrounding – it there an environmental contributing factor that is causing this illness. So to me I would like to understand spiritually why I developed an illness."

HE_3 related her motivation to include the spiritual in a whole-person approach to care to a personal loss suffered, this becoming a driving force for including spiritual in health care treatment in her practice: "We suffered a loss a few years ago and in that loss I realised that it was not my profession (psychology) and what they could offer that brought me through that loss. They (the psychology profession/colleagues) ignored my spiritual beliefs and needs completely in the therapeutic process. So looking from interactions drawn from that period of my life, I think I would like to be understood and treated holistically and integrated as a 'whole' person. To be understood for what my core value and driving force is. How I live and understand my life. So often we call that worldview, and yes it is that, but it is also respect for another person's worldview. I would want a respectful exploration of who I am and why I am who I am. And a keen interest in what the core area of need is for my 'healing' to take place."

4.2.3 Various spiritual care interventions

The success of incorporating spiritual care is not solely dependent on utilising an appropriate screening tool. The manner in which this is implemented and the skills required to respond to patient cues were a prominent code during the individual interviews with the experts that

influenced the framework as it is presented in chapter 3. The health experts interviewed related both good and bad examples of incorporating spirituality as part of a health consultation or care process: "Having worked with pastors from a church's perspective they also refer inter-disciplinary to a health professional; and then someone can give advice or counsel that is contrary to the beliefs of the church. And then they (spiritual leaders) become reluctant to involve the clinical fields. So as Christians we are also not a homogenous group and have different beliefs and to have respect for that within our treatment is important." HE_3 reflected on working as an inter-disciplinary team with spiritual carers, noting that sensitivity is required from the health professional to acknowledge the importance placed on the views of specific religious groups when counselling patients and prescribing treatment. She also related this to her own approach when incorporating spirituality in her clinical consultation: "Regarding the good: there is so much I can say about parallel processes or tapestries and my therapeutic tapestry is not complete unless I have the spiritual thread running throughout. In my work I can work effectively with a patient over a period of time and there will be no breakthrough and then when I refer inter-disciplinary to someone that can address the spiritual component in this therapeutic model, then the 'breakthrough' for the patient often happens. I am looking at the tapestry as a whole, and there is someone focused on that one thread in the tapestry, the spiritual, and if that thread is pulled too hard…the whole tapestry can unravel. And therefore, we need to know how to work inter-disciplinary and to whom to refer. In my experience when you treat the patient as a whole, then the response that the patient has to the therapeutic process is often greater". – HE_3 during an interview on 2 Nov 2017.

HE_1 was involved with a research study conducted on the Be in Health programme (Wright, 2005). He recalled potential benefits of this inter-disciplinary spiritual health programme that linked clinical outcomes to spiritual care interventions. HE_1 (during an interview on 28 May 2017): "If I can just summarise my experience with the Be in Health programme, then I think the three things that I found as the core issues that were changed were:

1. Negative religious coping were turned around: such as God is punishing me, the devil is out to get me – whatever has left the patient in a perspective of rejection. The programme measured how one can address the negative religious coping aspects (of patients). Now this was a Christian programme and the people that enrolled for this, this was in line with their worldview. So having something that does that in a way that is consistent with your worldview. Now if you don't have the Christian or higher power worldview, then one can look at other dimensions within the fear, guilt, shame domain (Cronje, n.d.), the instruments that are used to assess fear. There is also now recently one that can assess bitterness. Not yet one for shame. So one can start with spiritual risk assessment looking at the 'fruit' issues that gives your reason to go to the 'root' issues."

"(The metaphor could be used) You have a urine test, now there is reason to go to the lab. The closest to this is Frankl's logotherapy (Frankl, 1959), but that is at the level of reason. Do you follow where I am going with this? So one can address the spiritual symptom with a soul-

based meaning. Victor Frankl (1959) concluded that what allowed people to cope despite suffering was if they had a meaningful relationship, a meaningful task/purpose or if they could endure suffering in a way that was meaningful to them. But logotherapy is interpretive, which is at the level of the soul.

"This is then about relevance within that health context, and for that patient. What also that health practitioner feels confident and competent to address, and knowing when to refer. Knowing what is for primary care level addressing and assessing of spiritual care and what is for a more specialised level of care."

"The **second** thing was that it gave patients that lack a spiritual language for their issues, a vocabulary to express their experience. This was empowering."

"The **third** value lay in providing a framework of relational support that was less dependent on others. So there was a way of separating the person from his/her sin and be able to still name the sin, but consider the worth of the patient. So it does not become a source of torment, but a way of resolution."

Walker and Breitsameter (2017) describe Frankl's logotherapy as: "A form of therapy based on the belief that patients should be able to give meaning and purpose to their lives. If this meaning is absent, people suffer from existential distress." The value of the spiritual care intervention described by HE_1 is that after a spiritual distress was identified, the intervention included assisting patients to define this distress for themselves and relate this distress to their illness and experience in such a way that they could recognise their own value and meaning and plan a way forward to manage it.

HE2 _developed an approach to facilitate the health consultation, and specifically the spiritual-emotional needs of patients, that she calls The Ride of Life or the Dynamic Cycling Method: "I developed this model based on a bicycle and start the patient history looking at the two bicycle wheels. So the one wheel is my past and the other is what am I rolling out now, thus where am I going with my choices. The saddle is my presuppositions, my assumptions and opinions – what am I 'sitting on'. The handles represent what I have my hands on – what am I steering to. So it is important where you are coming from, your experiences that shaped you and then also where you are going now and what choices you are making. So the pedals become the choices I make to steer my bicycle in a direction. If my past and my future are aligned and I sit well in my saddle, then you have a better ride. The ride of life. I use this kind of model to obtain someone's history and also see where they want to be or go. So if you for instance have a genetic predisposition or family history for a certain illness, then you must make sure that your choices do not 'unlock' the expression of the genes that can cause that illness."

"So the bicycle approach is similar to the Functional Medicine Framework, and these, to me, the important aspects to cover are: In the history, what happened to you and your family history; also not just diseases, but repetitive cycles and emotional or traumatic experiences?

What would trigger this? What attitudes that you have that mediates this experiences? Your triggers come through five senses – what you see, hear, touch, smell and then this follows a neurological path to link you to previous memories, good or bad. This is all part of the back wheel. Then I will find out what beliefs they sit on: for instance, an inner vow such as I will never date another man. That creates then circumstances that when they are confronted with this, they have a stress response that has an impact on the body and your health. Concerning a person's timeline, you can then go back to specific traumas and help someone to resolve that issue; and then I have seen how some patients improve in terms of their health outcomes, e.g. they can later reduce or stop their blood pressure medication." – HE_2 during an interview in Aug 2017. The approach described by HE_2 related to what HE_1 described. The bicycle metaphor helped patients to identify possible spiritual triggers or distresses, with the components of the bicycle assisting the patient to find language for the spiritual experience within his life story. HE_2 stated that in her practice, the next step would be to assist patients to relate what surfaced in the metaphor to meaning-making in a practical way with a daily care plan as a way forward.

The social and environmental context were described as not only having an impact on an individual's spiritual beliefs, lifestyle choices and health, but was viewed as an important consideration to plan for when and how to approach spirituality in a health consultation or treatment plan. HE_3, during an interview in 2017, remarked the following concerning this: "When you work in spirituality and religion, people can be susceptible, especially for influence, and this can be harmful or helpful. We have to allow for exploration of the influences of the patients' atmosphere and environment and how this impacts on their health. Especially with adolescents, one can see how their school and peer environment and the opinions of their parents and family of origin shape their worldview and influence their experience around health or illness. I have also seen wives that take over a year to access their own spiritual beliefs, because they subscribe to a religion where they are submissive to the opinions of their husbands and it takes them very long to unpack their own feelings regarding faith and religion. They keep silent not to be different to the norm. And then it takes time to get down to the deeper layers of their own personal belief."

The framework discussed in chapter 3 described eight principles as one of the components to the framework to describe an approach to incorporating spirituality in practice as it was revealed through the research process and its relation to existing literature. To understand the various types of spiritual care interventions, one has to determine what of the spiritual domains can be measured. Sulmasy (2001) suggests four areas that are measurable and have been explored in various research studies – those of religiosity, spiritual/religious coping, support/spiritual well-being and spiritual needs. Table 4.5 is a replica of examples that Sulmasy (2001) lists for each domain.

Table 4.5 Classification of spiritual and religious measurement domains in health care (Sulmasy, 2002)

Religiosity	Strength of belief, prayer and worship practices, intrinsic versus extrinsic
Spiritual/religious coping and support	Response to stress in terms of spiritual language, attitudes, practices, and sources of spiritual support
Spiritual well-being	Spiritual state or level of spiritual distress as a dimension of quality of life
Spiritual needs	Conversation, prayer, ritual; over what spiritual issues?

Sulmasy (2002) elaborates on this by adding that although in health care there is a tendency to screen for all of the above as under one domain of spirituality, each area has its own unique characteristics, implications for overall health and treatment modalities. Spirituality and its inclusion in the health consultations and treatment process has three dimensions of inquiry, and the manner and depth with which is approached should be appropriate to the situation. The three dimensions are spiritual screening, spiritual history taking and ongoing spiritual assessment. HE_1 and HE_2 both referred to the CSI MEMO (Koenig, 2004) and FICA (Puchalski & Romer, 2000) spiritual screening tools, which could also guide spiritual history taking during a consultation. The spiritual screening tools could be utilised to identify a spiritual need which could then be explored in more detail. The four questions asked during the CSI MEMO address all four spiritual and religious domains that Sulmasy (2002) lists as important to explore in the spiritual health of a patient. This was discussed as part of spiritual care models and frameworks in chapter 3. Table 4.6 below briefly lists the four questions.

Table 4.6 CSI MEMO (Koenig, 2004)

1. Do religious or spiritual beliefs provide you **c**omfort or **s**tress?
2. Do they **i**nfluence medical decisions?
3, Are you a **mem**ber of a religious or spiritual community?
4. Do you have **o**ther religious or spiritual needs?

HE_1 reiterated the importance of the health professional understanding *why* the inclusion of spirituality in taking a comprehensive health history is important. Not only does this recognise that this aspect of the patient's life is important, but it enables the health practitioner to identify where spirituality might contribute to disease, be a stressor or assist the practitioner to identify a spiritual need that could be incorporated in the care plan (Koenig, 2007). All three health experts referred to the amount of *time* available during a consultation as an important factor to consider when deciding which screening tool to use. Koenig (2007) recommends a single screening question when time is a limitation during the consultation: "Do you have any religious or spiritual needs or concerns related to your health?"

The HEs all indicated that the health professional should be aware that not all patients might be interested in having a religious/spiritual conversation. Once a patient expresses no interest in a religious or spiritual conversation, inquiry should shift to other resources for coping, which include sources of meaning and purpose and other cultural beliefs that may influence medical decisions. In a case where a spiritual need has been identified, a treatment plan or action is necessary. Often, this is the component of offering spiritual care in the clinical setting that is daunting to the health practitioner, as the question is *how* this should be approached. LaRocca-Pitts (2012) describes a spiritual history tool that also includes a guide for a treatment plan. It offers more than a spiritual history, as it includes questions on how to conduct a spiritual assessment. This tool is intended for use by members of the inter-disciplinary team, which could be a health professional or a spiritual leader (e.g. chaplain) and is known by the acronym FACT (LaRocca-Pitts, 2012). FACT can be used successfully in a short first-visit patient consultation, as long as the health practitioner established beforehand that the patient is open to the intervention and has ensured that he/she is not overstepping any possible boundaries that the patient might have. Table 4.7 below describes the four areas questioned with the FACT spiritual history tool (LaRocca-Pitts, 2012).

Table 4.7 FACT spiritual history tool (LaRocca-Pitts, 2012)

F: **F**aith (or beliefs) – What is your **F**aith or belief? Do you consider yourself a person of **F**aith? Or a spiritual person? What things do you believe that give your life meaning or purpose? **A**: **A**ctive (or **A**vailable, **A**ccessible, **A**pplicable) – Are you currently **A**ctive in your faith community? Are you part of a religious or spiritual community? Is support for your faith **A**vailable to you? Do you have **A**ccess to what you need to **A**pply your faith (or beliefs)? Is there a person or support group whose presence and support you value at a time such as this? **C**: **C**oping (or **C**omfort, **C**onflicts or **C**oncerns) – How are you **C**oping with your medical situation? Is your faith (your beliefs) helping you **C**ope? Is your faith or beliefs providing you **C**omfort in light of your diagnosis? Do any of your religious beliefs or spiritual practices **C**onflict with medical treatment? Are there any particular **C**oncerns you have for us as your medical team? **T**: **T**reatment plan – If patients are coping well, then either support or encourage or reassess at a later date as the situation changes. If patients are coping poorly, then 1. Depending on the situation and relationship and similarity in faith/beliefs, provide direct intervention, e.g. spiritual counselling, prayer, Sacred Scripture 2. Encourage patients to address these concerns with their individual faith leaders 3. Make a referral to a spiritual leader of patient choice

The need for the practitioner to assist the patient to express his/her spiritual experiences and distresses is an important component that emerged with all three of the health expert interviews. Spirituality and how this is expressed should be viewed within the context of the patient's culture and social network. If certain practices are part of the social bedrock and spiritual rituals of a group or population, then this inevitably impacts on how the individual relates to his spirituality and to others. This can be a very positive thing, but it could also have

a negative impact. HE_3 related this to how women in the South African context often feel that they have to first involve their husbands in their decision-making process regarding their health, as with other decisions, more so than Westernised cultures. Ancestral beliefs in South Africa and Africa, and the perceived impact that forefathers might have on one's health and well-being, was cited as important to consider in the spiritual care approach. Treating the patient as a whole was mentioned, in order to take into consideration a specific sub-group of a culture and individual beliefs within a psycho-social context. HE_3 also noted that health carers often assume that just because people subscribe to a certain religion (such as Christianity, which the majority of the South African population professes as their faith), it does not equate to a homogenous group where everyone believes the same things. The subtle individual, familial and larger contextual nuances in spirituality, faith and tradition should be taken into account when doing a spiritual consultation, whether it be history taking or making treatment recommendations.

Patients have a valid and professed need to be treated holistically. All health professionals can be equipped to skilfully and comfortably screen for spiritual distress or a spiritual need. The in-depth assessment and management of this lies within the inter-disciplinary team, which includes specialised spiritual care such as chaplains, traditional healers and whoever else might be appropriate, from the patient's perspective, to meet his/her needs.

4.2.4 The role of the inter-disciplinary team

Analysis of the expert interviews highlighted the importance of the inter-disciplinary team and clarity regarding scope of practice. The health professional screening and diagnosing for a spiritual need could be different from the professional offering spiritual care. Who takes on the role during spiritual care was raised as an important point during interviews with the health experts and also later on in the focus group with the inter-disciplinary team. Practitioners need to be comfortable about what they can do and know what to refer for. Patients need to understand the role of their current health provider in offering holistic care, and also where his/her limitations lie, as well as what the health professional will refer to another colleague or spiritual leader/carer for: "If a doctor is seeing a patient from the spiritual perspective – there was an example of this with a patient with lung cancer – so if we identify this spiritual crisis in a patient, who deals with what? And are we equipped to deal with this? So if a spiritual trigger reveals itself in a clinical context, who is going to deal with this? I feel that in a clinical context we have to understand in which context we are going to treat it: will it be the doctor? Or the doctor and the psychologist or counsellor? So we have to dissect who is going to address what. Working with spirituality and religion, we have to create a framework that creates opportunity for treatment and exploration, but practitioners can also be mavericks and venture in areas where they don't have the knowledge, and therefore we (health professionals) need to have clear boundaries." – HE_3.

Walker and Breitsameter (2017) carried out a qualitative study in a number of hospices in Germany that explored the significance of spiritual care offered at these health care institutions. The study reported on the advantages of defining spirituality beyond a single

profession, that of the spiritual leader. The health professionals (such as nurses and volunteers) that worked in these institutions were found to have a measurable impact on addressing the spiritual needs of the patients, irrespective of their personal spiritual beliefs.

Spirituality and the offering of spiritual care in a health context should be approached within an inter-disciplinary team that includes counsellors, ministers of faith and spiritual leaders that share similar beliefs with the patient where possible. This team should work together with a health team to address patients' needs holistically. Health practitioners need to know whom they can refer to for specialised spiritual health care and also how to address basic spiritual needs of patients. Practice-specific consultation tools should be available in hospitals and other clinical settings for practitioners to use and implement. These could be individualised to specific practice and patient needs. The framework discussed in chapter 3 offers all health practitioners the opportunity to familiarise themselves with an approach and specific tools that fit their practice best. All patients can be screened (even if a single question screening for a spiritual need is asked), to identify a possible need or spiritual distress. Management thereof will often be approached from a team perspective, which could include the practitioner referring to a specialised spiritual carer.

4.2.5 Limitations and pitfalls of spiritual care

The health experts related that practitioner skill and knowledge in identifying a spiritual need or distress is far easier to master than the experience required to address the need. Both HE_1 and HE_3 were very upfront about the limitations of health practitioners in general to be able to address issues that might require a specialist intervention. "I think that medicine's ethos in developing instruments for spiritual assessment is based on the principle of first do no harm and assessment. I think the shortfall currently lays with that the person doing the spiritual assessment might not necessarily be the right person to address the issue. I will give you an example as part of the essay I wrote as part of a short course I wrote for Hospivision on spirituality and pastoral care. So the reason why Hospivision and pastoral care is working in this area is that they actually want to bridge the gap between the health practitioner consultation and the addressing and assessing of spiritual health needs of the patients. The perfect instrument of assessing the need is not necessarily the perfect instrument to address the spiritual needs." It is thus imperative that when a health professional endeavours to enquire about spiritual distress, he/she also be comfortable with offering some counselling/spiritual support or cognitive behavioural therapy advice, and if not, is able to refer. The health professional should have a 'back-up' plan in cases where more intensive therapy is required or where a spiritual leader would be more appropriate to offer care – being equipped with possible health team members to refer too in such instances.

The interviews with all the health experts had a personal note to the conversations that transpired during the interviews; one could say it was partly because the interviewees were in-part familiar with me as the researcher, but another reason that stood out during the interviews was that all the health experts had found their own unique way of meaning-making regarding the complexities of patient cases viewed through their individual spiritual lenses.

For any health practitioner to create space for a patient to express his/her own spiritual beliefs and preferences, the health practitioner needs to be not only skilled in how to address these, but emotionally intelligent and spiritually settled in his/her own beliefs. "Spiritual diversity has been conceived as a challenge from early on" (Walker & Breitsameter, 2017).

HE_1 elaborated on the health practitioner's possible discomfort when engaging on spiritual matters in health by saying: "I think the first thing is that health professionals need to become comfortable with their own mortality. You would be uncomfortable about it, just as with an end-of-life issue. So I would say that whatever this instrument is, it probably should be part of something that allows people to identify with the discomforts within themselves. If one does not do that then the tendency to remain as the professional in a 'therapeutic stance' becomes an impediment or undermines the goal of assessing the spiritual needs. We have found this to be a universal dilemma with doctors. Our identity as therapists is thus somehow at odds with the nature of the conversation. We are therefore reluctant to formally incorporate this into the health consultation: Not because we shouldn't, but because we are incompetent."

"And so I hope that what this research of yours will reveal, to an extent, is that in addressing a patient's spiritual needs, we are also confronting our own need to have this resolved within ourselves, regardless of having different worldviews. People would argue that we shouldn't proselytise people to faith, but the very nature of medicine is to proselytise people to atheism. We have a stereotypical idea of what spirituality is, as opposed to what is our perspective on life."

Timing and the nature of the spiritual history inquiry needs to be fit for the individual patient case: "What it boils down to is, particularly if it is not a sterile instrument (such as a tick sheet) used to facilitate the conversation, the context should not only justify asking the question, but it should avoid creating further distress. For example, if one asks this question when a patient present with an emergency at a casualty, the patient might think he or she is going to die and this might cause more harm than help. The aspect then of sensitivity must come into the context. The nature of the instrument. For instance, a sterile fill-it-in form might appease our conscience, but I think it is a cop-out and does not do justice to what the therapeutic encounter should be regarding spiritual care." – HE_1 during an interview on 28 May 2017.

The in vivo quote from HE_1 crystallised the dilemmas health professionals face when incorporating spiritual care. Health professionals need to understand their own limitations in practice. It is also important that the health professional is comfortable with enquiring about a spiritual distress or belief different from his own. Research indicates that where health professionals oversee patients with religious beliefs different from their own, their limited knowledge can impact on how health care is offered due to the professional being scared of not knowing what the correct approach would be to show respect for another's beliefs and treat such a patient with sensitivity and humanity (Walker & Beitsameter, 2017).

When enquiring about spirituality, the health practitioner needs to adopt an open approach that is non-judgemental and reflects on spiritual sensitivity. "I have to stress that our communication should be better and that we should make enough time to have good communication with the patient and connect. Confirming and supportive environment are both important in my opinion. Care for the person. Quality care is really important. If I can refer to Mother Theresa, and in her biography she wrote to her mentors that she was depressed. This was, however, circumstantial, and because of being overwhelmed by the suffering of others. Medication here would not have made the difference. Therefore, we need to listen and not be prejudiced, take time and put a hand of care on someone's shoulder. To me, spiritual care is touching someone. Holding someone. There is more healing sometimes in the touch than the medicine itself." HE_2's description is similar to the Callahan (2013:175) relational model, which includes domains of spiritual sensitivity being conveyed by expressing "personhood, personal touch, being present, listening and singing".

HE_3 listed the concern of health professionals possibly crossing a boundary with a patient, or misusing the spiritual health discussion to transfer the practitioner's own beliefs onto those of the patient. "I am going to draw from my research to answer this question. One concern would be insecurities in the profession we would need to look at: The question is whether spirituality and religion is scientifically verifiable, or whether it is just something esoteric. My field is concerned with *why* we are going there and if it is really essential for addressing the psychology of the patient, or is this a separate field? And the question is asked whether this is verifiable through research and evidence-based medicine. And you and I know it is, but many do not believe that yet. The second concern with my patients, and I see this often: once they have recognised that they can speak freely regarding their spiritual beliefs, and then I get the question back from my patients what I believe. And psychologists are very reluctant about this. You get a very value-laden environment. We also know that value and neutrality is not possible in any case, and then I prefer to be honest. The concern is that it changes the rapport and relationship. So I see what patients do: they ask me if I am Christian and then I will say back to them – I can see this is important to you. Why is this important to you? Sometimes patients also will say to me – I know you are Christian, but I am attracted to another man. And so when you are Christian it changes the dynamic, and judgement can enter. So I have found that it (spirituality and religion) inevitably enters the room, and the question is, when it enters the room we should be equipped to handle this. And the question is, are we equipped to deal with this? Often the health practitioner ends up ignoring this or backtracks as they are not equipped or comfortable to deal with this.

Another concern that I have is sometimes you go to a practitioner and then encounter someone that is overtly Christian, and that influences the therapeutic process. So let me give you an example: I have a patient that came to me after having gone to see another psychologist that at some stage during therapy interrupted the process or reason for the patient's visit and gave the patient a 'prophetic word' that God wants her to have another baby and that she was being disobedient. The patient did not agree with the word and actually

stopped going to that psychologist. So sometimes we misuse the clinical context for spiritual reasons. And this can confuse and leave patients in a religious crisis. This is a concern for me as sometimes practitioners can step outside of what is an ethical boundary. So if we are going to integrate spirituality in practice, it must have a rigid ethical framework, and part of that for me includes equipping people with the right knowledge." The patient example given by HE_3 overstepped a number of the ethical guidelines described in chapter 3. The comments were judgemental in nature, not person-centric in seeking where the need of the patient was at that stage, and not seeking to comfort and bring about good spiritual qualities expressed, such as peace. If these guidelines are followed and the patient dictates the need and the context within which this should be addressed, then patients will not be placed in positions where they feel a boundary is crossed to the detriment of continued care within an appropriate context.

4.2.6 The need for spiritual care education in health professional training and continuous professional development

Walker and Breitsameter (2017) argue that "Spiritual guidance is to some degree independent of religious belief because it refers to a *spirit* or *inner core* of human beings. But this guidance needs assistance from professional knowledge considering religious rituals if the patients are deeply rooted in a (non-Christian) religion. Here, the lack of knowledge could be eliminated by further education as an essential but not sufficient condition." The success of this lies therein: that health professionals be trained and equipped with knowledge of how to manage different patient beliefs practically, but also themselves emotionally, being able to distance themselves on the one hand, but also engage on a level that the patient feels not only heard, but listened too. Seaward (1991) describes a health educational model for spiritual well-being, listing (1) distinct focus areas that could be included in health education to foster practitioner well-being, and (2) equipping the health professional to engage with patients in a meaningful manner that could achieve the goals of "an insightful relationship with both oneself and others, a strong personal value system, and a meaningful purpose in one's life." Denmark's first professor of Spiritual Care at the University of Southern Denmark (2017), Niels Christian Hvidt, describes spiritual care as "a holistic approach for people in need, focusing on their need for hope, meaning, and fulfilment. It is an effort that has historical roots before the biomedical expansion, but has recently been rediscovered as part of the desire to focus on the patient and the different patient needs encountered: psychosocial, existential and spiritual." The Danish model since implemented at the University of Southern Denmark has seven key research areas for spiritual health care, one of which is spiritual health education (University of Southern Denmark, 2017). Hvidt (2018) describes spiritual care interventions by listing the following activities: training, spiritual screening/history taking or assessment, communication tools, leadership models and patient courses. Health education for practitioners should be focused on equipping practitioners to address and overcome these boundaries in practice. It is exactly these skills that cannot be taught by knowing the framework or an outline of a spiritual screening tool (whichever it may be) but that should be taught in patient cases and

through clinical bedside experience. The skills and knowledge that should be incorporated into health education and assessed as part of comprehensive health care should include patient vignettes and personal accounts, reflection on the experience of others and oneself. The health experts interviewed emphasised the importance of the practitioner's ability to reflect personally and the level of comfort and skill that the health professional should portray to enable complex personal conversations with patients with different worldviews and beliefs. "So I have found that it (spirituality and religion) inevitably enters the room, and the question is, when it enters the room, we should be equipped to handle this. And the question is – are we equipped to deal with this? Often the health practitioner ends up ignoring this or backtracks as they are not equipped or comfortable to deal with this." – HE_3 during an interview in Nov 2017. HE_1 also discussed the importance of the practitioner skills and knowledge to go beyond the know-how of a list of questions. The positive is that the inclusion of spiritual care as a component of health education curricula has increased dramatically in the last decade. The concern is to what extent this is incorporated in an effective manner that will equip health professionals to incorporate spiritual care in a quality manner. Koenig et al (2010) found that although 84–90% of medical schools include spirituality and health care as part of their educational curricula, only 39% of health educators thought this to be of value. In general, the health institutions also viewed evaluating student competencies with regard to offering spiritual health care as unimportant, although they recognised a professed need from patients. The interviews with the health experts and other research participants confirm what the past research has shown: There is a need to enrich and expand the content of the learning to move beyond didactic teaching or assessment of knowledge, to include the acquisition of the necessary skills of to enable quality spiritual care as part of holistic health care.

Chapter 4 discussed six distinct theoretical codes that emerged in the analysis of interviews with the health experts. These mid-level codes contributed towards the framework with its various components as represented in chapter 3. In chapter 5 to follow, the analytic yield from the contributions of the patient interviews will be described.

Chapter 5
Findings for patients: Facilitating a person-centric experience that is both professional and personal

This chapter unpacks the analytic yield from the ten patients who participated in the second round of data collection for the research. The crux of the patient interviews revealed the personal importance and individual preferences that patients expressed regarding incorporating spirituality in health care: "It is important to create a human experience. It's not a clinical experience. You have to stay the clinician but you also have to be a human being." Patients described the value of spiritual care in meaning-making and managing their health: "Having a condition or diagnosis does not ultimately define who you are as a person. Framing a diagnosis as a smaller component of who the person is, what the significance of his/her life is and how to live a meaningful life despite this is part of the goal of spirituality."

The patient interviews revealed practical preferences cited by patients that were coded and taken up into the final framework as recommendations on how to implement the principles. The recommendations on how to implement the principles are described in greater detail in this chapter, unpacking the interviews with the patients to allow the reader to understand better which theoretical codes emerged during patient interviews, as well as where the patients, as research participants, confirmed what the health experts voiced during the individual interviews. The theoretical coding of the recommendations made by patients will be discussed in this chapter under four headings: general guidelines, how to do and what to do. The fourth component of the theoretical coding unpacks thirteen mid-level codes that emerged through the various coding cycles with a strong component of in vivo coding. Table 5.1 summarises the four theoretical codes that will serve as the outline of this chapter.

Table 5.1 Analytically extracted theoretical codes of patient recommendations for spiritual care

1. General guidelines
2. 'How to do'
3. 'What to do'
4. Discussion of patient mid-level codes identified

The patient mid-level codes were identified as a second layer of data extraction. There are thirteen mid-level codes that emerged through subsequent cycles of analysis. Table 5.2 lists the mid-level codes that will be discussed as the fourth and last component of the theoretical codes later on in the chapter.

Table 5.2 Mid-level patient codes on spiritual health care practices as they emerged from the research

1. Patients want spirituality defined within the health context
2. The importance of how spirituality is introduced in the health consultation
3. A person-centric approach to spiritual care
4. Establishing rapport and meaningful patient-practitioner engagement as a foundation for a spiritual interview or treatment plan
5. Practitioner sensitivity is required to accommodate different worldviews
6. Patient perceptions on the link between spirituality, health and disease
7. Patients value spirituality as a resource to transcend their health challenges
8. The role of spirituality in comprehensive chronic care
9. The importance of spirituality in end-of-life care for patients and their families
10. The role of culture in spirituality and health
11. Barriers to offering spiritual care
12. Conditions conducive to quality spiritual care
13. The link between spirituality and nutrition

Similar to the health expert interviews, a brief background and summary of each patient interview will be given before the codes that emerged are discussed.

5.1 Description of individual patient interviews

Ten patients were interviewed at the High Performance Centre in Pretoria, South Africa. The patients were enrolled for a chronic disease management programme offered at the facility. The programme included monthly group sessions for the programme participants that focused on self-care education, which included spiritual care. This was offered by myself, the researcher, as a medical doctor employed by the health insurance company Bestmed at the time. The programme manager at the facility invited all the participants to volunteer for an interview via email. Patients were recruited on a first-come, first-served basis.

Patients interviewed had various diseases ranging from dyslipidaemia, hypertension and diabetes to breast cancer or another debilitating chronic condition (e.g., chronic lung disease). The age spectrum of patients interviewed ranged from 40 to 70 years old. Male and female participants from various cultural and religious backgrounds participated in the study. The interviews were scheduled individually between 28 June and 5 July 2018. Table 5.3 below is a brief summary of the individual patient interviews.

Table 5.3 Brief summary of interviews with individual patients

Patient no	Brief case summary and highlight findings
1	Female participant diagnosed with a chronic deteriorating lung condition that has had a significant impact on her health and functioning over the last few years. She described her beliefs as being non-religious, and contemplated whether she was spiritual. She was, however, open to applying spiritual practices if this could benefit her health or overall well-being. The participant was doubtful as to whether spirituality should be approached in practice as

	she was not sure how it could professionally be linked to good clinical practice. The patient described the following as important to her when a health practitioner engaged her on the topic of spirituality in a health context: She wanted to be seen, heard and understood from within her context and perspective. Principles that were identified during her interview included: • A person-centric approach that is sensitive and open to exploring her beliefs, at her pace and within a framework that is familiar to her • She considered creating a supportive environment through verbal and non-verbal communication and through activities offered on the programme as an important spiritual resource Although she professed to be non-religious, unsure about whether she would describe herself as spiritual, the patient still voiced a need to be cared for from an emotional and spiritual perspective. Death and dying, and the need to talk about this, especially when faced with a chronic condition, was mentioned more than once by this patient.
2	Female participant who described herself as spiritual, but did not belong to a specific religion. The patient linked grief and negative emotions to her (and others') illness as causative or contributory agents. The patient listed the following principles as being of value when offering spiritual care: • Practitioners should be open to varied patient responses and sensitive to patients' preferences (person-centric approach). Some patients may be hesitant, others defensive or have strong opinions. • Sensitivity in approach and also sensitivity to someone else's worldview: "We must be very aware that other people may have a different truth. One should be sensitive and aware that one doesn't necessarily have the right answers. And the other person may have answers that the health practitioner thinks are totally wrong but that person may have taken a long time to arrive at. It's not the health practitioner's duty or even place to try to convince a person to be aware of *the greater picture*." • Non-judgemental • Sympathetic and empathetic • The doctor must make *time* to *listen* to his/her patient • Create an environment that feels safe and generates trust
3	Female participant. Patient belonged to the Christian faith, but also viewed spirituality from the perspective of spirit, soul and body integration. The patient emphasised that it would benefit the conversation if the health professional first described what was meant by spirituality if asked about this during a consultation. Principles listed as important by the patient included: • Building rapport with the patient

	• Creating an experience where the patient feels that the quality of the conversation and consultation, also with regard to time, recognised their humanity • Seeing the patient as a whole person: recognising that a patient is more than his/her illness or current symptoms; and that a presenting complaint/condition needs to be addressed from a holistic perspective
4	Participant was a Christian and she believed strongly in each person's uniqueness and value. She confirmed what most patients reiterated: Patients are open to the idea of exploring their spirituality as part of a health consultation and treatment plan, but few have seen this happen in practice. The patient expressed that health practitioners (doctors) often do not spend enough time with patients during a consultation to have a discussion that is of value with regard to their spirituality. Important principles identified by the patient include: • The importance of quality and quantity of time with a patient • Exploring health and other problems holistically • Acknowledging the personhood of the patient beyond the presenting complaint was a theme throughout the consultation (person-centric approach) One of a few patients that could recount a consultation with a health practitioner where the spiritual components of care were also addressed. This was of great value to her. The communication skills, contact time and experience of being heard by someone all contributed to her having felt that it was a quality and valued experience. Patient also asked what the *boundaries* of addressing the spiritual needs of a patient during a health consultation and treatment plan were: One of two patients that expressed this concern. Inhibiting factors or barriers that came up during the interview included: the patient having a different belief or approach to spirituality than of the health professional and spending an appropriate amount of time with the patient to be able to discuss this in a resource (time) constrained health environment. A quality consultation in her mind included whole-systems thinking and a whole-person approach that accommodated the spiritual and also the individual worldview of the patient. Many patients, similar to this interview, described spirituality in health care as being linked for them to feeling recognised as important as an individual with inherent value, and also feeling heard for their presenting problem.
5	Male participant who professed to be Christian, but who was also open to African traditional medicine practices as part of his health care. One of two patients that linked their spirituality to nutrition on a personal level as having been of benefit to him. This has also been confirmed in the literature by various authors (Leaf, 2016), by the interview and by the Functional

	Medicine Model (Institute of Functional Medicine, 2014) that was used by HE_2, as described during her interview. The crux of health and nutrition as part of spiritual practices describes the link to spirituality and what we eat, how we eat and what we think when we eat. Linking spiritual practices to daily 'routine' such as eating to improve health overall, including mental health. The code that emerged with the interview with HE_2 and this patient who described the role of nutrition (including herbal medicine) was incorporated into the final framework. The patient defined spirituality as: "Being connected to God, that is my spirituality and just from time to time, I just have my quiet moment where I can just meditate to God through prayer." The following principles were listed as important: • The practitioner should be sensitive and accommodating towards the patient's worldview (person-centric) • Good communication skills (verbal and non-verbal) were raised by most patients as either a barrier or a resource in creating a conducive environment to having a quality spiritual health conversation. Moreover, the patient linked how one communicates (verbally and non-verbally) with the experience of having had a significant spiritual encounter in a health treatment context. • Creating a context that is honouring and accommodating: where patients and professionals can relax in being, expressing their beliefs without hindering one another's views The patient mentioned ancestors an important part of his traditional upbringing and greater family context. His personal narrative confirmed that health professionals need to be sensitive and equipped to deal with the interlinking of various cultures and religions, especially in the African context.
6	Female patient who strongly voiced that she considered incorporating spirituality in health relevant and of importance. She confirmed that she would be open to discussing this with a health professional, but felt there should be enough time. The patient was a retired health professional herself: She was an occupational therapist, with experience as an advisor to an inter-disciplinary team on holistic health care. In her personal life, in later years she developed more than one chronic condition, overcame breast cancer and lost a partner to suicide. The interview with her was multi-layered, with rich discussions on the complexities of dealing with one's own grief and health and illness questions through the lens of spirituality and religion. She listed the following principles for spiritual care during a health consultation: "First, create good rapport" "Establish a relationship of trust"

	"Take enough time" "Take care to create the right context and environment" A person-centric approach entails looking at the family, the social context and also the duration and level of trust in the patient's relationship with each of the members of the inter-professional team when deciding who should introduce the spiritual care and attend to it throughout the treatment plan. Informed consent and the patient's right to decline spiritual care should be honoured. Practitioner competence is required to meet the patient's needs and expectations during the consultation, whilst using language that is easily understandable. Allow the patient to list the order of importance of the care plan, as well as the order of importance that spirituality plays and how they live that out. Honesty with one's patient should be upheld and expressed in an honouring manner. Communication should be affirming and confirming of the patient. She mentioned a possible impediment when introducing spirituality during a health consultation: that either the health professional or the patient might lack the capacity or openness to look at care within a broader context and discuss this comfortably. The participant defined her view on spirituality as: "It's more than religion. It's also, as one would say, you know, mindfulness and your inside *gut feeling* that you've had." She stressed that spirituality is very important to her owing to her chronic disability: "It (spirituality) is playing a bigger role in my life than before." She described how she utilised spiritual resources do deal with the debilitating effects of her disease over time. She links spiritual resource to 'cognitive reserve' and emotional well-being. The following threads came out of this conversation: • Suffering in perspective of others' suffering as a spiritual resource to foster gratefulness • Meaning-making as a spiritual resource • Especially when having faced the death of a loved one or facing a chronic illness, patients want to explore their own frailty, mortality, issues of life, and concerns around death and dying • Dealing with anger, regret or guilt as emotions that had a perceived impact on her health • Accepting one's current condition – that you are not your diagnosis, that having a disease, does not have to mean you are 'handicapped' The reward of working with patients over time to achieve certain health goals came out in the interview with this patient from her own professional experiences: to see and inspire progress, to employ a myriad of tools and not only prescribe medicine.

	This patient's view of spirituality linked well to the transcendence model described by Cloninger (2010; 2013) and the logotherapy model of Frankl (1959) that is focused on meaning-making in suffering, which were also mentioned by HE_1. This patient strongly expressed that, in her opinion, without spirituality a person cannot move on and deal with the tragedies of life. She summarised the goal of incorporating spiritual care as: "Having a condition or diagnosis does not ultimately define who you are as a person. Framing a diagnosis as a smaller component of who the person is, what the significance of his/her life is and how to live a meaningful life despite this is part of the goal of spirituality." Her words on clinical care directly opposed the traditional 'objective' care approach. Patients want a professional experience, but they also want to attach a personal meaning to it: "It is important to create a human experience. It's not a clinical experience. You have to stay the clinician, but you also have to be a human being."
7	A female patient considered spirituality relevant but emphasised that she would only be open to discussing this with a health professional if he/she held a similar spiritual/religious view to hers. The participant was a Christian by faith and listed prayer as an important practice in her spirituality. She was concerned about the cost implications if spiritual care were to be added to the treatment modality. She listed the following principles as important to care: • Creating a relationship of trust • Spending quality time with patient
8	A male patient who felt comfortable that spirituality should be introduced as part of holistic care. He was, however, cautious that the timing when offering spiritual care and the reasons for doing so should be appropriate. The participant was a practising psychologist at the time and expressed that in his view this would not be fit for his practice. This linked to what HE_3 raised as a motivation for her PhD research in psychology and incorporating spiritual care. According to both participants, the psychology health discipline had very strict guidelines that often inhibited spirituality as a topic being explored during a consultation. He did, however, stress that he sees value in incorporating this into clinical care. He felt that a possible impediment might be that some patients would not be open to discussing this with a health professional. The patient professed to be a Christian and also considered himself as spiritual. The following principles were listed by the patient when introducing spirituality in health care: • Ensure that the patient is comfortable and at ease • Incorporate verbal and non-verbal communication (including appropriate physical contact) that makes the patient feel heard and respected • Allow the patient to dictate the importance of spirituality

	• The importance of the inter-disciplinary team and early establishment of who will take the lead on the spiritual component • Spirituality should not be offered as 'the quick fix' to all health problems • Spirituality could be utilised as a resource to make peace with and work towards acceptance of a diagnosis or disease
9	A male patient, originally from the USA, who immigrated to South Africa over two decades ago. One of a few patients who has gone for spiritual 'coaching' and health lifestyle consultation sessions with a holistic approach in the past. He was a pilot in the army and is also a scientist. The patient described his beliefs as being spiritual, but not religious. He expressed clearly that he benefited from these sessions to manage his health (and illnesses) and overall well-being. Patient voiced that he was open to spirituality during a health consultation, although he is not religious, because to him there was a component to health and diagnosis and treatment that is intuitive…that lies beyond cognition. Principles for offering quality care expressed by the participant included: • The health professional should be competent to discuss issues of 'risk and dying'. He, similar to other participants, reiterated the importance of end-of-life discussions in spirituality • A person-centric approach • Incorporating spirituality as a routine part of care, as normal as a physical examination or social history screening • The health professional needs to be comfortable approaching this topic with a patient • Good communication skills include honesty and an open approach • Creating a relationship of trust The patient described the benefit of exploring spirituality in a health context in relation to his personal health, saying that when he learnt spiritual tools for self-regulation of his emotions and behaviours, his clinical 'indicators on his blood pressure and glucose levels controlled better'. The following quote describes how the participant linked his clinical health outcomes to his emotional and spiritual state: "It took me a long time to accept the fact that I'm creating my blood pressure. I have used anger as a drive throughout my entire life." He described the following outcomes for what he would describe as a successful spiritual health session: • The health professional enabled the patient to do better self-care by introducing spiritual tools that can be applied personally by the patient • Creating a space that enabled the patient to self-explore and become more self-aware – in his words '*a better feedback system between me and me.*' • The health practitioner assisted the patient to find inner peace
10	A male patient with a tertiary qualification. He was an elderly, retired professional and professed to be both a Christian and a believer in the value of

	traditional healers and ancestral worship. He linked faith, spirituality and ancestral 'counsel' via a traditional healer in this quote: "The concept of body, mind and soul and the link between God the Father, the Son and the Holy Spirit; that is what the traditional healers are actually doing: to find the problem that this person has. This obviously is something that is worrisome to the patient. Either the patient is fearful or the patient has some guilt or the patient is feeling shameful for something that he or she has done. Now what they (traditional healers) do is to find out what the problem is. And they will then listen to the patient telling them their problem. They will then prescribe something and assure the patient that this is going to help you, but it's a question of faith. Do you believe in that or don't you believe in that? So, it's a faith." The participant reflected on the importance of an inter-disciplinary team, including the role of a chaplain or pastor and also a traditional healer. He recounted how each of these professionals at some point in his personal health or that of a close family member assisted their family in the integration of spiritual beliefs and concerns with the diagnoses and treatment plans. He motivated for this to be formalised in clinical care practice: "I believe the medical health professionals' body and these traditional leaders somewhere higher up, they need to try and form a coordinating body where they can work together." Principles considered important by the patient included: • Looking beyond the symptoms to the patient's family history, social context, seeing a person and not a disease (person-centric approach) • Spending quality and quantity time to address the patient needs The following quote described his thoughts on when to introduce the spiritual component of care: "At the beginning…bring in the spiritual thing in the beginning and then the other things will follow on, even the prescription, because once the spiritual comes in it affects both of us, and to me the Lord will speak to both of us." This participant, similar to another patient interviewed, mentioned the role of nutrition and that to him this is linked to his spiritual practices and health: "I'm on chronic medication for sugar diabetes and hypertension. Now I pray a lot for healing but we are told that, no, this is for life. Once you are on this medication, this is for life. Now I've been trying some herbs, reading a lot of books on herbs. There are two herbs that I found that I've actually grown in my yard. Rosemary and basil. Rosemary leaves, I prepare in a teapot, pour hot water; and then I take half a cup to a cup on a daily basis. That's what I did for a week, and within a week my sugar level had dropped from 6 to 4.2."

5.2 Patients' contributions to the framework

Much of the analytic yield from the health experts contributed towards the principles as the first component of the framework. Patients, in turn, contributed more to the practical implementation and the importance of the personal experience. Their recommendations for implementations and emphasis on the personal experience were taken up in the quality

requirements to the principles, as the second component of the framework. Although they contributed mostly in these respects, they also contributed towards the other components of the framework. In chapter three, the patients' inputs are integrated into all six components of the framework.

In the framework presented in chapter 3, the recommendations component describes the following dimensions as shown in table 5.4 below. These components were strongly influenced by the coding that emerged through the analysis of the contributions from the patients.

Table 5.4 Recommendations on how to implement the principles in the framework as one of the six components of the framework

Recommendations on how to implement the principles	1. 5 **W** questions for spiritual health care 2. General guidelines on applying the principles 3. 'How to do' from the perspective of the patient *and* practitioner 4. 'What to do' from the perspective of the patient *and* practitioner

The discussion that follows on the codes identified after analysis of the patient interviews follow similar headings to the recommendations above. The general guidelines on applying the principles, 'how to do' and 'what to do', were theoretical codes, captured as headings in the framework, identified after repeated cycles of analysis and levels of coding the data from the patient interviews. The 5 W questions were only added at the end with all the inputs from all three sources of data – health experts, patients and the inter-disciplinary group – as similar questions were asked by all three sources of data.

In the draft framework with the expanded patient theoretical codes, most of the codes identified were left in their original format with in vivo quotes making up most of the first-cycle codes. During the second cycle of coding, similar codes were grouped together under specific headings. In the final framework, the codes identified were added under of one of the components in the framework: principles, quality requirements for each principle, recommendations on how to implement the principles, catalysts, impediments and spiritual health tools. Most codes identified during the repeated coding of the patient data were similar to codes identified during the data analysis of the health experts' interviews. One new theoretical code that was added to the framework was that of *general guidelines*. In the final framework, this is captured as the third component: recommendations on how to implement the principles (as described in table 5.4 above). Although none of the eight principles captured in the final framework emerged for the first time during the patient interviews, the discussions with the patients helped crystallise the strategy needed to successfully implement

the principles. The analysis of the data from the second round of data collection with the patients coded all the principles that were initially identified through the health experts' interviews as relevant within spiritual health care.

The patients' examples and suggestions were coded and grouped together as recommendations on how to implement the principles. As part of the dimensions of the recommendations, the first dimension describing general guidelines was written as a product of the first two rounds of interviews, despite being derived from health experts and patients. The patient interviews, however, revealed practical preferences cited by patients that were coded and taken up into the final framework as the other two components of the recommendations, namely 'how to do' from the perspective of the patient *and* practitioner, and 'what to do' from the perspective of the patient *and* practitioner. The recommendations on how to implement the principles are described in greater detail in this chapter, unpacking the interviews with the patients to allow the reader to understand better which new codes emerged during patient interviews and also where the patients as research participants confirmed what the health experts voiced during the individual interviews. The reflections on the coding of the patient interviews will be discussed in this chapter under four headings: general guidelines, 'how to do', 'what to do', and mid-level theoretical codes that emerged during the patient interviews with thirteen specific codes. The four theoretical codes, as the outline for this chapter that was taken up into the final framework, are summarised in table 5.5 (similar to table 5.1) below:

Table 5.5 Analytically extracted theoretical codes of patient spiritual needs

1. General guidelines
2. 'How to do'
3. 'What to do'
4. Discussion of mid-level theoretical codes identified

Each of the four categories of codes will be discussed throughout the rest of the chapter.

5.2.1 General guidelines

The following sixteen general guidelines emerged in the coding of the patients' interviews:

1. A spiritual screen or history should be taken routinely for all patients.
2. All health professionals should be able to do a basic screening for spiritual distress, ask essential questions to identify needs that patients might have, be comfortable recommending spiritual care as part of a treatment plan, and know when to refer for specialised spiritual care and to whom.
3. Spiritual care is part of a holistic care plan that includes resource material, referral within the inter-disciplinary team and counselling for self-care.
4. A spiritual history should include that the health professional explore with the patient a possible link between his/her perceptions of his own health and spiritual or emotional distress, and weather this could contribute to the patient's health or illness, including an exploration of possible patient spiritual stressors and resources.

5. Spirituality as part of a holistic care approach should be addressed within the context of the inter-disciplinary team; it should also be clear which health team member will take the lead on the spiritual component to ensure continuum of care and a relationship of trust that strengthens the patient's perceived value of the spiritual care component
6. When approached about his/her spirituality, this should be defined for the patient in a way that is comprehensible by the patient and clarifies the relevance thereof in the health context and for the patient's own life context.
7. Spirituality and spiritual care should also be described for what 'it is not': Spirituality should not be offered as 'the quick fix' to all health problems.
8. The patient should also be aware that he/she has the right to not discuss spirituality as part of a consultation and care plan.
9. The motivation for including a discussion on spirituality should be clearly communicated to the patient: To assess possible resources/strengths and spiritual-emotional impediments to health and to offer alternative treatment to be included as part of a holistic care plan to address specific needs.
10. Exploring patients' spirituality and beliefs should be a process in which the patient is given an opportunity to take the lead, make the call on how in-depth they want to discuss this and also its importance to them personally, including the relevance and application in the health context.
11. The patient's personal narrative is just as important as the clinical history and patients should be given the opportunity to explore this in a health context as part of history taking.
12. Ethical principles to be adhered to include being non-judgemental and sympathetic, honest, congruent, genuine, respectful and sensitive.
13. Respect for the patient's autonomy – including obtaining informed consent, honouring confidentiality and establishing a relationship of trust – is an important principle to adhere to in establishing a meaningful discussion relating to spiritual needs and care.
14. Patients might be concerned about what the boundaries and limitations are when addressing their spiritual needs during a health consultation and treatment plan, and this should be discussed as part of spiritual care.
15. The practitioner's worldview or spiritual stance should not interfere with the patient's preference, and should be dealt with carefully (if ever shared).
16. Practitioners should consider that non-religious patients or patients that profess to be unsure about whether they consider themselves as spiritual, still profess a need to be cared for from an emotional and spiritual perspective that is supportive.

The patients' perspectives on a person-centric approach were a strong theme during the patient interviews. Patients made specific recommendations on how they want to be approached with regard to spiritual care. Patients also expressed that they have personally

experienced or knew of someone who had placed a too *high value or expectation* at times on spirituality to resolve an illness or medical problem and that this should be managed within the health consultation. The option to decline spiritual care were also raised as an option to be explicitly stated by the health professional. Patients described specific experiences with regard to spiritual care or the lack thereof. The patient vignettes, together with their recommendations, were coded into two practical categories: 'How to do' and 'what to do'. The next category that will be discussed is the 'how to do'.

5.2.2 How to do

The following seven recommendations on how to implement spirituality in practice were identified during the coding of the patients' interviews:

1. Patients want to have both a professional and a personal experience: For a patient to engage meaningfully on a spiritual level requires that the practitioner meet the patient as a human, allowing for vulnerability, connection and open sharing. Patients want to feel that the health practitioner is genuine and honest.
2. Health professionals should be sensitive about patients' concerns that the health carer's spiritual views and preferences are not imposed on the patient.
3. Practitioners should be open to varied patient responses and be sensitive to the patient's preference.
4. A person-centric approach should include that the health practitioner is sensitive and open to exploring patient beliefs at a pace that is comfortable for the patient and in a framework that is acceptable to him/her, supported by words that comfort and support him/her.
5. The doctor must make enough time to listen to the patient. This includes creating an environment that feels safe and generates trust.
6. The health professional should relate and integrate the spiritual component in a meaningful way to the patient assessment and treatment plan.
7. Seeing the patient in his/her context includes seeing his/her abilities, family, dreams and goals, current challenges and how this health issue is influenced by his/her life story.

The approach listed under 'how to do' was refined by the patients' inputs. The descriptions of each of these items were a product of the interviews with the patients. The interviews with the health experts also alluded to the point that for spirituality to be included meaningfully in a health discussion with a patient, it requires that the health professional 'let go' of the professional stance. Patients affirmed this by listing the value of having both a *professional and personal experience* in such a context. Time (spending enough time with a patient) and also timing with regard to when and how to introduce the topic of spirituality were discussed by all the health professionals and patients that participated in this research. A person-centric approach that acknowledged the patient and the practitioner as a human being within a greater context was a core principle that emerged as a golden thread throughout all discussion during the research. Meaning-making and assisting the patient not only to come

to terms with a diagnosis or condition, but to live a life of purpose, were reiterated by the patients as an important component of not only the impetus to include spirituality, but the outcome as well.

5.2.3 What to do

The following five recommendations on what to do to successfully implement spiritual care in practice were identified as codes during the analysis of the patients' interviews:

1. A compassionate approach with good communication skills that enables patients to explore their own spiritual-social resources to improve their health and disease management is preferred by many patients above asking direct questions related to their spirituality.
2. The health professional and the patient do not have to share the same faith to share similar values. Spirituality and adhering to principles that reflect quality care is still attainable.
3. Death and dying and making peace with one's own mortality should be addressed as an important theme to discuss for patients that have a chronic condition.
4. Spiritual resources include meaning-making, self-acceptance and peace. Practices that include mindfulness and self-awareness should be explored as part of a treatment plan. For patients living with a chronic illness, this should be included in the treatment regime as part of fostering transcendence and 'life beyond a diagnosis'.
5. Lifestyle factors that include exercise, nutrition, sleep, work and relaxation and their link to mental and spiritual health should be explored as part of a holistic health approach for patients.

This analysis and the coding of this section were initially included into the draft framework as 'what to do'. The codes complimented existing ones that were identified by the analysis and coding of the data yield from the health experts. The codes identified during the health expert interviews were expanded on during the interviews with the patients and contributed towards the construct of theoretical codes. New concepts that emerged here from the patient interviews included: 'Health professionals underestimate the value patients place on good communication.', 'Often, a good consultation is solely perceived based on how the issues were discussed and addressed, rather than what the clinical content was.', 'Health professionals often feel uncomfortable when treating a patient with a different spiritual belief or worldview if they have to address this component of care with a patient.', 'Health professionals should be taught to recognise and manage these emotions and discomfort and then focus on similar values shared that could foster a connection between the health carer and the patient.' and 'The focus should remain on assisting the patient in terms of his/her spiritual needs and preferences.'

The topic of death and dying was often avoided by health professionals. Many patients spoke on death and dying and preparing for this within a holistic approach that incorporated their spiritual beliefs, as a concept that they would want their health professional to explore with

them. Unfortunately, most also said this was never raised by their health carer in the past, despite them having various chronic diagnoses. Health carers should be taught how to broach this issue with comfort and tools that can assist the patient to foster the spiritual resources as listed here through his/her own experiences and preferences.

The value of nutrition as part of a spiritual ritual was mentioned by two patients: one who used herbs in a traditional African context together with his medicine prescribed by his physician to address his chronic condition, and a second who referred to the link between food and nutrition and mental health. The latter patient's experience resonates with the approach recommended by HE_2. One patient cited the work of Dr Caroline Leaf (2016) as of personal value. The Functional Medicine Model (Institute of Functional Medicine, 2014) fits what was described by this patient as part of a personal health regime that indicated the importance of nutrition on mental/spiritual health as a resource. Health practitioners should include spirituality in the management of chronic diseases by utilising this as a resource for patients towards making lifestyle alterations.

5.2.4 Discussion of codes that emerged during patient interviews

Thirteen codes were identified during the analysis process, where the in-vivo codes of the patient narratives captured the essence of the patients' inputs and added to understanding of how to practically implement the principles and recommendations to attain quality spiritual care as a component of the framework. The 13 codes are listed in table 5.6 below (similar to table 5.2).

Table 5.6 Mid-level patient codes on spiritual health care practices as they emerged from the research

1. Patients want spirituality defined within the health context
2. The importance of how spirituality is introduced in the health consultation
3. A person-centric approach to spiritual care
4. Establishing rapport and meaningful patient-practitioner engagement as a foundation for a spiritual interview or treatment plan
5. Practitioner sensitivity is required to accommodate different worldviews
6. Patient perceptions on the link between spirituality, health and disease
7. Patients value spirituality as a resource to transcend their health challenges
8. The role of spirituality in comprehensive chronic care
9. The importance of spirituality in end-of-life care for patients and their families
10. The role of culture in spirituality and health
11. Barriers to offering spiritual care
12. Conditions conducive to quality spiritual care
13. The link between spirituality and nutrition

The respective mid-level theoretical codes will be discussed throughout the rest of the chapter. The in vivo codes and patient experiences depict the importance of the approach when incorporating spirituality into health care.

5.2.4.1 Patients want spirituality defined within the health context

The definition, scope and approach to spirituality in the health context is a question that patients and health professionals alike grapple with. Walker and Breitsameter (2017:2241), in a qualitative exploration amongst hospice patients, found the "definition of spirituality proved to be highly indistinct." In my own research, not only did the health experts interviewed discuss their uncertainties of how the topic and concept of spirituality should be approached in various clinical settings and health professions, but much uncertainty still lies amongst the professionals regarding who would be the best person to approach spirituality and what would be the best way to incorporate this into practice. The patients interviewed highlighted that health care users shared similar concerns. Most patients started the conversation during the individual interviews with a clarifying question on what my/the definition of spirituality in health care was? The in vivo quotes below capture these concerns voiced by the patients during the interviews in June-July 2018: "If you want to approach this (spirituality and health) with a patient, one first has to define what is meant by spirituality. It's such a wide thing and to me spirituality means being aware, respectfully, of the whole creation. So I think from a health perspective yes, of course, you're not little compartments. You know, it's part of your being. I think it is relevant but it has to be handled very carefully so people don't take offence. I see spirituality as being aware of a higher being and having great respect for other people's point of views."

"It will depend to me on the time that we have available. I believe mindfulness and looking at spiritual abilities or inner strength and developing that can impact on your health. I also think it is important for the health professional then, if she wants to discuss it with me, to define the concept of spirituality because people, not me, but people will sometimes think only in terms of it as their straightforward religion."

"I am open-minded about life and thoughts and things, so to me, really, there would be no issue. I don't even know if there's anything that I would not be able to talk about."

"I think most people, especially the older generation, maybe we're still looking at the doctor or the medical practitioner from a medical point of view. And if you waste my time by talking about other things...now, then you're not doing your job. And I don't want to pay you for that. So I really think it's important to...let the patient understand. And then of course you will then find all the aches and pains that is there psychologically and not only medically. And. you know, the reasons why you become overweight and the reasons why you don't want to gym, and so on..."

The health professional should take caution in not making assumptions of shared spiritual expressions (Walker & Breitsameter, 2017) just because a similar religious belief is shared. On the other end of the spectrum, even those that profess not to be religious can still be spiritual (McSherry, Cash & Ross, 2004:938). One of the patients interviewed by Walker and Breitsameter (2017) stated: "Everyone is spiritual whether they know it or not." This is echoed throughout the findings of this research, as is evident in the discussions with the patients:

different beliefs, different religions, varied definitions of spirituality, yet the common thread remains that patients want to be seen and treated for their whole person.

5.2.4.2 The importance of how spirituality is introduced in the health consultation

Most would agree *why* it is important to include spirituality as part of a holistic consultation and treatment plan. It is the *how* that is often uncertain, even daunting to both health practitioner and patient. This patient quote summarises her views on what is important for a health practitioner to offer quality spiritual care: "The most important thing is to be knowledgeable about different things that people can experience as spiritual. And that goes as far as all the different types of religion. You don't have to know the nitty gritty of everything. But you must have some idea. If, if you're a Buddhist and I'm a Christian, it does not mean you want to make me a Buddhist just by telling me and explaining to me how it works. And I think to get away from that fear that people can influence you, in fact, because you will not be influenced if you don't want to be influenced into another religion or whatever, lifestyle or whatever it is.

Your own strengths which you can all take back again to the Bible, but somehow you must get past the books and the writings. And you must get into your gut. Because the Bible does not make me want to live every day in this difficult time that I've been through. I can read the Bible and I can read the verses that I know, you know. It says come to me if you are tired and I will revive you. It just doesn't do it. So you've got to go more. There's more…I think spirituality is also very much linked to emotions.

I think one has to be very sensitive or open to your own emotions. You can teach them (patients) how to get into touch with their emotions, if you are in touch with your emotions. In this process, the health practitioner should be affirming, and confirming of the patient."

A few things are evident from this quote above. The health practitioner cannot achieve assisting a patient to meaningfully engage with spirituality in the health context if he/she is not open to and comfortable with someone else's worldview. Such openness should be cultivated in health professionals without them feeling that this will jeopardise or infringe on their own beliefs. The second thing that is interesting to note here is that everyone might be spiritual, but not everyone places the same value on spirituality. The patient describes how, in both her personal and professional capacity, spirituality only has meaning as part of holistic care if one moves beyond doctrine or habit, into a living practice and experience of the spiritual. The patient also alludes to the importance of emotions in experiencing and interpreting the value of spiritual practices. The psychological and socio-emotional components of our being are often where and how we interpret and experience the spiritual. This could be a resource to health and wholeness, or an impediment. The patient described this process of harnessing the spiritual to influence health: to be able to help the patient identify, formulate and phrase his/her emotions, thoughts and experiences and frame this for him/her within a context of health, illness, care and development.

5.2.4.3 A person-centric approach to spiritual care

A person-centric approach allows the patient to list the order of importance of spirituality in the care plan. It also entails that the health system has been re-organised to accommodate those patient needs. Too often, health professionals still follow their own perception of what is in best interest of the patient when recommending a care plan, leaving little room for the patient to express personal preference, especially when it comes to incorporating spiritual care. One participant, who was a patient enrolled for the chronic disease management programme but also a retired occupational therapist, described a person-centric approach as follows: "To give you an example, if you become a quadriplegic through a car accident or something, or a spinal injury, I might, as the occupational therapist (OT), I might think that it would be best for you to learn first, if possible, how to brush your own teeth... or how to manage yourself at the toilet or whatever, which are the more personal care type of activities. Whereas... if I am your patient and you're the OT, and you ask me what would I want to learn first, I would probably say something to switch on my CD player to listen to Maria Callas. That is more important to me than brushing my own teeth. And I think that is in my job, in my interaction with clients: the most important thing is to take them where they are and not where you want them to be or where you think they must be at this stage, but to really take them where they are." Another participant had the following to say about enabling the patient to *make the call* on the how, what and when of spirituality in health care: "If you're dealing with people you have to, you can't come with preconceived ideas of what the questions are. The questions must actually come from them, so, because you know, if you have a net with big holes and you are going to see what fish are in the dam, the little ones are going to slip through. But if your net is too small, the big ones are going to break them."

5.2.4.4 Establishing rapport and meaningful patient-practitioner engagement as a foundation for a spiritual interview or treatment plan

Spirituality as part of a treatment plan requires more than prescribing a regimen; without meaningful engagement and personal relevance to the patient, it is an empty ritual: "In occupational therapy where we use activities to reinstate the patient back into his life and his level of functioning as high as possible, I can have a thousand activities which are all applicable to the patient...But if I cannot meet the patient, look him in the eye and say to him I'm not going anywhere. OK. Because then the patient, sometimes the patients get very angry with you. If you say to them, 'But we have got to start doing this and this,' and they get very angry. And then to say to them, 'I'm not going anywhere. You'd better get over it. I'm coming back tomorrow morning!'"

Most patients started the interview by asking what is meant by spirituality and also spiritual care. However, when interviewed, they all had their own opinions or thoughts on this. It was evident that they wanted to clarify that both I as the interviewer and they shared certain commonalities in our thoughts on this topic. In exploring the spiritual with a patient, it might be helpful to start off with seeking common ground first. Only then can one start to discuss the preferences or differences in approach that the patient prefers in incorporating spiritual

care. Certain values were reiterated by the patients and confirmed what was said in the interviews with the health experts. This quote summarised some of the values that many raised: "To be really honest when you work with patients. In terms of yourself and with the patient… I had a patient many years ago who said that the OT can only contribute to the patient's improvement, or whatever, if she is real and honest. Because it's like saying to the patient if the patient is paralysed, or has got this condition or whatever, not to say to the patient, you know: things are going to get better. But to rather say to the patient: we both know that this is not going to improve...I think honesty and congruence is very important. Ja (yes in Afrikaans), and then I think just sensitivity. And to allow the patient to be whoever he is. What is that again, there's also an academic's word for that. I've now retired for two years and I've already forgotten it. I know, unconditional acceptance. But that goes also with this whole thing of just being human. It doesn't matter who you are, I still see you as a human being that I can respect. Create a human experience. It's not a clinical experience. You have to stay the clinician but you also have to be a human being. I think it's important to explain to patients that you look at health and life holistically. And that is why you do more than just prescribe medicine, I think, you know, historically, people do not think that, there might be more people nowadays because more people are doing holistic treatment and they might have heard about it, but still not understand what it is about." This care approach described is in opposition to the traditional evidence-based care model that encourages objectivity and distance. Patients want a good clinical experience, feeling that they are assisted by an expert. They also want to have a genuine human experience that makes them feel valued, recognised and supported.

5.2.4.5 Practitioner sensitivity is required to accommodate different worldviews

If a health professional wants to achieve a meaningful conversation on the spiritual beliefs of a patient, a certain finesse and sensitivity is required to not only establish rapport, but generate a relationship of trust where a patient feels safe enough to share their thoughts and convictions. The health professional should communicate through verbal and non-verbal cues a sensitivity that is accommodating of the patient's worldview. Health professionals should be cognisant beforehand that some patients may be hesitant, while others may be defensive or have strong opinions. "We must be very aware that other people may have a different truth. The health professional should be sensitive and be aware that he or she doesn't necessarily have the right answers. And the other person may have answers that the health practitioner thinks are totally wrong but that person may have taken a long time to arrive at. It's not the health practitioner's duty or even place to try to convince a person to, you know, to be aware of, of the greater picture." – patient during an interview in June/July 2018.

One patient interviewed had a chronic lung disease that has had a significant impact on her health and functioning over the last number of years. She was not religious, and contemplated whether she was spiritual. She was, however, open to applying spiritual practices if this could benefit her health or overall well-being. She was unsure how this should be approached in practice and how this could professionally be linked to good clinical practices: "The main thing

for me would be that the practitioner must be able to think themselves into my place, into my position." Although patients profess a need for the incorporation of spirituality in health care as part of a holistic approach, health professionals will have to be skilled in how to introduce this topic with patients in a non-threatening manner that would enhance the patient experience and encourage relevant conversations that provide the opportunity to better address patients' spiritual needs.

5.2.4.6 Patient perceptions on the link between spirituality, health and disease

Patients interviewed discussed the influence that emotions and life events had on their health, i.e. amongst others, blood pressure or glucose control. Expressing their spirituality in a positive way (such as practising mindfulness, meditation and letting go of negative emotions such as anger or guilt, and linking spiritual practices to nutrition and herbal remedies) were mentioned by patients as personal experiences of the (positive) impact of spirituality on their health and/or disease. HE_1 and HE_2 both referred to this as part of their approach in offering spiritual care. The following patients' quotes captured the essence beautifully, not only of what patients profess to believe, but what evidence indicates: that our thoughts and emotional responses to experiences have an impact on our health and well-being: "Well I happen to go to a doctor who wouldn't say to me *what's wrong with you*. He said *who's wrong with you*; because somebody might be causing you grief. And to me that is a holistic view of not only looking at your sore toe, or your sore stomach, because there's a reason why you have that. Is it necessarily something physical or is it something else? Are you upset about people; is that making you sick?" Another patient stated: "I know it's not the medicine that gets my blood pressure up and down. The reason it's low today is I had an hour and a half conversation with one of my best friends last night and I touched reality where most of the time I'm working in an area somewhat removed and isolated." Facing and dealing with negative thoughts such as anger, regret or guilt as basic emotions came up in conversations with patients during the interview. Patients were aware of the impact these emotions and experiences had on their health. Wright (2005), Stydrom (2013) and Cronje (n.d.) all refer to a bio-psycho-social-spiritual model that links specific diseases (physical/body) to psychological well-being, including mental and emotional (soul) and transcendental (spiritual). This is affirmed by the WHO holistic health model that describes spirituality as the fourth dimension of health and health care (Yach, 2008) and is also described by the whole-person care of Sulmasy (2002). The benefits of harnessing positive emotions and overcoming negative emotions are not only a perception that patients have, but clinically proven to be of benefit (King, 2012; Koenig et al, 2001; Koenig, 2007; Koopsen & Young, 2009; Koenig et al, 2012). Screening for spiritual distress or a spiritual need should include exploring for possible negative emotions or thoughts around the patient's current health status or even suggested health treatment interventions to assist the patient to plan and progress in the best way possible towards health and wholeness.

5.2.4.7 Patients value spirituality as a resource to transcend their health challenges

The patients interviewed during this research stretched over various age categories and life-stages. One commonality shared by all the participants was that they belonged to a chronic disease management programme offered by a health insurance company they subscribed to. Some patients had serious chronic diseases that had a significant impact on their lives or within their family context. Other patients were diagnosed with hypertension or dyslipidaemia, but had no reported past event that was significant in their health history. The patients interviewed also came from various religions of faith and expressed their spirituality in certain unique ways. Despite all of this, throughout the interviews, patients were not only open to the idea of spirituality being included; rather, they welcomed the idea. The participants shared their personal experiences of practising spirituality and how this impacted on their health. Many patients voiced the need for their health professional to discuss with them how to prepare to age well, manage their fears about death and dying and discuss fears and concerns that they have surrounding their health with them and also with family members. Below are some reflections taken from the interviews with the patients: "A hopeful expression of life: Despite my illness. Despite my condition. Despite my past experience. Despite my challenges." My own reflection on a discussion with a patient with a chronic illness that has had a significant impact on her personal health and overall functioning during an interview in June-July 2018. The following words from the patient also describe the need to transcend and make meaning of a negative physical experience: "I understand now that I've become incapacitated to some extent. I walk behind people that walk quickly, like you did this morning. I was in the foyer when you came past there. I was too slow to stop you and to say wait for me. And get me up the steps. But I walk behind people and I think, gee, I hate it that you walk so fast, don't have to even think about walking. And I have to watch my right foot every time. And you have to get over that. And that is why the patient has to get, he's got to be bigger than life if he wants to get over his medical challenges" The reflections of the patient on the events before the interview and her mindful approach to life as part of making peace with her condition and finding fulfilment depict the value of spirituality as a resource to transcend physical challenges and aligns with the logotherapy model of Frankl (1959) that was also referred to by HE_1.

5.2.4.8 The role of spirituality in comprehensive chronic care

Patients were asked to reflect on the role and importance of spirituality since having been diagnosed with a chronic disease. The following in vivo excerpt captures a patient's thoughts on whether spirituality becomes more important to patients when they face a chronic disease or serious illness: "I think many people pray to God when they're in trouble. When they think they're going to die they make promises to be good; and so I think, I think a lot of people think that life is going to continue and suddenly when there's a threat and they think their life is going to end, then they think about how the universe works…what their place is in it. So I suppose for some, for people who are scared of death, I think it will play a bigger role being aware of this is how the world works. How, how everything functions, where this God is, who this God is, if this God is going to punish me because I cheated in primary school or I had

affairs and all sorts of things, you know." Another patient had the following thoughts on the importance of spiritual practices when faced with a serious medical condition: "I haven't got a chronic illness but I've got chronic disability, so I think it (spirituality) is important to me. It (spirituality) is playing more (of a role) in my life than before. I want to tell you that when I was diagnosed with breast cancer, 17 years ago now, I was not at all phased by it. I said thank goodness, I'm so glad I wasn't diagnosed with multiple sclerosis. I'd rather have cancer than multiple sclerosis. And at that stage I managed to go through the mastectomies and four days after my first mastectomy I was mowing my lawn with two drips... two drainage tubes in my pockets. You know, things like that. I just went on with life. However, afterwards, because of the chemotherapy, I had some very severe side effects, permanent side effects which started to disable me a little bit and then my knee packed up also because of the chemo, etc. So I became more dis... I really don't see myself as disabled but, what's the word now, ingeperk (incapacitated in English) in some aspects of my..., I couldn't run. I loved running. I can't run anymore. I can't walk fast. I can't do things fast anymore. In order to live with that you have to have a bigger picture at life than, you know, otherwise you will become, I will become very frustrated. So I think in the bigger picture to, to really stay in contact with your feelings..."

One patient shared this touching personal story during the interview: "I had a very good friend who was in fact my partner, who passed away four years ago with suicide. And I found it extremely difficult to continue living. OK. Even my straight religion couldn't get me up again. And still, many days I'm still there that I get up and I really don't feel like, what am I going to do, there's no meaning, there's no meaning. And then after my friend said to me, you know this is an active decision that you have to make to continue with life and to start enjoying things again. It's a decision. I actually thought that she is very correct… Mindfulness about yourself and life. And I actually found that that helps me a lot. I haven't been, I can remember one morning since then that I got up and I wondered what was I going to do today that was really meaningful."

Patients that suffer from a chronic illness or have chronic pain may struggle with internal conflict about why this 'happened to them' or how God, their religion and spirituality are tied to this experience. This includes the family members of patients who are ill or dying. Health practitioners can help patients to voice these struggles and questions and to resolve these for themselves, not only for improved mental and spiritual health, but also adherence to treatment. One patient interviewed underwent orthopaedic surgery for an arthritic condition years ago. He still had unresolved conflict about whether he should have had the operation despite the good surgical outcome many years after the surgery. His spiritual and religious beliefs challenged him as to whether he should not have trusted God longer to heal him without surgery. Patients need to be counselled with regard to the spiritual questions they might face before making big medical decisions. Various clinical studies have shown the benefits of including spiritual practices and counselling before and after surgery, including orthopaedic surgical interventions (Fitchett et al, 1999; McGraw, 2011).

5.2.4.9 The importance of spirituality in end-of-life care for patients and their families

Most of the patients interviewed voiced the need to explore (especially when having faced the death of a loved one or dealing with their own a chronic illness) their own frailty, mortality and not only life, but issues of death and dying, with their health professional. One participant recounted how she – as a health professional, an occupational therapist – incorporated spirituality to assist a patient in a chronic illness and also in his pathway to death and dying. It entailed accepting that a diagnosis does not define who you are as a person, that having a disease does not have to mean you are 'handicapped'. This patient's views are a practical application of transcendence as a spiritual tool to accept certain limitations, illnesses and present suffering. She expressed strongly the usefulness of this in her experience as both patient and practitioner. In fact, she felt that without this one becomes 'empty' and stripped of purpose: "I've worked with a gentleman who had ALS and he became extremely rigid. He could not move his eyes later, he could not speak. We could not open his mouth to clean his, you know, his mouth and..., and there was really nothing else except the fact that I could say to him there's something bigger in life. Because our bodies (sometimes) don't work anymore. And the fact that he didn't die, the fact that he kept on living, which was very difficult for him…for me, I would have let him die much earlier than he did. And for his family, for his wife. I just had to say it to him, that there's something bigger out there that we, that we must still do, that we must still achieve, that we must still help other people with. However, he could not accept (it) with the expression in his eyes, and towards the end he even lost that. He could not, he was just a rigid frame. Because I've worked with progressive long-term conditions, where people don't die easily. And, and you have to go there (spiritual concepts) then, to say but we've got to look at life differently now. To still make it meaningful. I think that for every human being there's got to be a bigger source of energy, whether it's God, or Buddha, or Muhammad or whoever. I think every person has to have something bigger. If you don't have that, you become what I call a 'sonsitter' (Afrikaans – literally someone who sits in the sun doing nothing all day). OK. And I've seen patients like that. I've seen patients who were highly functional and then they would have a car accident or something and they become a spinal quadriplegic. And that there is really nothing, and that is over a period of time, it's not as if it's a reactive depression type thing, you know, I'm now paralyzed and whatever else. It continues for the rest of that person's life where you can visit him and he sits on the stoep (porch in Afrikaans) and his mother who is now caring for this 48-year-old man, because his wife divorced him after the accident, or whatever else, she decides what he will wear today, when he will have his tea, and things like that. And when you talk to him or try to converse with him there's really nothing, he can talk about nothing. Not even about his own feelings, because he's totally shut off."

Walker and Breitsameter (2017) motivate for spiritual care as part of quality end-of-life care, positing that it is beyond the definition of the physical and psychosocial, although it intersects. The value of incorporating spiritual care as part of end-of-life care is that it could enable people to die with dignity and having found peace in an environment of care and love. In end-

of-life care and incorporating spirituality, the "content of the discussions and the practices are less important than the forms these practices take" (Walker & Breitsameter, 2017:2247).

5.2.4.10 The role of culture in spirituality and health

Culture and context should be taken into consideration when a patient is approached about his/her spirituality (Du Bray, 2001). Some of the patients mentioned the role of ancestors as part of their traditional upbringing; others believed in the healing power of crystals or tokens. Health professionals need to be sensitive and equipped to facilitate a meaningful spiritual health screening or treatment plan for various cultures and religions, especially in the African context. Patients related the following personal experiences: "My aunt believes in God and also (prays) to ancestors and you have to be very sensitive when you talk about those. Because we Christians, we feel we could be judgemental and we see that, um, these, we don't have any other God and then we want to shut them out, so we need to find a way of incorporating different cultures, like a Muslim's spirituality."

"I had taken my daughter…my daughter suffers from Lupus and the family then believed the aunt had some relationship with some spiritual people – that's traditional black people. And they said this young girl has spiritual gifts but she has to go, and we say "ukotwasa", to go and complain to their cause, so that she can be a healer also in future. Then we had to travel to Venda with a friend who had some people that he knew might be able to help us in that regard." In the African context, the intermix between Christian and traditional spiritual practices that include consultation with ancestors and traditional healers has been ignored by most in the Westernised approach to health care. Incorporating person-centric spiritual care includes creating space for people to express their customs and religious practices within a prescribed care plan. One patient remarked on the valuable role that traditional medicine and traditional healers may play in assisting a patient holistically: "What the traditional healers are actually doing is to find the problem that this person has. There obviously is something that is worrisome to the patient. Either the patient is fearful or the patient has some guilt or the patient is feeling shameful for something that he or she has done. Now what they do is to find out what the problem is. And they will then listen to the patient telling them their problem. They will then prescribe something and assure the patient that this is going to help you, but it's a question of faith. Do you believe in that or don't you believe in that? So it's a faith. (In an article I read) they mentioned that most people, I don't know what percentage they are quoting, prefer going to traditional healers than going to the new medical experts. Or some actually combine the two. Right, they will go to a specialist, medical specialist, and they will still go to the traditional healers. Because they get some sort of encouragement from the other side. They listen to them."

"I seem to understand the psychology behind the whole healing and prescription thing, that it's actually a question of faith. I seem to have an idea that this man is going to say you are sick, so and so has bewitched you, I'll give you this in order to remove that and you take that and because the man has promised you that this is what's going to be happening to you, indeed sometimes you get healed in (such) a way." Another patient reflected on what health

professionals can learn from traditional healers: "Traditional healers want the patient to talk: what is your problem? And then from that problem they are then able to use their minds to try and assist the patient. Now if I come in and say I have a problem and the physician says what is it, headache. Now to him headache could be this or that or that. They don't delve too much into my history, into how I feel, into how I perceive this thing. Whether it affects, my other aspects of my life or not. Whereas the traditional healer is more interested in that you should talk, that he should understand you better before coming to a prescription or what. But the specialist, the general practitioners just go *there*, tell him it's this, *okay it could be that, (but) what else*? That, and then from there immediately they prescribe and without letting the patient say more about themselves."

Below is a quote from one patient that crystallises a valuable discussion on the role of the inter-disciplinary team; including traditional healers and ensuring that patients are informed about holistic care options available to them. Patients need to be given time to process emotionally and spiritually what their personal preferred choice would be. This also reflects on the importance of a person-centric approach: "Start with the patient. Is the patient inclined or does he like traditional healers or is he for the health practitioners as we know them? And once he knows himself which way is he inclined, he can start with the health practitioner and if in two or three months there is no progress, then there should be some consultation between the health practitioner and a very genuine traditional healer. Now there is a body of traditional healers, I believe, and there are also leaders of those organisations that maybe if, if it is possible at all that contact details of these be made available and there should be some consultation between the health professionals body that's the medical health professional body as well as those traditional, they can meet at the top on the higher structures, but they need to try and identify the best so that you shouldn't be letting or giving a patient over, the health practitioner should not give the patient over to a bogus traditional healer. I believe then the medical health professionals body and these traditional leaders somewhere up they need to try and form a coordinating body where they can work together." Person-centric spiritual care should accommodate cultural and religious practices within a health care experience.

5.2.4.11 Barriers to offering spiritual care

Patients interviewed voiced concerns about possible barriers to care when introducing spirituality in the health context: "The health professional might not feel equipped, or fear that they will harm a patient or perhaps offend someone." Another patient stated: "That the person doing the approaching is frankly inadequate for the job. That my requirements and my expectations exceed the ephemeral and fluffy, if you will." One patient said: "The health professional should be dealing with achievement and performance beyond the physical level. Frankly, I think it should occur at the level of psychiatry. I think it also has to be tied to some measures of feedback. I think they have to do it in a way where the expectations are largely on the patient, more so than on the doctor." One patient mentioned that if the health professional does not broach the issue, often patients would be reluctant to discuss possible

spiritual concerns: "The doctor has to put it on the table as a part of the therapeutic process." Uncertainty about what is meant by spirituality and what the health professional wants to hear, versus the real need of the patient, can be a barrier to the patient opening up: "I think that is one of the most important things that I would do for patients, is to really have a good description of spirituality and explain…" Other barriers to care that could impede patients being open about their spirituality that emerged during patient interviews included: the health professional being perceived as judgmental or insensitive, the patient being a very private or closed person, the patient not being religious at all and lack of capacity from either the professional or the patient's side to discuss spirituality comfortably.

5.2.4.12 Conditions conducive to quality spiritual care

Patients indicated that creating the correct moment and timing is important to effectively enable the patient to discuss this sensitive topic. Good communication (verbal and non-verbal), including the softer skills such as general approach and values portrayed by the doctor, strongly influenced whether patients would be open to discussing their spirituality with a health professional or consider this beneficial. The following principles and conditions were listed by the patients interviewed:

"Directness, honesty, some basis for having created some level of trust."

"A demonstration of competency (in this area)."

"Clearly communicate the intent, including creating self-awareness and assisting the patient to move to a level of re-centring and peace."

"Enable skills and awareness for a better feedback system between me and me (my physical and spiritual health.)"

"Wait for the correct moment. I would definitely not do it if I do not know (the person) or haven't built up a good rapport with the patient or a good relationship yet. But later, when there is more trust in the relationship, I think I would then be able to talk to the patient, you know, taking that the time and the context is correct. Like the space, the physical space that we are in and privacy and that kind of thing."

Quality spiritual care is as much about how this is approached and in what setting as about what the discussion centres on. Patients indicated that they at times had specific spiritual needs that they wanted to discuss with a health professional. This often did not happen. Quality spiritual care includes enquiring about such needs with patients and introducing management plans that support the patients and enable them to cope better with a diagnosis within their psycho-socio-spiritual context.

5.2.4.13 The link between spirituality and nutrition

Nutritional psychiatry explores the link between mental health and nutrition (Leaf, 2016): "If you eat while you are emotional, your body does not digest food correctly. If you think right, you will eat right, and if you eat right, you will think right." D'Mello and Swain (2011) studied

the brain-liver connection and the impact of chronic inflammation on various illnesses and their origins in the body, as well as the impact these might have on the brain and mental health. "We don't think of our bowel as being part of our brains, or our liver being part of our brains, or our joints being part of our brains, but obviously, there must be a communication between them…It is becoming increasingly evident that peripheral organ-centred inflammatory diseases, including chronic inflammatory liver diseases, are associated with changes in central neural transmission that result in alterations in behaviour. These behavioural changes include sickness behaviours, such as fatigue, cognitive dysfunction, mood disorders, and sleep disturbances." Leaf (2016) argues that the brain-gut connection works both directions: That positive thoughts reduce inflammation and assist with proper food digestion and absorption. Health professionals could and should play a role in deliberately linking food and mental-spiritual health for patients as part of holistic lifestyle counselling. The Institute of Functional Medicine (2014) also describes nutrition and hydration as a vital component of patient lifestyle counselling. This includes not only looking at what patients eat, but also their thoughts and social interactions when they eat. Practising mindfulness during a time of ingesting food can strengthen good neurological pathway development and assist with overall emotional well-being. Two patients referred to the value of nutrition in their mental and spiritual practices as part of a holistic plan to manage their disease. "I grew up in a family that has had (high) blood pressure; and both my parents have had (high) blood pressure and cancer. My mom died from…initially she had cervical cancer and she died from lung cancer. And my dad… he was older when he died but he lived with prostate cancer and I could see that this is, I don't want it to be the trend, and when you hear people say it comes from their genes, I (also) know that we are what we eat." – a patient during an interview in June/July 2018.

"I'm on chronic medication for (sugar-) diabetes and hypertension. Now I pray a lot for healing but we are told that, no, this is for life. Once you are on this medication, this is for life. Now I've been trying some herbs, reading a lot of books on herbs. There are two herbs that I found that I've actually grown in my yard. Rosemary and basil. Rosemary, the leaves, I prepare them in a teapot, pour hot water. I clean them first in water and then I take half a cup to a cup on a daily basis. That's what I did for a week, and within a week my sugar level had dropped from 6 to 4.2 (mmol/l)." In the African context, traditional healers often prescribe herbal remedies that are considered both as physical and spiritual treatment. The cultural and social value of food can support spiritual practices towards improved health if utilised appropriately.

The codes identified through the analysis of the patient interviews were incorporated into the various versions of the draft framework throughout the research and were finally taken up into the final framework. The codes that emerged during the second round of data collection and analysis were also included in a *patient booklet for health professionals* that took into account the contributions of both the health experts and the patients. This was presented to the inter-disciplinary focus group for the final round of data collection that will be discussed in chapter 6 to follow.

Chapter 6
Findings for inter-disciplinary team: Experiencing spiritual care really matters

This chapter describes the analytic yield from the inter-disciplinary health professionals who participated in a focus group interview for the research. The nexus of this chapter captures the complexities faced by health professionals when addressing spiritual care in a multi-religious and multi-cultural society. The focus group motivated strongly for addressing spiritual care from a person-centric approach that would meet the patient within the context of his/her health and spiritual needs: "Holistic care includes the incorporation of the spiritual component in a manner that is acceptable and relevant to the patient. I believe we are different parts. We are body, we are mind, we are soul. So, I think the health care isn't complete until all the aspects have been addressed. When we consult a patient, we should always find out from the history checking. We must find out what the person believes in, because some patients will come in and if their beliefs are not what you're going to deal with them, then they will automatically walk out and go somewhere else where their beliefs will actually be addressed. So, we have to address it. It is something that is happening and we need to look into it."

The outline of this chapter is a representation of the theoretical codes identified during the analysis of the contributions from the health professional during the focus group. The following nine codes will be discussed in this chapter as listed in table 6.1 below:

Table 6.1 Spiritual health care codes that emerged from the health professional focus group

1. How health professionals define spirituality
2. Describing an approach to spirituality in health care
3. Practical suggestions to initiate the conversation
4. Practitioner concerns about incorporating spiritual care
5. The patient narrative as a contributor to health or illness
6. The patient narrative as a tool to identify spiritual distress
7. Recommendations to frame and guide practice
8. Impediments to quality spiritual care
9. Spiritual rituals in the health setting

A brief description of the various disciplines and research participants follows with a summary of the analytic yield of the focus group interview, after which each of the nine codes will be unpacked.

6.1 Description of the inter-disciplinary health group

The focus group represented the third and last cycle of data collection. At this point the draft ethical framework had been refined a number of times to include the analytic yield from the previous two sources of data: the individual interviews with the health experts and the patients. The draft framework at that point had become a lengthy document, and for the purposes of the focus group interview with the inter-professional team, this was summarised as a *patient booklet for health professionals* that included the contributions of both the health experts and the patients.

The health staff working at a University of Pretoria service-learning clinic, representative of over 12 disciplines, were invited to participate in a focus group. Those who indicated an interest were sent an email with the draft framework prepared as a health professional guide. Initially, ten health professionals indicated an interest in participating. On the day of the data recording, only eight were present to participate. The interview was held at Daspoort Clinic, Pretoria, South Africa on 12 March 2019.

All the participants were familiar with each other as they worked together as an inter-disciplinary team offering clinical care at the University of Pretoria service-learning clinic on site; this was linked to home-based care by a community health worker team offering care through household visits in the surrounding community. The community that they served was mostly impoverished and comprised people of various nationalities with a high burden of social problems. The research participants represented six health disciplines as described in table 6.2 below.

Table 6.2 Focus group participants representing the inter-disciplinary team

1. Patient case manager
2. Community dietician
3. Professional nurse
4. Professional nurse
5. Environmental health officer, CHW team manager
6. Community health worker (CHW)
7. Community health worker (CHW)
8. Clinical associate & counsellor

6.2 Brief summary of the inter-disciplinary focus group discussion

The following brief summary in table 6.3 below highlights points of importance raised during the focus group that will be discussed according to the codes identified during the analysis process throughout the rest of the chapter to follow.

Table 6.3 Brief summary of inter-disciplinary focus group discussion

The focus group unpacked the importance of the health professional being *skilled* to navigate the integration of spirituality and spiritual care with an appropriate *attitude* and *approach* during the consultation and treatment plan. A person-centric approach to spiritual care includes that the health professional *accommodate different cultures and beliefs*. The health professional should have knowledge and skills to integrate this successfully into the clinical care offered. The group discussed various personal and professional experiences that related to dealing with opposing worldviews, *managing one's own personal* stance as a professional and creating an opportunity for a patient to express his/her own beliefs and preferences within the health care setting.

One of the professionals related a patient experience at Daspoort Clinic where the patient gave permission to have blood drawn on himself, but when the health professional struggled to obtain the blood, the patient said it was because he did not ask his ancestors' permission before he came to the clinic to have blood drawn. Professionals need to know how to address patient perceptions, beliefs and needs in circumstances such as this to address the spiritual distresses of the patient adequately and in a sensitive manner. Within the African context, health professionals need to be equipped to manage patients within a community of practice that includes traditional beliefs.

The health professionals listed the following as possible introductions to spirituality in a clinical setting that they apply personally and would recommend to other health professionals:

'Tell me more about who you are, where you come from, your family and upbringing?'

'How can I help you with questions around your health/illness and spirituality?'

'Why do you believe this is happening to you?'

'Are you religious? Do you attend a church or belong to a religious community? If so, which church do you attend?'

'Are you spiritual? Describe to me how you live this out and link this to your illness or current health problem?'

The principles and recommendations for quality spiritual care described by the practitioners during the focus group had much overlap with what was identified during the health expert and patient interviews. The following were listed as important to quality spiritual care:

- Respect for the patient and his/her beliefs
- Good communication skills, including the ability to listen, a non-imposing posture and non-verbal cues that reinforce an open discussion and put the patient at ease, such as making eye contact
- An attitude that is accommodating, supportive and non-judgemental
- Creating opportunity for the patient to identify possible spiritual resources or support within his/her social environment to address spiritual needs linked to his/her clinical problem
- Keeping and assuring the patient of confidentiality
- Creating trust
- Establishing good rapport

- Incorporating a person-centric approach
- Displaying empathy
- Understanding the patient's perspective
- Having the patient's best interest at heart
- Making time (quality and quantity)
- Being supportive of the patient's decisions and preferences
- Knowing when to refer appropriately for a specialised need

The patient narrative, as a tool to enable a quality spiritual discussion, was unpacked with various patient-practitioner cases described by the research participants.

It was also evident that amongst the group it was felt a quality consultation could only be achieved if the health professional was comfortable with his/her own spirituality and able to express this. This affirmed what emerged during the previous rounds of data analysis: Patients and practitioners described a need to incorporate their spirituality practically throughout the health experience.

The codes that emerged during the data analysis of the inter-disciplinary focus group will be described individually throughout the rest of the chapter.

6.3 Discussion of the codes that emerged in the inter-disciplinary focus group interview

Nine codes were identified during the analysis of the data gathered during the focus group interview. These codes complimented what was identified in the coding of the data from the health expert and patient interviews. The inter-disciplinary focus group had a strong focus on an appropriate approach within a multi-cultural and multi-religious context, specifically the African context. In the second round of data collection, two patients interviewed referred to the value of spiritual rituals where they consulted traditional healers or spiritual carers specifically for a health problem. The patients recalled that they wanted spiritual care to be incorporated throughout the treatment plan and coordinated by their health professional. The inter-disciplinary focus group expanded on the code described as spiritual rituals as identified during the analysis of the data yielded through the patients' interviews. The focus group described specific patient cases where spiritual rituals had to be accommodated within the health care setting. This will also be discussed below as the last theme in this chapter.

6.3.1 How health professionals define spirituality

Walker and Breitsameter (2017) interviewed various health professionals offering spiritual care in a hospice setting. They report the 'concept of spirituality to be highly indistinct' (Walker & Breitsameter, 2017:2241). McSherry et al (2004) described spirituality as a concept that includes God, but that also exceeds religion. Everyone is considered as spiritual. The research participants during the focus group were asked to give their definition of spirituality, since most patients interviewed wanted a health professional to define spirituality before commencing with an in-depth discussion on the topic. The following in vivo codes capture

their responses: "To me, spiritually means do I believe in God or whether do I not believe, or do I have faith in whatever I do."

"Spirituality doesn't involve only Christianity. It involves the beliefs that (one may have), whether it's traditional or Christian beliefs."

"I think spirituality means what you believe in and what your morals and values are."

"For me spirituality, I think it is an *inner feeling* of a person or beliefs that a person has towards the religious."

"Spirituality is a complex concept, but simply I would define it as what one basically believes, (in something) which is not necessarily physical, but something that is inside somebody that determines who they are and where they come from and what their purpose is in this world. That's spirituality."

"Spirituality is something that, perhaps it's inside of you and it determines your wellness. If you neglect your spirituality, then perhaps you don't feel…your inner health is not good. So, it can be influenced by your upbringing, your environment and perhaps your religion. Your core values."

The recommended framework in chapter 3 includes that the health professional should be comfortable about his/her spirituality and be able to create a context within which spirituality can be discussed with the patient. To be comfortable about spirituality, a practitioner has to be able to define his/her view of spirituality when a patient enquires about it. The research participants described different components of spirituality. One definition of spirituality in health care is "that part of a person that gives meaning and purpose to the person's life. Belief in a higher power that may inspire hope, seek resolution, and transcend physical and conscious constraints" (Canfield, Taylor, Nagy, Strauser, Van Kerkhove, Wills, Sawicki, Sorrell, 2016). This definition was constructed from the inputs of thirty nurses who participated in a study on spirituality and spiritual care. The definitions cited by the health professionals in this study are very similar to those of the health care nurses in the study conducted by Canfield et al (2016). The focus, however, is not necessarily on having an exact definition, but on establishing a connection, creating a context where the spiritual and the relevance of this within the health care experience can be explored. The inter-disciplinary focus group participants remarked after the data gathering for this research that they would love to have a follow-up session, not for the sake of the research, but for the personal benefit they experienced in discussing spirituality and specific patient cases amongst their colleagues. Creating a context within the inter-disciplinary team to discuss with colleagues the complexities of spiritual care by unpacking individual patient cases should be incorporated into clinical patient care planning meetings just as any other clinical problem would be deliberated. During the focus group interview, health professionals also described their own need to make sense of certain patient cases where the patient's experience became spiritually and emotionally distressing to the professionals themselves. Debriefing and emotional

support of health professionals should also enquire about possible spiritual distress that the health professional might be experiencing and ensure that this is explored appropriately within a context that addresses the need of the health carer, enables self-care and fosters transcendence and hope despite suffering of the ones that are most often in the position of extending such care.

6.3.2 Describing an approach to spirituality in health care

As part of the research, health professionals were asked how they incorporate spirituality into their health care practices. The inter-professional group described approaching spirituality in the African health care setting as requiring that the health professional be informed about various religious beliefs and enquire on this in a sensitive manner that is affirming of the patient and his/her context. The African context offers unique perspectives and beliefs that should not only be considered, but accommodated when offering health care. The theme of an 'African' interpretation of illness, health and spirituality is of particular relevance for the South African context (De la Porte, 2016): "In the African worldview, illness is not linked to bacteria, viruses and infection, but to a disruption of the system, the societal order and the web of life. The question *who* caused the illness is important in the African interpretation. Suspicion of underlying factors and the influence of evil powers are therefore present." This was cited also by one of the patients interviewed during this research as an approach followed by her general practitioner on enquiring as to the spirituality that she valued. Understanding a patient's underlying beliefs and fears becomes important if a health professional wants to meet the needs of patients holistically. Understanding the spiritual and social beliefs of a person can also be harnessed to positively influence their health and lifestyle behaviour. Louw (1998) argues that all human behaviour is rooted "in cultural contexts in which attitudes, values, customs, and rituals play an important role".

The focus group participants reiterated the importance of understanding culture and context in their professional experiences and accommodating different worldviews: "We need to understand the different beliefs and the intercultural influences that we have (in South Africa). First, I should note that she believes in certain things and that in that case you can integrate whatever (belief the patient has) during our discussion. Because if she doesn't believe and I try with my beliefs and everything, it is going to end up maybe chasing (the patient away), because it's not what she believes in."

"I want to say that all of us have different beliefs. So, if I'm going to somebody as a community health worker, I need to respect the person's belief so that if we communicate, then our consultation will be good. If I tell, then the person will realise that I am sure of my beliefs, that I don't care of about her beliefs; it's not right. We need to accommodate our patients."

Taking a patient history should include an enquiry on the patient's spiritual history and current spiritual state, screening for distress. One of the participants remarked: "How we can integrate it? Isn't it that during history taking, if you take a proper history: are you a Christian, are you religious? Ask all those things. Proper history should be taken then you will know the

beliefs of somebody. Then you won't be able to step on the person, because you know him already, what does that person believe in." The enquiry approach was mentioned to be of importance in establishing a connection with the patient, generating trust and creating a context where spiritual concerns and values can be discussed: "Holistic care includes the incorporation of the spiritual component in a manner that is acceptable and relevant to the patient. I believe we are different parts. We are body, we are mind, we are soul. So, I think the health care isn't complete until all the aspects have been addressed. When we consult a patient, we should always find out from the history checking. We must find out what the person believes in, because some patients will come in and if their beliefs are not what you're going to deal with them, then they will automatically walk out and go somewhere else where their beliefs will actually be addressed. So, we have to address it. It is something that is happening and we need to look into it."

Incorporating spirituality during a health consultation requires that the practitioner display good communication skills, including putting the patient at ease, picking up on verbal and non-verbal cues and taking time to listen to the patient's needs. "I think we need to have listening skills also. We mustn't impose ourselves. If you are a good listener, then you will get everything that you need." Another participant described her approach by stating the following: "Perhaps also ask the person if they have a (spiritual/religious) problem? Do they have somebody that they can talk to? Who do they go to that will support them in this difficulty? Then try to get from them what do they see as their support structure."

6.3.3 Practical suggestions to initiate the conversation

The moral argument for incorporating spiritual care has been made throughout this thesis. Puchalski and Ferrell (2010) captured the essence of this with the following statement: "People deserve 'total care' where they can speak authentically about their illness and where their spiritual needs as well as their physical, social and emotional needs are addressed. Illness, aging, and the prospect of dying can trigger profound questions about who people are, what their life meant, and what will become of them during the course of their illness and perhaps when they die. Who am I? How will I be remembered? These questions have the same importance in patients' life as do questions about treatment." Health professionals and patients alike readily confess to wanting to offer and/or receive whole-person care that includes looking at their spiritual wants and needs. Despite several publications in this regard (Anandarajah & Hight, 2001; King, 2002; Fitchett & Risk, 2009; Puchalski & Romer, 2000; Cloninger,2013; De la Porte, 2016), uncertainty remains from both sides of the consultation table on how to approach the subject and what to expect in terms of the patient interview and treatment plan. This includes questions on how much to probe or share, what questions to ask, how to address different worldviews and accommodate spiritual needs (e.g. rituals) in the clinical setting.

The inter-professional team shared the following practical experiences on their approach in practice: "I think when I want to open up the conversation with a sentence with a patient regarding spiritually, I will just ask directly if the patient is a religious or non-religious person.

Then if they say they are religious, then I'll take it from there." Although most of the interviewees were not familiar with published spiritual screening tools, this participant's response relates very well to the FICA Spiritual Screening questionnaire (Puchalski & Romer, 2000) for health professionals that consists of four questions. The first question centres on faith or belief and asks: "Do you consider yourself spiritual or religious?" or "Do you have spiritual beliefs that help you cope with stress?" The various participants shared relevant questions that (without their knowing) were similar to current recommended practice: "You first need to find out who your patient is and where they come from. Just start there: Where do you come from? And then your parents, where do they come from? Then is where you are going to be able to get (understand) what kind of a person this one is. Then you can at least, if you open up the conversation further and then ask...how can I help you? Then the patient can relate the problem. And then, what do you think is, why is this happening, then you'll hear all the source of things. Maybe the patient might think he has been bewitched. Or no, he thinks it's just an illness. It's where your medical intervention starts – you'll intervene properly." Another interviewee from the inter-disciplinary team commented: "We hardly think about that when we consult patients, but I think I will just be straightforward. I will just ask them, are they spiritual? From there, if they say yes or if they say no, probably I'll take it from there." The approach described by the research participants could be compared to the second question of the FICA screening tool (Puchalski & Romer, 2000) that centres on the importance that religion/spirituality plays in a patient's life and viewing of his/her illness: "What importance does your faith or belief have in our life? Have your beliefs influenced how you take care of yourself in this illness?" Another interviewee from the inter-disciplinary team contributed the following: "I will ask the person which church do you go to and then a follow-up question will be based on the answer." This was reiterated by another participant: "From the professional perspective, we have been taught to ask the patient about their schooling, do you go to church, like do you drink, whatever. Those questions will lead you, because you know if a person will tell you yes, every Sunday I go to church then you can start, but if she says I don't believe in going to church then you need to get another route of asking some of those things." This correlates with the third question proposed by Puchalski and Romer (2000) "Are you part of a spiritual or religious community? Is this of support to you and how?" The fourth question posed by Puchalski and Romer (2000) as part of the FICA spiritual screening tool is focused on how the practitioner can address the patient's expressed spiritual needs during the health care experience: "How would you like me, your healthcare provider, to address these issues in your healthcare?" The inter-disciplinary team discussed their own discomforts in addressing a patient's spiritual needs, often because they do not want to offend the patient, or were unsure of how to detach their own spiritual beliefs from those of the patient. This reiterated what the health experts conveyed during their interviews, and what has been discussed in the literature. Patient cases where opposing worldviews and requests for religious ritual were made were discussed amongst the team. The research participants related the importance of being comfortable with one's own spirituality, if this were to be addressed successfully with a patient. "I think you must be comfortable yourself

with your spirituality in the conversation, so sometimes I think there were barriers where we were taught that you don't bring Christianity in. So, I think sometimes for me to cover, if the students even ask are you a Christian, I would, if I see the patient's uncomfortable, I would cover and say we're just asking because we want to know if you've got any dietary restrictions, but actually, you then close a door. You shouldn't defend. You should just open and say do you have a religion, what do you feel? I think the open-ended approach would be better. So, I think we need to be comfortable with our own spirituality. That you're not going to judge, but you need to put it out there. It's important."

6.3.4 Practitioner concerns about incorporating spiritual care

"It becomes difficult when it's…when somebody believes differently from your belief. So, the conversation becomes a bit difficult, especially if you don't know (everything about that religion or belief system) or you don't know the route that the person is taking. Let's say, for example, the person usually goes to a traditional healer and then says that no, I don't want this medication or I'm not going to give my child this medication, because I take medication from a traditional healer, then that's when it becomes difficult for me," one of the research participants remarked. "In African spirituality God appears to be both distant (remote) and near, transcendent and immanent. Divinity is perceived in terms of vitalism, as a force that moves and rules humanity and determines their fate in the world. In African thought inclusiveness is important and, therefore, African religion is both communal and anthropocentric. The role and veneration of ancestors in African spirituality emphasise the unity and continuity of life. African spirituality cannot be separated from the complexity of guilt and shame experiences" (Louw, 1998). HE_1 also referred back to the Wright (2005) model that identifies spiritual distress as being linked to three distinct emotional roots: fear, guilt and/or shame. The health professionals' patient cases discussed during the focus group illuminated underlying fears and guilt that are experienced by patients. One health professional described a case where a patient raised thoughts during a consultation that their ancestors might be angry with them if they did not ask for permission for a medical procedure beforehand. This is, however, not much different to questions that are asked in other faiths (e.g. Christian), where patients ponder whether their having contracted an illness is a punishment from God. Practitioners might be concerned about having the skills and knowledge to address questions and concerns raised when facing patients with different spiritual views and how to bridge this 'gap'. Walker and Breitsameter (2017) recommended that health practitioners need to be equipped to be comfortable and familiar with various religious practices so that they "know how to react in any given situation." Health professional education and continuous development should include this topic of uncovering and managing patients' spiritual distress within the context of different beliefs with practical learning through patient cases.

Traditional medicine plays an important role for many patients in South Africa and the African continent. **"**Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures, whether explicable

or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness. Traditional medicine is generally available, affordable, and commonly used in large parts of Africa, Asia, and Latin America. The World Health Organisation (WHO) estimates that about 80% of the population in developing countries still depend on traditional medicine for their primary health care needs" (Kasilo et al, 2010). The WHO supports countries in Africa to effectively implement a Traditional Medicine Strategy. To this end, South Africa has developed traditional knowledge legislation: "This is a relatively new subject area and, as a result, only a few countries such as Eritrea, South Africa, Uganda and Zimbabwe, have developed or reviewed their legislation to include the safeguards provided for this in the Trade-Related Aspects of Intellectual Property Rights (TRIPS)." There are, however, still a number of challenges that are now being faced by health practitioners having to counsel and treat patients that utilise both traditional and clinical health services. The WHO reports (Kasilo et al, 2010) that there are still limited research data available on the quality, safety and efficacy of traditional medicine. Health professionals also have limited knowledge on traditional medicine, as this has not been included formally as yet in health sciences education. One of the focus group participants said the following concerning this: "I do have a concern. I'll only explain the advantage of a thing. Even though I know the patient might be wrong, she must leave the room with the right information. It's like those people that are taking those herbs (traditional medicine). Because I normally tell them, if you start with the herbs, this is good, it will control the blood pressure, whatever, but if you go to the medical side, don't mix things, because at the end of the day your blood pressure is gonna drop. It's either, you follow one rule. Don't mix things." One of the health professionals interviewed added to this concern by saying: "My concern normally is, I normally tell them what is special with the herbs, because the dosage is not measured and we don't know the mixture and the quantity. So, some of them from ICU, they landed up with liver cirrhosis and kidney failure." Another research participant responded in a similar vein to the concern raised by a fellow health professional during the interview: "For example, talking about myself, I remember I took these herbs one day, because people will sell those things to you. They will tell you these are good. Like, I'm asthmatic, so they told me that the asthma is going to be finished (healed). Things like that. Then I started this medication (natural remedies) that they gave to me. That medication reacted to me, I was sick like the, like allergies. My body was swollen. I understand my colleague (name deleted) when she said okay, they (the patients) will tell you what they are using, but you need to give them hard talk about those things." These in vivo quotes expressed the importance of understanding patient perceptions and values and how traditional beliefs and spirituality intertwine with personal health practices. It also highlights the complexities faced by health professionals to honour and accommodate patients' preferences and offer good clinical care.

The intertwining of traditional practices within a Westernised clinical health care approach and the complexities that have to be dealt with were raised by various health professionals during the focus group interview. The conversations amongst the inter-disciplinary team during the focus group reminded me of two patient interviews where the use of natural

remedies/herbs were cited as useful by patients and considered by both as part of their spiritual health care practices. The overlap between culture and spirituality and underlying beliefs of patients that are linked to fear or guilt was raised by a member of the inter-disciplinary team during the focus group: "The trick for me there is when they believe the condition they have is from the spiritual reasons. It is very tricky to convince them. They are convinced, but you educate somebody otherwise, because we are practicing Western medicine. If somebody believes that what they have is traditional things. It's caused by 1, 2 and 3, so then we can take these herbs, as much as I have given information on the Western medicine, but it will be, for me, I will still have to somehow engage to why they actually do think these other things. Well, as I mentioned before, I will probably say, you know, if you believe this is why you have this and you have been taking these herbs for it, you should never mix that with the medication that we give you, because if you don't like, you don't know what's happening. But if they don't themselves give information you say, maybe you need to consult the spiritual healer, because they will give you correct information and advice based on what you're suffering from. But otherwise, in any consultation, it's something you should look at." Another participant added to this with the following: "I think the point that I want to bring is, whatever people believe in, it works for them. So, in most cases, what they believe in, it works for them. So, it becomes very difficult when we have to advise, medically so." One of the inter-disciplinary members reiterated this: "It is like the placebo effect. So, even if it's not necessarily effective, but the fact that spiritually they, in their mind, they believe these will work, because of 1, 2 and 3 reasons, in most cases it will work for them. That's why it's so hard." One participant's comments elaborated on having a person-centric approach within the context of different spiritual beliefs and health care practices: "If it is not going to be harmful, then don't change it: If they (patients) believe it and from a medical point or a dietetics point you don't think there's going to be harm, let them continue with it." The incorporation of traditional medicine within a scientific health care approach will have to be explored further. The starting position should be that whatever is practised or prescribed does not cause harm. If that is upheld, then the practitioner should create a context within which the patient's beliefs and preferences for care can be accommodated.

6.3.5 The patient narrative as a contributor to health or illness

The Functional Medicine Timeline (Institute of Functional Medicine, 2017) and Matrix (Institute of Functional Medicine, 2014) both recognise the importance of the patient's narrative as a possible mediator or perpetuator of clinical symptoms or illness. The health experts and patients interviewed during the research affirmed this. The focus group interview also highlighted that the inter-disciplinary team considered the patient's life-story, perceptions of fulfilment and achieving a purpose and experience of emotions such as peace and joy as important components when taking a spiritual history. They recommended enquiring, if the patient consultation and context permits, about the following: "Ask them if they are happy about their life. Are they currently happy with their family, their children, themselves? Do they feel that things are well; or do they wake up and they don't feel well; or do they not fit in where they are? Are they uncomfortable?" Another participant contributed

to this conversation by saying: "Maybe also, to add that, when you can ask them things like do you feel like you achieved your purpose or anything around finding one's purpose. I don't know how to rephrase, but it may be one can also pose many questions relating to problems to spark that conversation of spirituality." This relates to the model by Wright (2005) and De la Porte (2016) that describes emotions that stem from experiences and perceptions as triggers or the 'spiritual roots' of diseases that were also described by the health experts as relevant pathways to improved health outcomes in their practices. Puchalski and Ferrell (2010) also state that patient questions on their identity and contribution to society as linked to their purpose and meaning-making of a diagnosis is, to them, just as important a component of the consultation as the discussion of the treatment plan. Often, this is still neglected during the health consultation, but if health practitioners are open to enquiring from their patients what their personal thoughts are around their illness and how this fits within their greater life-story, it could be beneficial to the patient and practitioner.

6.3.6 The patient narrative as a tool to identify spiritual distress

Taking a spiritual history or performing a spiritual screening during a clinical consultation includes assessing whether the patient is experiencing spiritual distress (Puchalski & Romer, 2010; Koenig, 2007). The CSI MEMO was developed by Koenig (2007) to understand the role religion might play in a patient's life in coping with his/her illness or identifying whether it is a source of stress. The inter-disciplinary team shared personal patient narratives that emerged during health consultations where patients relayed spiritual distress indirectly when an experience was shared. The health expert interviews also indicated that health practitioners should look out for this as a 'natural hiatus', as referred to by HE_1, to introduce a spiritual discussion. De la Porte (2016) argues that the patient narrative plays a vital role in empowering the patient in a multi-cultural context: "Not only do we have diverse cultures in society playing a role but also the 'culture' of the medical environment and health care. This environment has its own language, principles and interpretative systems. Often patients experience that their own interpretive systems break down in this environment." The following anecdotes from the interviews describe this approach in practice as told by the participants during the focus group interview: "There was this one lady, she tested HIV positive and then only to find out that she's a housewife and the husband is the one sleeping around. So, at some point I felt like, she felt like… is God punishing me or like blaming God for that? Because she's not the one who's sleeping around. So, it's very difficult to go that route if they're not expressing it. Only when they express this concern, then you'll be able to go down that route of advising or trying to tell a person that it's not your fault or it's not God's fault." One code that emerged repeatedly during the patient interviews was finding peace and acceptance of a chronic illness and preparing for possible death – not only for the patient but also for the loved ones staying behind. One of the participants told this story that relates the role that health professionals can play in a patient's life to improve functioning and overall well-being by discussing these concepts with their patients in the light of loss or suffering: "I had a patient, it was a lady patient. She said: Sister, you know I don't have the desire to have sex. Now, I had to speak to her about what the reason is. Unfortunately, her husband was

outside and then she compared the late (deceased) husband with this one. Now, I think every time I try to tell her that she's – that if you're with somebody you need to call him during the day, ask him this and that. But in the end, and I asked her, I said, you know I normally miss the motivation, then I started opening up…Then she said, oh Sister, no, but you are counselling, and I said, no it's just work, talking; I'm not counselling. But I can see there is something that is changing. I said it must come to you. You must think of when you see your husband, you must have that thing that I want to sleep with this man, because you got married to this man. Don't try to push him outside. And then the husband came, because I called him. Then when we were talking he said things, I said things, she said things. Then she said, Sister, thank you, because you know we've got parents at your age. They can't discuss some of the things that we ask. When we are with them, we cannot ask them, even if you've got problems, because they are our parents. We'll just leave it, but at least you are older, we can understand what you are saying." The value of being present, listening to patients' stories and being intentional in relating patients' experiences to their spiritual and emotional context is an important component of quality spiritual care (Magrath, 2016).

One health professional in the focus group described a patient case and the difficulty that a patient had with accepting a diagnosis of being HIV+, and how counselling her on finding peace and moving towards an attitude of acceptance and meaning-making assisted her with hope for future fulfilment: "When we started with HIV, there was one Afrikaner lady. She was having it and she couldn't take it, and every time she came, she cried, and with different beliefs and whatever I will try to ask her, how is your husband? No, my husband is around, but he still loves me. What do you do at home? Can you please try, I know it's not easy, every time you prepare a table for two try to make things which will make you happy? I gave her the example that I have got two couples**:** This one is HIV positive, this one is HIV negative. But from the negative side there's no love. From the positive side there's love. Which one would you choose? Because the negative will leave you at home, go whatever. The positive will hold you with the hands. You still have loving friends and family. Which one do you prefer? And all my patients, I normally help them that they must feel I'm part of that. And after some time I will tell you, can you please come even next week. Just knock on my door and then try to build that. To me that person feels… I'm still loved. I say, don't shield. There's no HIV that is written here (on your forehead). When they leave my room, they must feel comfortable." One of the focus group participants shared her own story of overcoming severely symptomatic asthma by moving towards acceptance of her condition and social context: "I grew up like with asthma. I'm an asthmatic. So, the time – it started when I was 23 years, I remember, then it was worse. It was very worse. Like, people would tell me this thing killed my aunty, this thing killed my mother, killed – it's like – I'm gonna die, I'm gonna die, I'm gonna die. At that time, I couldn't even realise that I'm getting thinner and thinner and thinner. It's like I was dying. Then one day, like time and again I was hospitalised. Then one day the doctor came to me and she started to say to me, you know what, it's not only you who are having asthma. Even my child. I was like, a doctor? Her child? Then he said to me, if you're not so upset that you are having asthma, you will live long, and from that time, I accept it. It's difficult, but I accept

it. I started to be better and better and now I forgot that I may have asthma. Just like that. It was something positive to me. Like I remember somebody told me that I need to accept this. It's happening to me, to my body. It's in my system, just like that. Accept it. I accept it. Now, I'm okay. I'm with my pump everywhere. Those people, those who saw me those years, like twenty years before, were like, is that you? It's something, because they thought I'm dying. Just like that." The value of creating a context where patients can share their fears and reframe their experiences by making meaning, finding hope and transcending circumstances, could have a life-long impact on a patient's clinical experience of an illness, as described in this story.

During the interviews, in response to the examples given, I (the researcher) noted the following: "The stories you now told, patients interviewed for the research also told me: That they want to feel that they are not just their diagnosis and they want to have hope beyond this disease, and that's why I'm asking, how can we create that experience? You know, you're telling stories of how we can create that. Even by relating to someone that has a faith as you said, (name deleted), that you don't have a similar faith, but you can understand if that is so important to someone else, then we can harness that. And sometimes it's weird to us, but to another culture it's normal. And that could be anything. For instance, the Greek Orthodox Church has specific beliefs, and then Jewish, Christian and even just in Christian faith, you can ask ten Christians and they will tell you ten different things they believe. So, it's nice to, as a multi-disciplinary team, to discuss how do we approach that. Because if we get our patients to say, okay, but despite *this* I have a full life or I have this, I have hope, I have love, then we have helped them."

6.3.7 Recommendations to frame and guide practice

The health practitioners made the following recommendations that were also included as part of the framework discussed in chapter 3. The health professional should adopt an approach and attitude that:

- is non-judgemental;
- is accommodating of different beliefs and worldviews;
- upholds patient autonomy and assures patient confidentiality;
- reflects an approach that is person-centric;
- establishes good communication (verbal and non-verbal) and rapport;
- displays empathy, understanding and respect;
- creates an environment where the patient is at ease and comfortable to talk;
- promotes listening and being present to enable the patient and his/her narrative;
- seeks 'common ground' that the practitioner and patient can agree upon as a treatment plan or way forward;
- makes adequate time to have a quality conversation; and
- refers appropriately for a specialised need.

The recommendations made by the practitioners during the focus group had much overlap, with the codes identified during the health expert and patient interviews. The emphasis during the focus group was, however, slightly different. The health practitioners interviewed worked in a setting with a variety of very distinct worldviews. Daspoort Clinic served an impoverished Afrikaner community in the immediate catchment area surrounding the clinic; however, in recent years various informal settlements were also established in the areas with thousands of refugees and undocumented immigrants settling in the area. Each sub-culture brought with it unique beliefs and practices. The team conveyed, through stories shared and principles recommended, the importance of not looking down on someone because they hold a different worldview or spiritual belief. Traditional practices and medicine played a strong role in many cultures that influenced the uptake of recommended health and lifestyle choices. The team emphasised that only when the practitioner is able to respect the patient's beliefs and display empathy and understanding would one be able to make recommendations that could be acceptable to a patient and have an influence on health outcomes. Spirituality and creating a space for a patient to not only share, but incorporate his/her beliefs within the health plan, was a cornerstone to impact lifestyle choices and overall health.

6.3.8 Impediments to quality spiritual care

The health professionals discussed the following possible impediments to offering quality spiritual care:

- Lack of knowledge (from the health professional) on different spiritual beliefs
- Reluctance or discomfort of the health professional with regard to discussing spirituality (One participant remarked, "we are trained not to bring your beliefs to the table.")
- Patient fears/concerns that the health professional would not be open to discussing spirituality
- Spiritual practices in health care that exclude certain faiths/beliefs

Often impediments can be overcome if health practitioners choose to address patient concerns with an open mind and create an environment that is person-centric.

6.3.9 Spiritual rituals in the health setting

Walker and Breitsameter (2017) describe the importance of 'rooms, rituals and symbols' in the hospice and chronic care setting that accommodate various beliefs and religions. De la Porte (2016) also adds to this discussion with the following: "Traditionally, health care practitioners did not want to engage with 'spirituality' because it was more or less equated to 'religion' and thus seen as outside the scope of health care. The health care benefits of religion and spirituality are acknowledged and it has become part of the discussion about health and illness. There is broadening consensus that must be taken into account by health care workers in general when diagnosing and developing and accessing treatment plans. Religion and spirituality can also play an important role in the life of a health care worker. In many cases it is tied to a sense of calling or a personal philosophy about care. It also plays a role in resilience, coping with a stressful environment and preventing burnout."

Both health care workers and patients interviewed during this research indicated the need and benefit of being able to express their spirituality as part of their health experience through preferred individual and corporate spiritual rituals. The inter-disciplinary team cited in various instances that prayer played an important role in one-on-one health consultations. The team also cited the value of corporate prayer in a community site that patients were invited to participate in the morning before health care consultations commenced. The research participants commented on the benefit of this collective spiritual ritual on their own well-being. One participant raised the concern that some patients might not share a similar faith (in this instance Christian) to the rest of the group and that patients could feel excluded. "I guess somehow we started praying in the morning. So, I think it works badly and also good in a way. For instance, let's say before we proceed to sing and pray or ask patient if, we'll tell them that we don't force anyone to participate and then the bad way of it is that the one who is not gonna participate, the others are gonna look at them as if, why is he not participating or is the belief that this person believes in other things? But the good thing about it also, is that it's building them spiritually. So, I'm not quite sure whether it's good or bad when we do it on a public setting, when we do the same thing to a group of people." Another participant added: "The question is what about those who are not participating. How can we accommodate them?"

The complexity of practising corporate faith in a 'secular' clinical setting, however, is something that has to be well planned and implemented in such a way that different religions and faiths are accommodated. This does not have to happen at the same time, but patients should be able to express preferred spiritual practices within a health care setting. If patients should be able to practice their faith and express this in the clinical setting according to their perceived needs, then a person-centric approach should also accommodate the health practitioners' participation in such activities and their expression of their own spiritual and religious beliefs. This should, however, be done in a respectful manner that accommodates varied beliefs.

One participant related a spiritual ritual that family members came to perform after the death of a loved one in hospital: "It's like in a hospital situation there are some other people with the belief that they are coming to fetch the soul of a person that has passed on. I mean, if a patient is in a situation like this, you draw the curtains. You let them perform their own things there on the bed. They will come with something like tree (a branch) or whatever, a stick, with which they go collect that soul. Then somebody will open the door. The ones with the soul will follow." This was an experience that one of the health professionals relayed about working in a hospital setting where a patient had died and the family came to 'collect the soul' of the person according to their custom. A member of the inter-disciplinary team also relayed the story of two Jehovah's Witnesses patients who refused to have their blood drawn for pathological tests owing to their beliefs. "It happened, I think twice last year. We encountered the spiritual beliefs that influenced care from two patients. A medical student wanted to draw blood from one patient and that patient said no, my church's belief is that you don't have to

draw any blood from me or maybe do a blood transfusion. I called a colleague to assist the student, because myself, I didn't know what to say to the patient or to the student. They (the patients) were here for a second visit and they (medical staff) asked for routine bloods. And then he said, no, we are not allowed to take out the blood from me or even put any blood in me."

The theme of ancestral and other religious beliefs and the influence these might have on clinical care was evident in the patient interviews and inter-disciplinary focus group. One of the participants discussed the complexities of managing different spiritual needs related to rituals by describing a patient case: "I encountered a patient who believes in ancestors. So, basically, according to that belief, you cannot take blood before you speak to the ancestors if you go to the hospital. You should explain to the ancestors that you need to. They might take blood, so they (the ancestors) must allow you to do it. So, basically, the story is we struggled to take blood from the patient. We struggled. And it didn't makes sense, because I mean, the event alone isn't necessarily hidden. It's quite strange. I don't know how it happened, but so he says: 'By the way guys, I didn't ask for my ancestors that I'm gonna take blood today, so that's why you are struggling.' I was confused, but it's only later then I realised that some of these things can affect you if you don't believe, if you don't believe in them. I don't know, but it did happen. I can tell you, we couldn't get blood from the patient."

The personal anecdotes shared during the focus group uncovered the need for patients to be addressed, not only with regard to their spiritual needs within a context that supports their spiritual rituals, but also in order to support the health professional team in a similar matter. Whether prepared or not, health professionals in the African setting face different spiritual beliefs, needs and requests that they would not only address better if this were part of their formal clinical training, but personally cope with more effectively.

In chapter 7 to follow, my personal reflections on the research process will be described.

Chapter 7
Autoethnographic reflections on the research process and findings

Chapter 7 is a reflection on my thoughts and experiences on the research process and data yield with the various participant groups throughout the research. The chapter contains my autoethnographic writings after each cycle of data collection. The chapter first describes what I called the 'triad components of quality spiritual care' as a model that emerged through my reflections. The triad was also in the discussion in chapter 3. The rest of the chapter contains the reflections for each of the participant groups. I followed a way of writing up my personal reflections for each of the cycles of data collection as described in this chapter.

7.1 The triad of quality spiritual care

The triad of quality spiritual care described in this chapter is my own model as an outcome of the research process and findings. The triad comprises a patient profile/narrative, spiritual screening and/or a care tool and an appropriate health team member. This model was derived through the theoretical coding that was used to describe relationships detected between various categories of codes identified. As mentioned in chapter 2, the value of theoretical codes in grounded theory is that they can contribute to research that is relevant, as this type of coding can maximise making meaning of the data with greater scope (Glaser, 2005). In this case, the model assisted me with meaning-making in support of building patient resilience and addressing spiritual needs or distress as an outcome of this research process and findings.

Three distinct theoretical codes, as the components of the triad, were identified as interacting when implementing spiritual care in practice. These should be balanced to achieve the best possible outcome in a person-centric approach. The three components were written down during my reflections on the interviews with the health experts. The second round of data collection during the patient interviews helped me to formulate my own ideas on this even further. The three components of the triad for quality spiritual care are as follows. The health professional becomes familiar and takes time to understand the patient narrative and background within the patient's current health and social context. This includes the acknowledgement that to affectively address a spiritual need, the patient within his/her personal, social and cultural context, cannot be ignored if one wants to address care holistically and incorporate spiritual care appropriately. The second component of the spiritual care triad is that the health professional is able to utilise and implement the most appropriate spiritual screening or care tool. The last and third component is knowing when to refer, and to whom, if the health professional is not equipped or best suited to address the spiritual need. Throughout the interviews, all three groups raised the importance of having

the most appropriate team member address the spiritual needs of the patient. This includes knowing what to address when conducting the health consultation and when to refer for specialised care.

I consider it appropriate that any member of the health team should be able to do a spiritual screen. Depending on circumstantial factors such as the time available, the relationship established, the nature of the distress and the skill of the health professional, the health professional might take a brief or a full spiritual history and/or incorporate spirituality in the care plan, or refer the patient for specialised care. The skill and art lies in matching the right spiritual screening and care tools to the individual patient, facilitated by the appropriate team member. Figure 7.1 below depicts the three components of quality spiritual care in relation to each other.

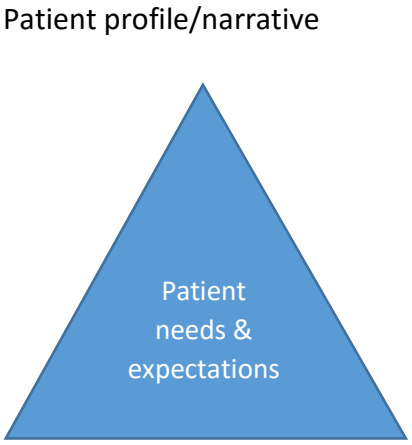


Figure 7.1 Spiritual care triad

Throughout the rest of the chapter my reflections of the various participant groups will be discussed, starting with the reflections on the conversations with the health experts.

7.2 Personal notes on the conversations with the health experts

My memos and reflections on each of the three individual expert interviews will be described in the text to follow.

7.2.1 Reflections on the interview with Frans (health expert_1)

The interview with Dr Frans Cronje, a medical doctor with experience in incorporating spiritual care into health consultations and practice took place in Pretoria, South Africa on Sunday, 28 May. On 26 and 27 May, we were both presenters at a conference organised by a local counselling institution named Abba Care that focused on a holistic approach to offering health services at individual and community level. He presented his own research on incorporating spirituality within the bio-psycho-social model. His presentation on the second day of the conference, was a well-researched model with him having ties to international research done on this topic with Duke University and having presented on it at numerous conferences and

meetings around the globe. The formal interview was done at 11:00 on the Sunday in a study in my parents' house. The entire interview was audio-recorded and I also made written notes of the interview draft that we both had a copy of beforehand. The interview took nearly two hours. The transcription of this into written format and its incorporation into the framework took five months. It was not easy to give a dense account of what we discussed that could unpack all the wisdom and genuine care to meet the patient's needs and offer holistic solutions as portrayed during the interview. I had to repeatedly go back to the audio version or the transcript to make sure that what was said was not only accounted for accurately, but portrayed the richness and fullness of the principles and approach he described during the interview. During the interview, I asked him questions that were prepared beforehand and linked to the draft framework, also sent to him before the interview via email. The idea was not that this should be followed point by point, but to give Frans an opportunity to formulate and express his own opinions and experiences on the topic. Whenever a new theme or discussion not included in the draft framework arose during the interview, this was explored to the extent that both parties felt enough was said. Frans had much more to say than I asked in a single question. Although he was assured beforehand that he could choose not to answer a specific question or label it as not important in his opinion, he had valuable ideas on every question and also introduced his own thoughts beyond what was presented in the first draft framework, which influenced the research process and helped to expand on the existing draft framework.

7.2.2 Reflections on Frans as a health expert and a person

I had been familiar with Frans' professional work for a number of years. This included videos that were available online that described his model or approach clearly. I was also familiar with his ties to and research collaborations with one of the first authors on this subject, Dr Henry Wright (2005), of the Be in Health programme described in a book titled *A more excellent way: Be in health*. The research with Dr Wright and Frans' own research and publications have given him credibility as a *health expert* on this topic. He was also trained in research in spirituality and health care by Harold Koenig and has published as a primary author on the impacts of spiritual programmes on physical health.

Although we had not met in person before the interview, I had phoned him on a few occasions to pick his brain on patients that I had seen in my own practice where the spiritual component of the treatment for a chronic illness had seem to be key for progress in the management plan. He had always been professional, insightful and open to sharing from his vast knowledge and experience.

The Sunday after the two-day conference, he came to stay over at my parents' house (whom he also did not know) so that we could first have a more informal discussion on my interest in the field. He also discussed with me his personal motivation to become involved in research on spirituality in health care: As a young medical student he described having seen that the biological approach to disease management often only led to controlling symptoms and minimising harm from disease, but did not offer long-term solutions to the underlying social,

emotional and spiritual roots. Frans' knowledge on genetics and its links to certain diseases as well as the emotional experiences that are often associated with having certain genetic codes expressed in an illness became an interesting conversation for not only myself, but my family. The discussions had around the dinner table the Saturday evening and Sunday morning before the interview offered insights to my family's social construct and personal health stories. This set the tone for a very open interview where deep discussion was possible. Frans, however, navigated the interview to continuously link experience to international research and current best practice on the topic.

I conducted the interview in the study room of my parents' house with only the two of us present, and I audio-recorded this for subsequent perusal. I gave Frans a printed document outlining the interview the day before. A week before he came to Pretoria for the conference (as he resided in the Western Cape), I emailed him a copy of the draft framework and interview schedule to familiarise himself with what my research entailed. Frans was of the opinion that he would have preferred not to see the questions beforehand, but rather talk 'off the cuff'. He felt that he was indirectly led by my questions and would have wanted to start the interview by talking about his own experiences and opinions, not being informed beforehand about others' experiences and approaches. Frans' knowledge on the subject was, however, substantial and he was familiar with most (if not all) local and international authors on the topic. He had a well-defined approach and had published his own model on the body-soul-spirit link to diseases based on embryology, genetics and individual expression in socio-emotional and biological interfacing that had been cited by others and was supported through independent research in succession to his work.

The interview was more than a formal discussion to me, unlike other interviews I have had in the past in a professional capacity, as it was impossible not to expose underlying thoughts, prejudices, experiences and fears, but also joys and triumphs in my journey as a doctor seeking holistic care and solutions that go beyond a reductionist approach or disease-based model. His philosophy on spirituality in health care exposed my own motivation to do research on spirituality in health care, and this was also the reason we were able to have such a meaningful conversation, although he was actually a stranger to me: "I have found (at least for myself) that when it comes to addressing spirituality in the health consultation, I first have to be comfortable with my own spirituality and worldview. I was at first very uncomfortable about my own spirituality and addressing patient needs in this context. I felt that it was as if I was having some sort of agenda. I was very defensive and felt as if, in some vague way, I was going to impose my own opinions and worldview and intrude on someone else if I addressed this in the health consultation as I want to bring about some change to the person. Then I realised that spirituality is a physiological feature of mankind. With that concept in mind, it is far easier to have just a human-to-human conversation with the safe assumption that spirituality is a physiological feature, and that the conversation and language we use and have, spirituality may either be facilitating of the conversation or raise unnecessary objections. The realisation and perspective that this (spirituality) is an attribute of man, rather

than a tool of therapy, is what I want to explore." His words helped me reflect on my own journey up until this research and helped shape my approach to follow with the rest of the interviews.

7.2.3 Personal thoughts on codes that emerged after the interview with Frans

A person-centric approach came across as a golden thread throughout the interview. With a person-centric approach, attention is given to the various roles that the person portrays in society – those of being a parent, spouse, member of a social club or society, subscribing to a belief group or fulfilling a certain professional role. A person-centric approach also recognises the clinician in the room as a person participating in the health process. Person-centrism is health-focused, more so than only disease-focused. A person-centric approach is just as much interested in the patient's illness experience and response to his/her disease as to the clinical indicators of the illness. Although my draft framework had a patient-centric approach initially, over time, with interactions with my supervisor (Professor Werdie van Staden) and also subsequent to the interview with Frans, I realised that his words helped crystalise my own thoughts and intentions on the topic: "One of the most important paradigms that I have come to appreciate is that patient care should be a patient-driven rather than a therapeutic-driven process… Being patient-centric (person-centric) is very dynamic and one cannot assume because the physical medical discussion follows a particular slant of avenue or level, that the spiritual health discussion will follow a similar trend. And therefore, it is really focused on the patient and non-judgemental. Patient-centeredness is not a homogenous aspect when it comes to the different areas or domains of existence. Confirming, supportive – absolutely! Non-judgemental. Graceful opportunities to bow out."

The interview with Frans offered practical examples on how spirituality could be incorporated into a health consultation, whether that be active or passive. I became distinctly aware of the importance not only of what was said during a consultation, but also how this was approached and the importance of timing during the consultation. Frans' mentioning of waiting for a natural hiatus before venturing to have a conversation regarding spirituality with his patients gave insights to his approach.

Frans felt very strongly that quality care is as much a perception as an objectively verifiable standard that should be attained. His remarks on the importance of the patient's experience and expectations of the experience, and how this would greatly influence the perception of quality, had me re-evaluate the South African context of various cultural expressions and their influence on how individuals choose to express themselves. After the interview, I was acutely aware of the importance of patient perception on quality care and its links to a person-centric approach.

I realised that the draft framework at that stage did not accommodate flexibility for practice-specific context. Frans used the example of an over-busy cardiothoracic surgeon vs someone whose practice was more focused on community or contextual individual health. The

approach for the two clinicians would differ when addressing spirituality in a consultation, although both might have the same intention to address the spiritual needs of a patient.

I noted this internal conflict that I was having on what would be considered good and ethical care with regard to spirituality and health issues when encountered in the clinical setting. Frans mentioned the various differences in approaching a patient and described this metaphorically as representative of a male or female approach, which he called *mothering* or *fathering: where the first would be more nurturing and the latter focused on giving instruction and perhaps even (moral) direction.* He pointed to the ethical delicacy with which this should be approached: "Moving from the mothering to the fathering style, and if you are imposing your views of spirituality this would be considered a potential violation of patients in a vulnerable state, but not making use of dimensions that could alter a patient's lifestyle would also be negligent. And I would like to refer you to the structured equation models that look at the primary modifiers in the whole assessment of spiritual health outcomes: social support, mental health and risk-taking behaviour. And so, the ways in which those elements that are so vital to many health outcomes should also be framed within spiritual health outcomes. And so not being able to respond to these modifiers could be considered negligent, because then you are not using a patient's value system to guide them back to healthier living. But, this is delicate as it can come across as accusatory or trying to convert someone to your value system. It is still something that needs to be explored."

When I asked Frans what he would consider as possible impediments or catalysts to offering spiritual health care, he asked what exactly was meant by a catalyst. He gave a descriptive definition and we had a useful discussion about what I meant and what he understood. I realised that I would have to clarify this going forward by giving a definition or description of what I asked from the research participants interviewed.

Useful theories were identified during the interview that needed further exploration and were incorporated into the final framework. These included the FICA model by Christina Puchalski and the CSI memo tool by Harold Koenig: CSI memo – Do you have concerns? Does it cause you stress? Is there anything spiritual that will influence the care that you want? Are you a member of a spiritual community? Do they support you? Are there any other spiritual considerations? Frans commented: "These are established models that screen whether a patient's spirituality is a resource to him within his health context, either because of himself, or his community of faith that are a practical extension of his spirituality. So it could be an asset to him or a liability such as with negative religious coping or when a person feels punished."

The first interview also influenced the planning and structuring of the research to follow. I made a note to consider this after his words: "First obtain the patient/professional's views of what their spiritual health expectations are and then present the framework to them to respond to this. And press into this by giving them clinical cases or vignettes. So give them example such as Ms X is terminal…give them just enough flesh to respond to this." His words

made me consider differences in approach in a terminal patient versus someone suffering from a chronic condition, a hurried surgical consultation vs a primary care consultation. His recommendations were helpful during the interviews to follow.

Frans recommended that after the expert interviews were conducted I then move towards interviewing patients before presenting the framework to health professionals to ensure that the needs and preferences of the patients were incorporated into the framework appropriately. Frans recommended approaching Andre de La Porte, the chair of Hospivision, who had organised two national conferences on the topic of spirituality and health care. Andre de la Porte was also linked to the University of Pretoria. I mentioned to Frans that I attended both conferences and also heard Dr Puchalski present at the last conference held in Pretoria on this topic, and that she, together with the Spirituality and Health conference I attended in Poland two years earlier where Dr Koenig and Dr Carson presented, all had an influence on the drafting of the initial framework and research process. Frans' recommendations on authors to read up on confirmed that the literature review and draft framework for the research up until that point was in-line with what other leaders in the field had described. Another positive was that I had spoken to Andre de la Porte beforehand about this research, as I also considered doing an interview with him. Frans' suggestion to involve patients that approach Hospivision when conducting interviews strengthened this view of mine that the involvement of professionals and patients linked to the organisation would be a good idea. The second health expert interviewed also attended the conference in Poland and the spiritual health conference organised by Hospivision in Pretoria. The third health expert had presented her own research at one of the conferences organised by Hospivision prior to the interview.

7.2.4 New awareness due to my interview with Frans

I realised that the interview with Frans did not only influence my research approach, but had an impact on my own future approach with patients, professional development and interactions with the inter-disciplinary team. His words made me question how I would want to be approached as a patient with regard to my spiritual care and by whom: "I hope that what this research of yours will reveal to an extent, is that in addressing a patient's spiritual needs, where are also confronting our own need to have this resolved within ourselves, regardless of having different worldviews. People would argue that we shouldn't proselytise people to faith, but the very nature of medicine is to proselytise people to atheism. We have a stereotypical idea of what spirituality is, as opposed to what is our perspective on life.

I think that medicine's ethos in developing instruments for spiritual assessment is based on the principle of first do no harm and assessment. I think the shortfall currently lays with that the person doing the spiritual assessment, might not necessarily be the right person to address the issue. Coming up with the perfect instrument of assessing the need is not necessarily the perfect instrument to address the spiritual needs."

7.3.1 Reflections on the interview with Liz (health expert_2)

The interview with Me Elizabeth de Kock Myburgh took place in Pretoria, South Africa on 18 Aug 2017. The interview was conducted on a Friday morning at my house over a period of almost two hours. The interview was audio-recorded for later perusal and transcription to written format, in order to facilitate referring back to it and incorporating it into the research document over time through analysis and coding of the content. Elizabeth (also known as Liz) had prepared herself well for the interview. She brought in a number of printed documents that described her own approach to spirituality and health care and also the works of others that had informed her practices in the field. The Functional Medicine approach was amongst the documents she stressed as having been instrumental in this area of practice for her. We sat at a table, discussed personal matters over a cup of tea (as we had known each other for years) and then moved to the formal part of the interview, at which point the audio recorder was switched on. The interview began with me stating her name and the date and thanking her for agreeing to do the interview. Liz spoke easily on the topic and had read through the draft framework and interview guide beforehand. Throughout the interview, I also made handwritten notes that were used during the transcription and the incorporation of the codes into the next version of the draft framework. I did the transcriptions myself, similar to the previous interview with Dr Frans Cronje. I listened to the audio recordings numerous times, going back to my notes on that day and her own words to ensure that a true account of what she said was portrayed and that nothing was missed. Liz had been given an updated version of the draft framework. She received the framework and interview guide two weeks before the interview and had the opportunity to familiarise herself with the types of question I would be asking and the current version of the framework. I worried before sending this to her that she might choose to speak 'off the cuff' from personal experience and not prepare or familiarise herself with the content beforehand. She came well prepared. The interview was concluded after she had nothing more that she wanted to add to the discussion, after an hour and forty-five minutes, and the audio recorder was stopped at that time.

7.3.2 Reflections on Liz as a health expert and a person

I first met Elizabeth a number of years before because of her health background in bio-kinetics and her application within the context of spiritual health counselling and skills development. In her practice at the time she had a strong focus on pathology counselling and worked with patients suffering from a chronic disease, from a perspective that included spiritual components and lifestyle in relation to disease management. Most patients that came to see her had a chronic disease such as high blood pressure or diabetes. I trained with her for Kilimanjaro, which I climbed in 2012 as the team doctor for a group of women raising awareness against human trafficking. Liz had climbed Kilimanjaro earlier as part of a team from Unashamedly Ethical. She coached me on utilising spiritual resources to excel physically. She had learnt through this experience to navigate through layers of physical, emotional and spiritual challenges to improve overall health and performance. Although I advised the other climbers to use medicine to prevent altitude illness, I did not do so myself, and rather focused on using spiritual techniques such as mindfulness, prayer and deep-breathing exercises to

keep these symptoms at bay. Although I had less time to train than many of the other climbers, as I had a young baby at home and could only start training five months before (after he was born), this focus and the grace of God allowed me to climb much faster than my 48 teammates, and I had an amazing spiritual as well as physical experience when I did summit hours before the rest of the team. I knew that Elizabeth, although she calls this pathology counselling now, was wholeness-focused and person-centric in her approach. Her ministry was also called Wholeness, and she had published her first book on this and was almost done with a second.

The Functional Medicine approach offered a practical tool in her practice that met her holistic approach. The first health expert had also used this as one of a number of tools in his practice. Elizabeth applied it to most, if not all her patients. The usefulness of this tool is that it summarises a patient history beyond the history of the disease. The timeline notes or records all the significant events in a person's history from birth to the present. One would record any traumas or difficulties that patients had experienced. The timeline also leaves spaces for noting triggers or triggering events and documenting possible mediators/perpetuators of health or disease experience, including making a link between circumstances that would mediate a patient's experience of improved health or events that would make it worse. With each of these events, one also would record any signs, symptoms or diseases that the patient reported. Family history or significant things that happened before conception or before birth were also recorded. This is linked to exercise, nutrition, stress, and emotional, mental and spiritual status. Her words summarise this approach: "To understand this person and where he is now, I need to understand how the health that is represented in the body is linking to the spirit and soul, as this is interlinked. We are one complex being that functions systematically. So, is this body moving from homeostasis or survival mode?"

Elizabeth preferred using a spiritual pre-screen in her practice where patients had to complete a questionnaire beforehand (she considered this part and parcel of the health consultation) and also a form with a relevant medical history in a health practitioner's waiting room. This was a somewhat different approach to HE_1, as Frans expressed during his interview that a spiritual pre-screen had its place, but in his opinion it was very limited in picking up anything apart from identifying spiritual distress. Both, however, felt that a pre-screen in combination with the approach that incorporates spirituality into the health consultation appropriately would be best. The patients that came to see Liz at this stage in her practice, however, were there because of an identified spiritual or emotional need, whilst in the case of Frans, with his work as a medical doctor, patients came to see him for a number of reasons, with some booked the consultation in the knowledge of his incorporation of spiritual care in his practice. The difference in practice between the two struck me.

Elizabeth's spiritual approach to offering care was from a Christian perspective. She spoke about this openly and with great conviction, but also empathy and love for people. I knew that Frans was also a Christian, yet this was not discussed in depth during his interview, except when he highlighted the success of the Be in Health programme and research that he was

involved in to evaluate this approach on a group of chronically ill patients at Duke University. It could be said of both interviews that the compassion of the professionals interviewed deeply imprinted on me.

Liz's person-centric approach came out as a strong theme during the interview. When asked what she considered as an ethical and quality approach to introducing spirituality as part of a health consultation, she said: "I think you should always have the patient in mind. First find out what your patient believes and see how you can connect to that... Let your patients feel at home with you and be able to share what they believe. And don't judge your patients. It is important to be non-judgemental."

Liz stressed the usefulness of prayer as a spiritual tool in her practice, both for her and the patients. I had mixed emotions about this. I did really believe in prayer myself and often had used it. However, I was aware that this would not be something that all patients would be comfortable or open to receive when visiting a health practitioner. Over the years, in my clinical experiences, I have however prayed with patients from time to time after having asked their permission and witnessed its benefits. The usefulness of this for the patient outside of the clinical consultation as a spiritual tool has been recorded. Within the clinical context, I thought this to be a tool, but perhaps not one that would be used regularly.

Liz mentioned forgiveness and creating an opportunity for patients to go through their life experiences and *let go* of negative emotions that are holding them back, as a tool. This strongly links with gratefulness. These two concepts, although they seem simple to me, have over time become relevant and have surfaced in many scientific articles I read on mindfulness. But it has become more than that in both my own practice and work with patients, and in my personal life I have become more acquainted with the benefits of incorporating this into daily practice. *Forgiveness in health, medical and social sciences* was also the theme of the 6th European Conference on Religion, Spirituality and Health and the 5th International Conference of the British Association for the Study of Spirituality scheduled for 17–19 May 2018 at Coventry University, UK. I would present the qualitative findings of the three expert interviews conducted as part of my research thus far, and Elizabeth's approach and description of how she applies this to health consultation and counselling sessions had been a definite link to an international theme in the field.

Elizabeth described another tool that she used, which was her own work: She calls this the *Dynamic Cycling Method.* This tool had some similarities to the Functional Medicine approach, yet what was so nice about Liz's tool was that she had an image of a bicycle with descriptive words on the various areas that guided the patient through the consultation, giving imagery and words to questions asked and allowing a patient the opportunity and time to formulate his/her own thoughts. In my mind this tool could be easily used in many cultures and across a variety of age categories. Her description of how she used this tool became a very practical example of using a metaphor to uncover a patient's history and current needs/ wants: "I developed this model as a bicycle with two wheels. So the one wheel is my past and

the other is what am I rolling out now; so where am I going with my choices. The saddle is my presuppositions, my assumptions and opinions. What am I 'sitting on'. The handles represent what I have my hands on – what am I steering too. So it is important where you coming from, your experiences that shaped you and then also where you are going now and what choices you are making. So the pedals become the choices I make to steer my bicycle in a direction. If my past and my future is aligned and I sit well in my saddle, then you have a better ride. The ride of life. I use this kind of model to obtain someone's history and also see where they want to be or go. So if you for instance have a genetic predisposition or family history for a certain illness, then you must make sure that your choices do not 'unlock' the expression of the genes that can cause that illness."

I could clearly see the value of what Liz was describing: she used her health background in combination with her training in counselling to navigate between neuro-science theory, coaching a patient on healthy lifestyle practices and integrating this care with the spiritual and emotional needs of the patient. Her holistic approach to offering care was an example of what had sparked my original interest in the topic and had me explore this formally through research. This quote captures the essence of this beautifully: "So the bicycle approach is similar to the Functional Medicine Framework and these to me are the important aspects to cover: In the history, what happened to you and your family history, also not just diseases, but repetitive cycles and emotional or traumatic experiences. What would trigger this? What attitudes that you have that mediates this experiences. Your triggers come through five senses – what you see, hear, touch, smell and then this follows a neurological path to link you to previous memories, good or bad. This is all part of the back wheel. Then I will find out what beliefs they sit on: for instance, an inner vow such as I will never date another man. That creates then circumstances that when they are confronted with this they have a stress response that has an impact on the body and your health. Concerning a person's timeline, you can then go back to specific traumas and help someone to resolve that issue and then I have seen how some patients improve in terms of their health outcomes, e.g. they can later reduce or stop their blood pressure medication."

7.3.3 Personal thoughts on codes that emerged after the interview with Liz

The interview with Liz revealed a number of areas that I noted to explore further and include in the framework. My notes included the following that were later used as codes for inclusion in the research: the Functional Medicine Timeline; Elizabeth's own model, the Dynamic Cycling Method and its relevance to other approaches; and forgiveness as a tool in itself. Practical values to display when incorporating spirituality in health care came across as a strong theme during the interview.

7.3.4 New awareness due to my interview with Liz

My interview with Elizabeth (Liz) not only conveyed a well-balanced approach, but highlighted values in quality care such as humility, patience, person-centrism and creating an environment that is supportive and non-judgemental. The importance she placed on incorporating spiritual care into practice is clearly seen in these words: "I do not see the body

as units, but as a whole. Just as when someone has a muscular problem in the back one has to look at the hip and the knee etc., similarly the whole person should be treated, not only the disease. Spirituality is at the core of healing and health. I think if the profession could just understand this. If someone is spiritually connected, then they have already put healing in motion. Our bodies were created by God to function from homeostasis. So if the sympathetic nervous system takes over then health cannot be restored and therefore patients need to be educated on their thoughts and emotions and its impact."

7.4.1 Reflections on the interview with Wendy (health expert_3)

The interview with Wendy Greyvenstein, a clinical psychologist, took place on 2 November in Pretoria at her practice. I had made an appointment to see her over a month before and she had requested to see the framework and interview questions. The interview was audio-recorded as with the previous interviews and I also took along a printed copy of the questions and the latest draft framework for the interview.

Wendy had prepared well for the interview and we not only discussed the questions as per the interview guide, but her ideas on the topic were clearly formulated and she had made notes on the interview guide beforehand with comments on ideas that she would want to add addressing spirituality in the health context. I made written notes as I conducted the interview and referred back to the draft framework, but also allowed her to dwell on any topic as long as she wanted or to introduce a new concept during the interview. The interview took over an hour and a half. I transcribed the interview (as with the other two experts' interviews) myself. This process took several hours and required that I listen to the audio more than once to accurately record all that had been said. I had found that this process added to my own understanding and analysis of the content of the discussion and often made me aware of a nuance of a topic that I had not identified before.

The transcription was used to identify codes and add content and dimension to version 4 of the draft framework. This was the last health expert interview, and the continuous revision and adaptation of the earlier versions to where the document was at that point not only took months to write up, but had produced a robust and lengthy document that included as much as possible of the interviewees' own words and original thoughts.

7.4.2 Reflections on Wendy as a health expert and a person

I had asked Wendy for an interview as I knew that she was busy with her PhD exploring the topic of religion, spirituality and mental health from a Christian perspective. Not only was she a clinical psychologist working full-time in private practice, but she had vast experience in the area of psychiatry. Wendy started a multi-professional forum in Pretoria earlier that year that met from time to time to discuss patient vignettes, unpacking the ethical issues regarding spiritual care in various clinical settings. She had also presented on this topic at national conferences in South Africa, one of which I attended a year earlier. It was evident during the interview that Wendy was very passionate about addressing the spiritual component during a health consultation or treatment plan as part of a holistic approach. Wendy reflected on the

concern of health professionals, especially in the field of psychology and psychiatry, to address the spiritual component in health care: "Specifically in my field people have been nervous about the difference and intersection of spirituality and religion and how to address this in practice. For me it is a devastating place for psychology as a field to be: If we are working in a 'sacred' space of the patient every day as a practitioner working with a person that is vulnerable and in pain; if we are not open to incorporating spirituality into our therapeutic model then I feel that we are managing that patient unethically."

During the interview it was clear that Wendy was driven by both personal experience and her understanding of professional practice that followed a holistic approach. She conveyed how after a personal loss she consulted with a colleague in her own profession and found that the person ignored her own (Wendy's) spiritual beliefs and values during this process for a number of reasons, including professional discomfort and not sharing the same spiritual and religious beliefs as Wendy. This experience made Wendy reflect on her own practice as she felt that she could not adequately move on and come to a place of mental and emotional health if she did not unpack her spiritual beliefs regarding this experience. Since then Wendy introduced in her informed consent document that her patients sign before their first appointment with her that during the health consultation patients would also be asked about their beliefs, values and spirituality if they consented to this.

Wendy discussed concepts similar to those that emerged during the transcriptions of the interviews with Frans and Elizabeth, including being non-judgemental, creating a 'safe space' to unpack opposing worldviews and allowing for a person-centric approach. Just as the previous two respondents did, Wendy mentioned the FICA tool as a practical approach to introducing spiritual concepts during a health consultation to identify and help address patients' possible spiritual distress. One new concept that was not mentioned before was that of *transparency.* Not only did Wendy feel that the health professional should be transparent about the process, but also about his/her own beliefs and spiritual views in combination with creating a space for the patient to feel safe and discuss his/her own worldview. I was still not sure whether all situations required of the health professional to state his/her own spiritual and religious view, but could see the value of this in certain situations. The delicacy of addressing this in the health context struck me.

Wendy stressed the importance of research on this topic and formulating an approach that is evidence-based. She raised concerns that professionals might have with regard to addressing spirituality as part of a health consultation or care plan, such as that some do not consider it appropriate to discuss this as it is not 'neutral' and can impact on the patient-professional relationship. Her response to this was: "I have found that it spirituality and religion inevitably enters the room, and the question is when it enters the room we should be equipped to handle this. And the question is, are we equipped to deal with this? Often the health practitioner ends up ignoring this or backtracks as they are not equipped or comfortable to deal with this."

It was clear that Wendy felt very strongly about a team approach to addressing the health of the patient, including the spiritual component. She discussed openly the 'grey areas' that needed to be defined more clearly, including when to refer for spiritual care, whom to refer to, what should be addressed by a medical doctor and what the domains of a spiritual counsellor and a psychologist are. These items need to be teased out during later interviews with the multi-professional team as part of my research.

Wendy remarked that because she stated in her informed consent document that her consultation would follow a bio-psycho-socio-spiritual approach, this assisted her in creating a natural hiatus to introduce this topic during the consultation. She explained to her patients what this entailed, which allowed her to follow the discussion up with questions such as: "How important is your faith to you? What value do you place on this in your life? Following up on this answer I will ask whether they go to a specific church or religious gathering. I ask this because I want to be respectful also about the place where they feel they are spiritually safe. I will ask if they are receiving spiritual counselling from someone there."

Wendy unpacked ethical issues such as creating an environment that is safe for patients to discuss their spiritual beliefs. She also highlighted the 360-degree view of a person-centric approach to including the beliefs, preferences and opinions of both the health professional and the patient. She emphasised the need to have an ethical framework that could guide a person-centric approach when including spirituality in health care. She also raised the opinion that for a health professional not to be able to voice his/her spiritual beliefs when appropriate could be unethical and not constitutionally grounded. This was an interesting discussion that made me rethink how to practically formulate principles that would guide both patient and professional as part of the framework. Wendy's remarks on the importance of the health practitioner being comfortable about his/her spirituality reminded me of similar words spoken by the other two health experts that I interviewed. It struck me how important it is to know how to formulate what one believes on the one hand, and on the other to feel comfortable enough to allow a patient to discuss his/her own worldview. The conversation made me realise anew what HE_1 alluded to: Confusion or anxiety regarding one's own spirituality and religion can create a barrier for an ethical and quality approach to addressing the patient's needs.

Wendy discussed something that Frans also brought up during my interview with him: "One thing that comes up often during our inter-disciplinary meetings is that a health professional will struggle with the duality of being a Christian and wanting to give a value-laden interpretation to what they consider right or wrong. That is so complex, the practitioner sits with a patient that wants to do something that is contrary to his/her faith and then they often feel either like a lesser professional or lesser Christian." Her words made me rethink the discussion Frans and I had regarding this as he raised the question of whether there is a difference between doing health education regarding lifestyle for diabetes or safe sex practices and that of good spiritual practice. The difficulty would lie in not imposing your own moral opinions on your patient and creating a negative experience or aggravating guilt or

anxiety in the patient. I realise that this is an important issue, but I was still unsure exactly how to address this in the framework.

7.4.3 Personal thoughts on the codes that emerged after the interview with Wendy

Wendy listed both the FICA tool and RUSH model as useful. She did, however, ask whether that was appropriate for the South African and African context and whether this should be rethought for our context.

The interview made me realise the importance of defining the roles of the various health professionals as part of an inter-disciplinary approach to addressing the spiritual needs of patients. I noted that this should be clearly mapped in both patient preferences and professional opinion during the next phases of the research.

I also made a note to read up on the works of authors listed by Wendy, although the contents of their works were not discussed. These included: Kenneth Pargament (also mentioned by Dr Frans Cronje) and Mark McMinn (in his book *Integrative psychotherapy* he presents a model that Wendy considers practical to implement). Wendy also mentioned the stages of spiritual development and how these overlapped with the other phases of emotional or physical development; an example of this was Ericson's model, mentioned as important by Wendy. She felt health professionals needed to have an idea of the spiritual stages of development of a person over a lifespan to fully understand how to incorporate spirituality in health treatment.

7.4.4 New awareness due to my interview with Wendy

Wendy referred to a number of articles by scholars on spiritual care. Her own research for her PhD on including spirituality within psychology was valuable in shaping her thoughts on ethical aspects to consider and also our discussion and important concepts that I had to consider in my own research. The importance of spirituality for patient care emerged repeatedly throughout the interview. The need for clarity on how this should be addressed and by which member of the professional team, as part of a person-centric approach, was a golden thread throughout the interview.

Wendy felt very strongly that "in order to address the patient's needs effectively, spirituality and religion must enter the room." She quoted this as part of a study done in the United Kingdom that she had read that described principles for a person-centric approach. It struck me how we should actively seek out opportunities for holistic care. I also became aware during the interview that one needed to continuously develop the skills and focus on a correct attitude to address this both ethically and at an appropriate level of quality. Understanding local context and the various sub-cultures, even in a religion or population that might seem homogenous, is very important. Her words summarised this well: "I think that religion and spirituality is often flippantly placed within the world of culture. But culture can be viewed on a macro and micro level. When I look at the patient's spirituality I want to understand how the macro-culture influences the patient, such as society or church, as well as how the micro-

culture, like close family and friends, view their spirituality, as both impacts on the patients' beliefs and experiences."

7.5.1 Reflections on the interviews with the patients

On 26 June 2018 I jotted down memos in preparation for the patient interviews. The patients that were interviewed for the second cycle of data collection were invited via email to participate in an individual interview at the High Performance Centre, where they attended regular health and fitness sessions in individual and group settings. The patients were enrolled for a chronic disease programme that was offered by their health insurer, Bestmed medical scheme. I had been facilitating spiritual health workshops on a monthly basis in a group setting over the last two years that included addressing the latest evidence-based health practices for controlling disease in combination with spiritual health tools such as mindfulness and breathing exercises. Managing spiritual distress included dealing with emotional stumbling blocks that could perpetuate illness such as anger, bitterness or struggling with forgiveness. These concepts where explored in group sessions. Individual patient consultations to address specific spiritual concerns were booked on patients' request and were not routinely included in the programme offered by Bestmed.

The patients that belonged to the scheme were sent an email with details on the planned research and were invited to participate should they be interested. Patients could respond to the health programme manager at the scheme, and those who did were scheduled for interviews until the time slots were full. It was decided that the first round of patient interviews would include ten patients, and depending on the data saturation, a second round of interviews could be conducted with respondents who could not be accommodated during the first round. The individual interviews were scheduled at the High Performance Centre of the University of Pretoria.

The informed consent document used for these interviews was in the same format as that used for the interviews with the health experts. Before the interviews commenced, the interview guide was adjusted to use terminology that reflected on patients as research participants, not health professionals as in the other interviews. Questions that contained phrases such as 'If you were a health professional' were altered to use phrases such as 'From your perspective as a patient'. A number of questions were added to frame the conversation in contrast to that of the health experts, who were accustomed to incorporating spiritual care into their health practices on a daily basis. The patients were not necessarily familiar with spirituality being addressed during a health consultation, outside of their exposure in the group setting that their health insurance scheme offered them as part of managing their chronic diseases. The questions that were added include:

1. If you were approached by a health practitioner during a health consultation about questions pertaining to your spirituality would you consider this relevant?
2. If you were approached by a health practitioner about your spirituality during a health consultation would be open to discuss this with the health practitioner? Please discuss why you feel this way?

3. Would you describe yourself as spiritual?
4. Do you belong to a specific religious group? If yes, which religious affiliation would describe your beliefs best?

The above questions were added in the beginning of the interview guide as introductory questions. I added these to put patients at ease and to make sure they were comfortable discussing the more detailed questions on spiritual care within a health context.

I also wanted to know whether they considered themselves spiritual and/or religious to see whether patients did link the two concepts and to what extent this was important to them, as expressed during the interview and potentially during a health consultation. This was in response to the third interview with one of the health experts, where the participant responded that in her experience as a psychologist, patients often see their being religious and spiritual as the same thing, especially in a country such as South Africa, where 90% of people profess to be Christian. This is often integrated with local African spiritual practices.

My plan was to begin the interviews by asking the questions as guided by the interview framework, and then to present patients with the latest (at that stage numbered as the sixth draft) framework that was titled the *Patient Booklet*. After obtaining their opinions, I would also have them give inputs on what had been developed thus far.

The motivation for making the changes not only to the research questions asked to the patients, but also to the structure of the interview, was to let the patients guide the relevance of a question, the depth of the discussion and the trail of where the discussion would lead. The intent was to determine, from the bottom up, the real needs, wants and expectations of patients with regard to their spirituality. The patients' questions were seen as a loose guide to initiate a conversation, and patients were given the opportunity to speak freely about their views on spirituality, what they considered relevant to the topic in their health context and whether or not they viewed this as appropriate during a health consultation or treatment plan.

7.5.2 Reflections on individual patient interviews

The patients were very excited to participate. Both the first interviewees considered themselves spiritual, but not religious. The importance of confidentiality was stressed by the participants, with both providing examples of this not being honoured in the past.

The first research participant (patient) was a librarian at a tertiary academic institution before she retired. She valued the past inputs of colleagues and the multi-disciplinary team at the High Performance Centre as part of the programme. She related these as spiritual experiences that had impacted on her health and well-being.

Patient one had a chronic lung disease that required specialist and inter-disciplinary health management, and because of this she said that she did believe her illness influenced her spirituality. I was struck by her soft and almost tentative approach to the topic and also by the amount of thought she had given to death and dying. She said that although she

considered her physician to be a good doctor, he never discussed this with her and she felt that this was an important topic. She thought he might not do this because then it would seem like his 'treatment had failed'.

The second patient interviewed, in contrast to the first, was not terribly ill (although she had a chronic diagnosis). She did not perceive the burden and complications to be too serious. She was an educator with a PhD and also research experience. Her lively expression, zest for life at a late stage in her life, and open worldview struck me. She could cite from Buddhism, Christianity, Greek philosophy and various worldviews and religions. She gave me valuable insight into the research approach to be followed with the patient interviews and said that she had pondered beforehand how I would approach this. If my approach was too wide the smaller fish would escape; if the questions were too specific then the bigger fish would break the net, she said. She related her own research experience, saying: "You only have to ask one question to a participant, and if it is a good one, they would be able to talk," referred to the FAI attitude towards interviewing where you ask only one question, let the participant talk, summarise, wait long enough for participant to speak again, and let this continue until the participant has said all he/she has to say. This bottom-up approach was what I found worked for me during the patient interviews. It was also the goal that I had with a person-centric approach, with the patients informing the research rather than the previous work and contributions from others dictating their responses.

The changes made to the questions proved to be important and very useful. My memos at that point noted: "Starting the interview with whether a patient would consider it relevant to be asked about their spirituality during a health consultation has elicited the same response from ALL the participants up to now. Every patient's question to that was: What do you mean by spirituality? I turned that question around by asking whether they consider themselves spiritual and what their expression of this is? All patients considered themselves spiritual thus far, with half being religious also and the other half (four patients interviewed up to now) not belonging to a specific religion."

I found it interesting that all patients believed a holistic approach to care that included spirituality was relevant, but most were unclear on their preferences regarding how this should be addressed. I pondered whether it had to do with the fact that most patients had never had any exposure to a health professional asking them questions relating to their spirituality and health. One patient remarked that this would be a deviation from what is considered 'The normal work of a doctor'. I was surprised by how our profession's disease-based approach has influenced the expectations of our patients in terms of what to expect and want from a health consultation.

The next patient I recorded as Mr Y. He was a psychologist by profession. It was interesting to me that our contact within group sessions in the past had highlighted that he thought mindfulness was very useful. However, when asked about spirituality and its relevance during a health consultation or therapeutic process, he was open to the idea, but said that he had

never explored this during his own practice. He said that he did not feel equipped to do so. We discussed the role of the multi-professional team and he thought it best to have a chaplain or someone with a background in a specific religion take on this role. It struck me with this interview that his hesitance was related to personal stories of wrongful application of spiritual practices being harmful as it produced hope of a possible cure (a miracle) and let to death and disappointment. I took it from this conversation and also from the work by Koenig, King and Carson (2012) that spirituality and its application within a health context should first not harm. It should be appropriately applied and meet the needs of the patient, but should not be presented as a magic wand or quick fix to problems.

The subsequent patient interviewed I noted down as Mr Q. He was a patient with whom I was very familiar as part of the chronic disease management programme. He had attended a number of the wholeness and chronic disease educational sessions that I had facilitated in the past. He had also seen me for one-on-one health sessions with a spiritual coaching health focus. In light of this, he volunteered to participate in the study and was enthusiastic about what worked for him with regard to incorporating spiritual care and what did not. He had strong opinions that he did not hesitate to voice. I enjoyed that he was very open and forthcoming about being spiritual, but not Christian, and that he valued exploring the benefits of spiritual tools such as mindfulness, living aware of what contributes to the worsening of his clinical parameters related to his hypertension and diabetes. He described positive and negative spiritual and emotional experiences' impact on his health: Mindfulness and spending time in nature to feel connected were mentioned by him as spiritual practices that had a positive influence on his health and controlling his glucose, blood pressure and weight. On the other hand, he described how emotions such as anger or hopelessness had in the past influenced his health in a negative manner I found it very interesting that someone who praised the benefits of incorporating spirituality into health throughout the consultation process and treatment plan also felt that if it was not done in an honest, patient-empowering and competent manner, it would be a waste of time and money for both patient and practitioner.

Mr M, my last patient, explored the role of traditional healers. His thoughts on the value of them as part of a multi-disciplinary team within his family context was striking. He was a Christian and did not believe in ancestors, or at least had never visited a traditional healer for personal reasons. Despite this, he spent quite some time discussing the value that they could add to a holistic care plan to attend to the spiritual needs of patients. He found prayer and the gardening of herbs at home to be useful as part of a remedy for his diabetes and hypertension. He remarked that this contributed to spiritual peace and improvements in clinical outcomes in terms of blood pressure levels and glucose control. I was reminded during his interview that if we as health practitioners really want to be person-centric, we have to start by listening to our patients. Making a real connection was voiced as pertinent by most patients who participated, as was spending quality time on the consultation to get the know the patient, including his/her preferences, greater social context and other needs.

During the interviews I followed a similar approach, and it created a context for meaningful discussions that were personal anecdotes on the value of spirituality and its incorporation into a holistic health lifestyle.

7.5.3 Personal thoughts on codes that emerged after the individual patient interviews

All the patients questioned what was meant by the word spirituality, assuming that each participant would interpret the word differently. Despite this, they all viewed themselves as spiritual and only one of the three professed to be both spiritual and religious.

The value of care and the actions and attitude (the non-verbal communication) of the health professional, more so than what words that were used, were important for what patients considered as a spiritual approach in health.

A strong theme that emerged was that of the attitude and communication skills of the health professional. All the patients considered how something was asked to be more important than what words were used. Ethical values such as honesty and confidentiality were mentioned often. Patients in this group belonged to a chronic disease management programme, and all of them linked spirituality to end-of-life issues and wanted their health professional to be open and honest about risks and possible diseases linked to death and dying. The importance of this topic and the exploration of underlying fears of how and when this might occur, and what could be done now to make life worthwhile, struck me. The patients all said that their health professionals had never ventured talking to them about this (spirituality or death and dying), despite one of the patients having a severe medical diagnosis related to a chronic lung disease. Patients all noted that they felt the health consultations were too rushed and that contact time and a personal interest were more important than asking questions related to specific things. Listening to a patient seemed to be more important than trying to elicit a specific conversation relating to spiritual and emotional needs.

Death and dying, and the role of spirituality as a tool to ‘re-package’ one’s problems or help a patient with meaning-making and concepts such as forgiveness, hope etc., featured in this interview. Patients cited honesty and trust as pertinent. I realised that patients wanted to feel that someone sees them and values their individuality. I noted that this should be explored also in terms of *who* (what member of the multi-professional team) explored the patient’s spiritual needs.

All patients interviewed were open to the idea of discussing their spirituality. The how and what, however, were of concern to them. They were also very focused on trust and good communication, including having enough time to discuss their thoughts and fears. Death and dying and the impact of their disease on their long-term health and happiness were a major concern. Patients voiced their openness to exploring how their spiritual resources and new skills could enhance their health and overall well-being. The patients also described the importance of timing. This included the timing of the conversation and also having enough time for the consultation. Building a relationship of trust and openness were important

principles cited by patients. I could hear from what the patients described that good rapport and creating an experience that made patients feel heard and recognised as a person were important to them. The interviewees repeatedly referred to their need to not feel rushed and to have a meaningful conversation during the consultation. I was reminded of the importance patients place on the opinion of the professional that they are consulting. Health professionals should be cognisant of the value that they add to a patient, clinically and emotionally. If we lose the human connection during the consultation, then we have not reached or helped our patients.

The importance of spirituality when a patient faces a chronic illness were raised numerous times. Patients with arthritis, pain or who required a surgical intervention all viewed the spiritual component as part of a quality care plan. This included having a discussion on the spiritual needs and possible distress in preparation for surgery. I thought that offering spiritual support as part of a chronic disease programme within a hospital setting or as part of a patient's medical/health insurance for specific conditions could be another way to include an opportunity to address the patients' needs within a health care environment. I made a note after the patient interviews to include practical ways to address this at the systemic level as an outcome of the research.

The patient interviews also made me consider including my own experience as a health professional on the Bestmed programme and the benefits of incorporating the spiritual component as part of the autoethnographic component.

I was wondering how to define the limits of spiritual care? What are the borders in terms of caring for your patient spiritually or holistically? Also, when should a professional intervene beyond the spiritual beliefs or practices of a patient, if ever? Perhaps one of the more obvious examples was where the patient's beliefs were contradicting the best treatment option, such as in the case of a Jehovah's Witness who needs a lifesaving blood transfusion. All individual rights and needs were limited in the balancing of recognising another person's rights. This made me aware that clarity and a process is needed for a professional to know when the clinical needs should receive preference above the spiritual needs.

7.5.4 New awareness due to my interviews with the patients

The interviews with the patients reminded me of what Dr Chris Steyn (international coordinator of Christian Healthcare Fellowship) said about spirituality and being a good health professional: "soft touch, caring eyes, getting up for your patient and not just calling from behind your desk for the next one… listening and talking with a voice that affirmed the value of the patient as a person." I made a note that managing a patient holistically requires a team approach. Patients with chronic diseases should be supported not just by their doctor, but by every member of the team. Support could include group sessions, individual coaching and linking the management of disease to spiritual and emotional support and resources.

7.6.1 Reflections on the focus group with the inter-disciplinary team (HP)

The focus group was held at Daspoort Clinic on 12 March 2019. The group interview started at 14:00 in the afternoon. The eight participants all signed informed consent forms and were familiar with each other as they worked together as an inter-disciplinary team offering clinical care at the primary care facility. The care was also linked to personal care within the patients' own environment through household visits to patients in the surrounding community. The community that they served was mostly impoverished, comprising people of various nationalities with a high burden of social problems. All the participants also knew me as I had worked at the clinic as a medical doctor in the past and was still linked to the health team through services offered in various informal settlements in the area within the community. The team was enthusiastic to participate and shared personal and professional stories. Even after the audio-recording was stopped, they still continued to discuss the topics that were raised during the group discussions with each other, and re-iterated the value of such a platform to share their own feelings and inner conflict on managing spiritual needs of patients that might differ from theirs or evoke strong personal feelings that they struggle to let go of afterwards.

7.6.2 Reflections on individual health professionals that participated

The health professionals related their own experiences on integrating spirituality with patient care by stating that they had at times discussed their 'own stories' with patients, prayed with patients or shared resources on how to accept their disease and transcend beyond this overwhelming illness.

Some health professionals shared that they started with singing and worship before the clinic started. This was practised in such a way that patients were invited to join in should they wish to do so. I noted that a number of the interviewees felt that this built relationships on a deeper level, with patients and also amongst staff. I also noted that care has to be taken that someone with a different belief does not feel excluded. One of the participants mentioned that she had been concerned about this in the past. Creating 'spiritual space' for different beliefs amongst colleagues and patients was raised as important to fostering an environment that is conducive to sharing spirituality.

An example was given of a patient who gave permission to have blood drawn on himself, but when the health professional struggled, the patient said it is because he did not ask his ancestors permission before he came to the clinic to have blood drawn. Professionals needed to be equipped to assist a patient in circumstances like this to address the spiritual distresses and needs. I was reminded by this example of what one of the patients interviewed said about his continued spiritual distress almost a decade after his surgical intervention for arthritis of his knee, as he still wonders if he should have trusted God longer for a miracle healing that would not require surgery. Health professionals often underestimate the long-term impact a seemingly acute medical intervention can have on patients, and specifically on their spirituality. If patients are not asked about this and offered support to come to a resolution

for themselves that gives them peace, it could linger as an underlying spiritual distress in their daily lives.

The health professionals openly shared their own spiritual concerns and distresses. The patient narratives of severe diagnoses, loss and suffering were not easy for the health professionals to let go of. This also made them ask questions on a personal spiritual level. Health professionals asked questions such as: "Why does God allow so much suffering?" The focus group also described the difficulties they faced in knowing where the boundary was when having a spiritual interview and discussion with a patient as the conversation by nature was often very personal and created an opportunity for the health professional to identify with the patient on a human level that allowed for more open sharing. I made a note that health professionals, similar to the patients they serve, needed continuous support and an opportunity to debrief. This should include the spiritual and not only focus on the emotional and psychological.

7.6.3 Personal thoughts on codes that emerged with the focus group

I was struck afresh by the patient vignettes described by the participants – how different beliefs could complicate the conversation between the health professional and the patient when enquiring about spirituality. One example that was described by many participants during the focus group was that of a patient who placed a high value on the health advice of a traditional healer and herbal medicine that he recommended in a context where the health professional was concerned the combination of this remedy with other medicine (for instance TB treatment or anti-retroviral treatment for HIV) could have a detrimental effect or reduce the efficacy of the medical product prescribed. The participants described how they struggled to know what the best approach would be in cases where patients followed certain practices because of spiritual beliefs that were potentially clinically harmful. I wrote down a note after their discussion that the health professional needed to be able to 'distance himself and make room' for the patient to voice his/her own beliefs and make personal choices about how to combine spiritual beliefs with the medical regimen prescribed as far possible, with the requirement that the bio-medical principle of 'first do no harm' is upheld. I realised as I listened to the discussion amongst the professionals, the importance within the African context of exploring with a patient not only what they believe, but how they personally incorporate this into their health care and lifestyle. When a patient believes that the root cause of his/her illness is spiritual, this needs to be engaged just as any other emotional or social contributing factor to disease.

The contributions of the inter-disciplinary group further unpacked what emerged during HE_1's description of a mothering vs a fathering style of incorporating spiritual care. Frans described how a mothering style would 'allow or make room' for beliefs, although this might not be thought the most suitable or 'best'. This was likened to counselling for lifestyle choices that impacted on having a risk of contracting a chronic disease, e.g. chronic stress. HE_1 described a fathering style as being more direct in its focus to counsel a patient towards making healthier choices. The inter-disciplinary discussion with the various participants

represented different health professions with different cultural and religious beliefs. Their discussions revealed the complexity in the African context, where patients often wanted to supplement the recommended medical treatment with traditional medicine or a ritual prescribed by a traditional healer. The conversations on a person-centric approach that was honouring of the patient's beliefs and that upheld autonomy made me come to the same realisation that was described the participants in the focus group: If a patient had a spiritual belief or practice that would not harm the patient's health, it was not the role of the health practitioner to try and convince the patient otherwise.

I realised as the participants described various patient cases that the patient narrative was a tool in itself to identify spiritual distress. This would perhaps be more useful in understanding the context of the distress than a direct approach where a patient is asked whether they have spiritual distress. The value of listening to patients retell their stories surfaced throughout the interviews. The focus group described their own personal stories and experiences. They also described the stories of their patients and how the narrative and being interested in your patient's story and listening and making a connection with your patient based on genuine care and interest could assist the patient to not only express a spiritual distress, but 'work through it'. I made a note to include this in the framework.

The focus group described experiences on the value of spiritual rituals. This was the 'practical next step' that had not been described by the other participants. I made a note to include this in the framework – specifically, what had been described during the focus group and also what had been written in existing literature. I was struck by how much had been written about screening and history taking within the context of spiritual health care, and in comparison, how little information was available on how to incorporate the spiritual rituals in practice as preferred by patients. More research would be needed to explore how health professionals should incorporate spiritual care in a multi-cultural setting. The importance of spiritual rituals described in the patient cases by the focus group participants were wonderful patient vignettes that not only described the importance that patients might place on incorporating a spiritual ritual within and/or throughout the clinical experience, but the variety of patient preferences and expressions that the health professional should be equipped to respond to.

7.6.4 New awareness due to the focus group with the inter-disciplinary team

The role of cultural and traditional health practices, in combination with expression of one's spirituality, in opposition to a more Westernised approach to care can often be complex for the health team to manage and discuss with their patients, but this does not mean it should be ignored or excluded from a holistic care approach. One needs to know when to refer to a team member that specialises in addressing spiritual needs/concerns.

The final chapter to follow describes the findings of the research in the context of existing knowledge on spiritual care in a health consultation. The implications and applications of the research, as well as the study significance, are unpacked.

Chapter 8
Appraisal and implications of the study

This chapter appraises the findings as described in the preceding chapters and their implications. It is presented in three sections. In the first section, the main findings of the research are discussed in their African context and situated in current literature on spirituality and health care. The second part of the chapter reflects on the methodological aspects of the research. The third section considers the implications and applications of the findings, both for practice and future research.

8.1 Research findings

The discussion below describes the research findings within the African context and also within the context of existing literature on spiritual health care. It also includes a discussion on the significance of the findings within this context.

8.1.1 Research findings within the African context

The argument for incorporating spiritual care has been made throughout this thesis. Puchalski and Ferrell (2010) captured the essence of this need with the following statement: "People deserve 'total care' where they can speak authentically about their illness and where their spiritual needs as well as their physical, social and emotional needs are addressed. Illness, aging, and the prospect of dying can trigger profound questions about who people are, what their life meant, and what will become of them during the course of their illness and perhaps when they die. Who am I? How will I be remembered? These questions have the same importance in patients' life as do questions about treatment."

Taking a patient history should include an enquiry on the patient's spiritual history and current spiritual state, screening for distress. In the words of one of the research participants: "Holistic care includes the incorporation of the spiritual component in a manner that is acceptable and relevant to the patient. I believe we are different parts. We are body, we are mind, we are soul. So, I think the health care isn't complete until all the aspects have been addressed. When we consult a patient…We must find out what the person believes in, because some patients will come in and if their beliefs are not what you're going to deal with them, then they will automatically walk out and go somewhere else where their beliefs will actually be addressed. So, we have to address it. It is something that is happening and we need to look into it."

This research was conducted from Pretoria, South Africa and its findings reflect the African context within which it was conducted. The participants were sampled purposefully from various sites in South Africa. Three scholars participated based on their roles and experience as health practitioners (irrespective of whether they were for or against a framework). Two

of the scholars resided in Pretoria at the time and one in Stellenbosch, Western Cape. The views of ten users of health care services (i.e., patients) who belonged to a chronic disease management programme in Pretoria were purposefully sampled. For the third round of data collection, eight health professionals representative of various disciplines participated in a focus group at a clinic based in Pretoria. Participants were invited to take part in the research with the specification that they had an interest in holistic care and more specifically the inclusion of spiritual care in the health consultation and care plan.

Traditional medicine plays an important role for many patients in South Africa and the African continent. **"**Traditional medicine is the sum total of the knowledge, skills, and practices based on the theories, beliefs, and experiences indigenous to different cultures**,** whether explicable or not, used in the maintenance of health as well as in the prevention, diagnosis, improvement or treatment of physical and mental illness." (Kasilo et al, 2010). Research participants, both from the perspective of the patient and that of the practitioner, cited the need to have (varied) spiritual practices incorporated into clinical care. The complexities of how to address this in a manner that would satisfy the patients' needs and be acceptable to the practitioners within a care context were described with different patient-case experiences: "It becomes difficult when somebody believes differently from your belief. So, the conversation becomes a bit difficult, especially if you don't know (everything about that religion or belief system) or you don't know the route that the person is taking. Let's say, for example, the person usually goes to a traditional healer and then says that no, I don't want this medication or I'm not going to give my child this medication, because I take medication from a traditional healer, then that's when it becomes difficult for me," one of the research participants remarked.

The role that culture plays in how spirituality is expressed and in which manner patients want this to be addressed was evident throughout the interviews. The health expert interviews and inter-disciplinary focus group all referred to the skill and sensitivity required to deal with different religions and cultures. In the African context, the belief in ancestors and their involvement in health and illness of patients' stories, should be accommodated. One of the patients interviewed stated: "My aunt believes in God and also (prays) to ancestors, and you have to be very sensitive when you talk about those. Because we Christians, we feel we could be judgemental and we see that, um, these, we don't have any other God and then we want to shut them out, so we need to find a way of incorporating different cultures, (like) a Muslim's spirituality."

Patients and practitioners interviewed reiterated that traditional medicine and consulting with a traditional healer is a reality of the health context in South Africa and Africa that cannot be ignored. "Start with the patient. Is the patient inclined or does he like traditional healers, or is he for the health practitioners as we know them? And once he knows himself which way is he inclined, he can start with the health practitioner. And if in two or three months there is no progress, then there should be some consultation between the health practitioner and a very genuine traditional healer," said a patient interviewed during the research.

De la Porte (2016) argues that the patient narrative plays a vital role in empowering the patient in a multi-cultural context: “Not only do we have diverse cultures in society playing a role but also the ‘culture’ of the medical environment and health care. This environment has its own language, principles and interpretative systems. Often patients experience that their own interpretive systems break down in this environment.” Throughout the interviews with the various participant groups, the narratives were weaved throughout the principles and recommendations and as subscripts to the framework. The patients and practitioners interviewed emphasised the importance of spiritual rituals as part of a spiritual health experience that would be relevant in addressing their needs.

Walker and Breitsameter (2017) and De la Porte (2016) refer to the importance of making room for spiritual rituals and experiences as part of a quality health care experience. Both health care workers and patients interviewed during this research indicated the need and benefit of being able to express their spirituality as part of their health experience through preferred individual and corporate spiritual rituals. The inter-disciplinary team cited in various instances that prayer played an important role in one-on-one health consultations. The team also practised corporate prayer in a community site where patients were welcomed to participate before primary care consultations commenced and cited the perceived benefit this had on their own well-being.

The findings of the research were presented as a framework describing an approach for integrating spirituality into health care. The framework comprises principles for practice, quality requirements to attain the principles, recommendations for implementation, and catalysts and impediments for successful implementation and spiritual health tools. The framework components are listed in table 8.1 below (see also chapter 3, table 3.1).

Table 8.1 The six components of the framework for integrating spirituality in health care

1. Eight principles for spiritual care
2. Quality requirements for each principle
3. Recommendations on how to implement the principles
4. Catalysts to implementing spiritual care
5. Impediments to implementing spiritual care
6. Spiritual health tools

The first component of the framework unpacks eight principles for incorporating spiritual health care during a consultation. The second component describes the quality requirements for each principle. The principles and quality requirements are followed by recommendations on how to implement the latter. There are certain catalysts that could enable the successful implementation of the principles or impediments that could achieve the opposite that are also part of the framework. The final component of the framework includes connections to existing spiritual health tools. The spiritual health tools are summarised into three categories, viz. frameworks, screening and treatment tools. The synthesis of this framework is integrated into existing literature as presented in the thesis in chapter 3 and during the discussion of the

data of the three participant groups in chapters 4, 5 and 6. The research participants, especially the health experts, referred continuously to the works of others and how those influenced their practice. The evidence-based approach founded in existing spiritual resources in the health care context was a valuable component of the yield and the framework.

8.1.2 Research findings within the context of current literature

The patient interviews revealed a definite need to have spirituality in the health context defined. One of the patients interviewed remarked: "If you want to approach this (spirituality and health) with a patient, one first has to define what is meant by spirituality. It's such a wide thing and to me spirituality means being aware, respectfully, of the whole creation. So I think from a health perspective, yes, of course, you're not little compartments. You know, it's part of your being. I think it is relevant but it has to be handled very carefully so people don't take offence." Walker and Breitsameter (2017) reported that the definition of spirituality is still a vague concept when explored amongst caregivers and those receiving care. The reported advantage of this broader definition is that spiritual care is no longer bound to a single profession, but could be offered by more than one member of the inter-professional team. Encounters of meaningful spiritual care described by the patients interviewed in this research revolved around the health practitioners being able to connect with their patients on a human level and creating room for them to express their unique spiritual beliefs and needs in a manner that addressed their concerns.

Patients interviewed described the *how*, or the approach to spirituality and spiritual care during the consultation as having a greater bearing on the perceived quality than *what* was asked. Most would agree *why* it is important to include spirituality as part of a holistic consultation and treatment plan. It is the *how* that is often uncertain, even daunting to both health practitioner and patient. This patient quote summarises her views on what is important for a health practitioner to offer quality spiritual care: "The most important thing is to be knowledgeable about different things that people can experience as spiritual. And that goes as far as all the different types of religion. You don't have to know the nitty gritty of everything. But you must have some idea. If, if you're a Buddhist and I'm a Christian, it does not mean you want to make me a Buddhist just by telling me and explaining to me how it works. And I think to get away from that fear that people can influence you, in fact, because you will not be influenced if you don't want to be influenced into another religion or whatever – lifestyle, or whatever it is… I think one has to be very sensitive or open to your own emotions. You can teach them (patients) how to get into touch with their emotions, if you are in touch with your emotions. In this process, the health practitioner should be affirming and confirming the patient."

The patients interviewed confirmed what was reported in previous research. Walker and Breitsameter (2017) define quality spiritual end-of-life care as a form of expressiveness through the ability to listen and talk, but also describe silence as a core element – irrespective of whether spirituality is a topic of conversation, and whether it is shared or not. They also

argue that spirituality is successfully interwoven when a patient's fears or guilt are addressed, when questions relating to identity, worth and finding peace are resolved. Throughout the interviews, patients were not only open to the idea of spirituality being included; rather, they welcomed the idea. The participants shared their personal experiences of the impact that practising spirituality had on their health. Many patients voiced the need for their health professional to discuss with them how to prepare to age well, manage their fears about death and dying and discuss fears and concerns that they had surrounding their health with family members within a spiritual context.

Sulmasy (2001) underscores the potential value that can be created in the interaction between the health practitioner and patient: "Research should pay attention to the importance of the relationship between the health professional and the patient as a possible context for the patient to work out and express spiritual concerns and struggles." In her description of a biopsychosocial-spiritual model, Sulmasy (2001) illustrates the narrative of a patient diagnosed with cancer who admitted that he wanted to stop the chemotherapy regime, but continued for the soul reason that he enjoyed his oncologist's support so much, and he feared he would lose the relationship if he discontinued the therapy. Spirituality is inevitably linked to our experiences and emotions, whether in the consultation room at a certain point in time or outside the room in everyday life. It is important to note that spirituality may be linked for the patient to an experience, emotion and/or illness, and that the doctor can assist the patient in making connections between experiences, emotions and his/her health and health care plan: "Well, I happen to go to a doctor who wouldn't say to me *what's wrong with you*. He said *who's wrong with you*, because somebody might be causing you grief. And to me that is a holistic view of not only looking at your sore toe, or your sore stomach, because there's a reason why you have that. Is it necessarily something physical or is it something else, are you upset about people, is that making you sick?" This comment was made by a patient during the interviews conducted. Another patient stated: "I know it's not the medicine that gets my blood pressure up and down. The reason it's low today is I had an hour and a half conversation with one of my best friends last night and I touched reality that most of the time I'm working in an area somewhat removed and isolated."

Patients are often more open to discussing spirituality than the health professional might anticipate: "I am open-minded about life and thoughts and things, so to me, really, there would be no issue. I don't even know if there's anything that I would not be able to talk about." It is, however, important to create context that is patient-specific, as one interviewee stated: "I think most people, especially the older generation maybe, were still looking at the doctor or the medical practitioner from a medical point of view. And if you waste my time by talking about other things...now, then you're not doing your job. And I don't want to pay you for that. So I really think it's important to...let the patient understand. And then of course you will then find all the aches and pains that is there psychologically and not only medically. And you know the reasons why you become overweight and the reasons why you don't want to gym, and so forth..."

Various acronyms have been developed to assist the health practitioner when conducting a spiritual history. These include the **FICA** spiritual history tool (Puchalski & Romer, 2000), which stands for F: **f**aith and beliefs, I: **i**mportance of spirituality to the person, C: spiritual **c**ommunity of support and A: preferred way to have this **a**ddressed; and the **CSI MEMO** (Koenig, 2007) consisting of four questions: 'Do religious or spiritual beliefs provide you **C**omfort or **S**tress?', 'Do they **I**nfluence medical decisions?', 'Are you a **MEM**ber of a religious or spiritual community?' and 'Do you have **O**ther religious or spiritual needs?' There are also other spiritual tools available including the **SPIRIT** tool (Maugans, 1996) that enquires about **s**piritual belief system, **p**ersonal spirituality, **i**ntegration in a spiritual community, **r**itualised practices and **r**estrictions, **i**mplications for medical care and **t**erminal events planning; and the **FACT** spiritual tool (LaRocca-Pitts, 2012) that contains questions on **f**aith, how **a**ctively this is expressed, **c**oping or concerns regarding spirituality and the **t**reatment plan. Another spiritual screening tool known as the **HOPE** tool (Anandarajah & Hight, 2001) looks at sources of **h**ope and meaning, **o**rganised religion, **p**ersonal spiritual **p**ractices and **e**ffects on medical care.

These tools are all valuable in that they assist the practitioner to easily remember what to ask when enquiring about the spiritual in the health care context. Using these, however, does not guarantee that a meaningful discussion will be conducted. Before attempting to ask questions that are an important component of who the person sees him/herself to be and the implications of these beliefs on the health care experience and the patient's journey, it is important to establish a rapport and trust that will enable an open and genuine conversation.

The research participants reflected on the delicate balance between ticking off a list of questions asked and having an unfolding discussion that enables better care and addresses a person's needs in a manner that acknowledges his/her personhood. "One of the biggest challenges is the way in which the topic of spirituality is introduced into the health consultation. There are active and passive approaches to this. The active way is to specifically solicit the patient by asking whether they have any particular spiritual needs during the consultation process. The danger of that type of approach is that is can seem so profound that you can get a very evasive or limited response. In the passive, if the consultation is of an appropriate length, the approach of the practitioner is to respond to a verbal cue of the patient and then to weave this into the conversation about the outcome of her diagnosis or the therapeutic process. An example of this: Ms Jones says: 'Doctor, I realise that I am very ill, but I have faith that I will get better.' Then the doctor says to Ms Jones that 'I hear you mentioned the word faith, can you elaborate what that means to you in your health context currently.' The patient will give you openings that you can pursue then quite legitimately: Important to note that the doctor is not asking this question out of curiosity on the person's worldview. The practitioner wishes to assess the needs that the patient has, and to how far their spirituality is either an asset or liability to their health goal and health care process – to *understand* that their spirituality could either be a health resource or a liability. I think that emergencies and intractable or life-threatening conditions are the extremes of context in which spirituality is very relevant, but the approach might be very different. In an emergency

the person is still processing what happened. In a chronic situation they have to navigate the issue of hope and just what the rest of life would look like, and even end-of-life issues. The context is critical. The difficulty is navigating the range and for the clinician to calibrate the approach to a person's spiritual needs based on those frameworks. So again, context is critical, but how this is communicated and assessed in each situation needs to be fleshed out." – as described by HE_1.

In terms of spiritual rituals and care practices, the findings of this research have some distinct differences from what is written in current literature in terms of how spirituality is expressed in practice and where the line is drawn in terms of professional boundaries. Puchalski (2001) states in no uncertain terms that in her opinion, "The physician should not initiate prayer with patients, as this blurs the boundary of physician and clergy. Leading prayer involves specific skills and training that physicians do not have. Furthermore, a physician leading a prayer might lead a prayer from his or her tradition, which could be offensive or inappropriate for the patient. If the patient requests prayer, the physician can stand by in silence as the patient prays in his or her tradition or can contact the chaplain to lead a prayer". She also opines that in-depth spiritual counselling is crossing a professional boundary: "It is important to recognise that patients come to physicians to seek care for their medical condition. In delivering this care, physicians can be respectful and understand the spiritual dimension in patients' lives. But to go beyond that, for example, to lead prayer or provide in-depth spiritual counselling, is inappropriate…it is critical that when discussing spiritual issues with patients, that the physician listens, supports and does not guide or lead."

The findings of this research suggest that certain patients seek out health professionals that are skilled in both medical knowledge and spiritual care integration. Patients interviewed during this research were open to exploring spirituality and receiving care from a health professional (as long as a similar religious/spiritual faith was shared). Professionals interviewed during both the health expert interviews and focus group discussion cited several patient cases where in-depth spiritual counselling was offered and/or prayer undertaken as part of a spiritual ritual during the consultation. The African perspective and importance of incorporating spiritual rituals throughout the health experience are seemingly different from the Westernised current worldview on *how* and *to what extent* spirituality should be incorporated. Patients described the value of prayer within the health consultation when faced with drastic medical decisions. Patients also described a need to have ancestral beliefs accommodated, which included linking the consultation of a traditional healer to the medical consultation. Non-religious patients who described themselves as spiritual expressed a need to explore spiritual concepts and to include this in the health consultation.

8.1.3 Significance of the study

This study was conducted with the premise that spiritual care of patients is a fundamental component of quality, compassionate health care (Puchalski, Vitillo, Hull & Reller, 2014:11). Despite several publications on spiritual care and various screening tools available, there is still much uncertainty about what should be included as part of spiritual care. "Spiritual

diversity has been conceived as a challenge early on" (Walker & Breitsameter, 2017). With spiritual health experts, patients and an inter-disciplinary team, this research explored how spiritual care is best approached within in a multi-cultural and multi-religious African context. The research undertook to develop a more detailed framework by which health practitioners could integrate spiritual aspects into the personal health management of patients during clinical consultations. The narratives of the individuals and focus group contributed new nuances and practical interpretations to existing content on this subject in the literature. A person-centric approach came across as a golden thread throughout the interviews and focus group. With a person-centric approach, attention is given to the various roles that the person portrays in society – being a parent, spouse or member of a social club or society, subscribing to a belief group, or fulfilling a certain professional role. A person-centric approach also recognises the clinician in the room as a person participating in the health process. Person-centrism is health-focused, more than disease-focused. The interviews revealed the importance of the patient narrative in understanding the patient's spiritual needs and context within which spirituality should be addressed. The interviews unpacked the value of different spiritual screening and care tools. They also highlighted the limitations of a spiritual tool in that meaning-making is created in how spirituality is approached and discussed between the practitioner and patient.

Puchalski, Vitillo, Hull and Reller (2014) recommend 12 (top) standards for spiritual care, including that (a) spiritual care is supported by evidence-based research, and (b) health practitioners are knowledgeable about the options for addressing spiritual distress and needs. The first standard recommended (Puchalski, Vitillo, Hull & Reller, 2014) states that spiritual care is a vital component of compassionate whole-person care. This research was undertaken with that as a cornerstone for why an ethical approach that would be culturally appropriate should be further explored. This study contributes to evidence-based research in the area of spirituality in health care. The research defines and compares various spiritual tools available and currently in practice. It goes beyond defining currently available screening tools to explore what the requirements are to meet the recommended standards for spiritual care such as (c) compassionate, person-centred care and (d) a spiritual care model tailored to the African context and setting (Puchalski, Vitillo, Hull & Reller, 2014), which are also listed as important standards for care. The remainder of the top 12 standards (Puchalski, Vitillo, Hull & Reller, 2014) include the importance of including spirituality in health education, working in an inter-disciplinary manner and incorporating spiritual care on a health systems level. These components were also described by the participants during this research and taken up into the final framework.

This study may contribute to improving practice by describing various approaches that can be customised to fit individual practice. This framework may also serve as a guide to educate and equip health providers on the spiritual aspects of health in relation to themselves and their patients. The spiritual needs model and dimensions of spirituality (Monod et al, 2010) related to codes that emerged during the analysis of the interviews with the research participants. The inputs from the research participants generated codes to help gain insight into what is

required of a health professional to conduct a meaningful spiritual health consultation that addresses the spiritual needs of a patient. These were described as codes in chapters 4, 5 and 6. The codes generated from the participants' inputs, and explored and described the necessary competencies required to engage in a spiritual conversation as part of a health consultation in a meaningful way. The competencies were taken up into a framework recommended for practice as described in chapter 3. The framework consists of principles for practice, quality requirements to attain the principles, recommendations for implementation, catalysts and impediments for successful implementation and spiritual health tools. The framework components described in this research are listed in table 8.1 above (see also chapter 3).

The first component of the framework unpacked eight principles for incorporating spiritual health care during a consultation. The codes that emerged in the analysis of the narratives describing the requirements for each principle were presented as the second component of the framework, as quality requirements for each principle. The principles themselves derive meaning and purpose from the manner in which they are implemented. The quality requirements for each of the principles were discussed in detail in chapter 3, with the inputs from the patients, practitioners and health experts. Implementing the principles successfully in practice requires an understanding of how to practically apply them. The third component of the framework consisted of a description of recommended guidelines that describe practically how spiritual care can be approached against the backdrop of the principles and quality requirements, and what a practitioner can do to facilitate this successfully in practice. As the fourth component of the framework, the catalysts were described to help identify in which areas a health professional, health care practice, unit or institution is currently enabling a holistic approach to health care and where changes could be made on micro or macro level to incorporate quality spirituality in health care. The fifth component described possible impediments to quality spiritual care. The sixth and final component of the framework described existing frameworks, spiritual screening and history taking tools, and recommended available approaches to treatment and how these link to the principles and approach recommended in this framework.

Table 8.2 Descriptive summary of the framework components that were described in this research

Framework components	Description
Eight principles for spiritual care	1. Spirituality should be part of the health consultation 2. An evidence-based approach that is ethically grounded should be followed 3. The practitioner should attend to his/her attitude during a spiritual health consultation 4. The practitioner should create a receptive environment that takes into account the

	spiritual needs of the patient within his/her personal context 5. The practitioner should adopt a person-centric approach 6. The practitioner should foster communication that suitably addresses spiritual health needs 7. The practitioner should be sincerely interested in the person and his/her spiritual needs (to achieve quality spiritual health care) 8. The practitioner should co-mobilise spiritual resources that build resilience for the patient
Quality requirements for each principle	Described in the chapter
Recommendations on how to implement the principles	1. 5 **W** questions for spiritual health care 2. General guidelines on applying the principles 3. 'How to do' from the perspective of the patient *and* practitioner 4. 'What to do' from the perspective of the patient *and* practitioner
Catalysts to implementing spiritual care	1. Enabling conditions on a health systems level 2. Enabling conditions on a health implementation level 3. Health professional competence requirements 4. A holistic patient from screening to treatment

The findings of the study may potentially contribute towards improving policy in South Africa and Africa as they address practical components required to assess spiritual distress and implement care towards spiritual well-being in a multi-cultural and multi-religious context. Health policy and how health services are organised within a health system can have a major impact on whether spirituality in health care is addressed effectively and perceived to be of good quality and value for patients utilising the services offered. Health policy should acknowledge the importance of spiritual health, and legislation should support the offering of such services within clinical settings. Health care systems should adopt a wellness approach to patient care that accounts for the spiritual. This should filter down to how health services are offered on different levels of care. Traditionally, the disease-based approach to health care focused primarily on the patient's presenting complaint. A welcome shift in health care to a wellness approach has been adopted, at least at the policy level, by many countries. The

wellness screening in resource-constrained settings currently focuses mainly on prevention of the most prevalent chronic conditions. The spiritual influence on wellness and adherence to care should be accounted for at both the policy and service delivery levels. In the South African and African context, one has to take the individual patient preferences and community context into consideration and incorporate these role-players as stakeholders into a care plan that is best suited to addressing the patient's needs.

8.2 Methodological aspects of the research

The study aimed to develop qualitatively a practical and ethically sound framework that would assist the health professional in the "how-to" in the integration of spirituality in a patient-practitioner consultation. A case study design was followed that drew on a grounded theory approach. The purpose of drawing on this theory was to generate research data that were established and rooted in the ideas and perspectives of the participants regarding a specific phenomenon (Hays & Singh, 2012:48). The methodological aspects that are discussed include the research approach followed, strengths and limitations of the research and validity of the findings.

8.2.1 Methodological approach followed for the research

The study was based in Pretoria, South Africa. Data sampling was done at various locations in Pretoria to accommodate the research participants. The participants were sampled purposefully. Three scholars participated based on their roles and experience as health practitioners (irrespective of whether they were for or against a framework). The views of ten users of health care services (i.e., patients) that belonged to a chronic disease management programme in Pretoria were purposefully sampled. For the third round of data collection, eight health professionals representative of various disciplines participated in a focus group at a clinic based in Pretoria. All data collected with the health experts, patients and inter-disciplinary group were recorded and transcribed verbatim.

Data were collected by means of individual interviews with the three health experts and the ten patients for the first and second rounds of data collection. For the third round of data collection, a focus group was conducted with an inter-professional team of eight participants. Field notes of all data gathering sessions were maintained. Summaries of the major findings together with the personal reflections on the data collection were recorded as memos for each interview conducted throughout the research process.

Participants under the age of 18 were excluded from participation in the study, mainly for ethical reasons. Participants for all categories were included irrespective of their faith and/or religious beliefs. Participants represented various faiths and religions (including Christian, agnostic, spiritual without a specific faith, beliefs in ancestors).

The theoretical coding that was used to develop a draft framework was that of structural and pattern coding. The existing theories on spiritual health care included standards recommended for practice (Puchalski, Vitillo, Hull & Reller, 2014), models and tools for

spiritual needs and care (Koenig et al, 2012; Puchalski & Romer, 2000; Monod et al, 2010). Structural coding "results in the identification of large segments of text on broad topics; these segments can then form the basis for an in-depth analysis within or across topics" (Saldana, 2009). Structural coding was used to identify various broad topics for spiritual care as described in current literature. Pattern coding was used to group similar codes into sub-sets for a draft framework and as part of preparing an interview schedule with the insights gained from the information available on spiritual health care. This included a good understanding of what the current international literature conveyed, and also what questions still need to be pursued to meet patients' needs in a health consultation with regard to their spirituality and incorporating of practices that could address this.

There was also an approach and understanding from the start that there would be a certain category of openness for new codes that arose that were not previously identified in the other research, and therefore all the documents used during interviews were presented as draft frameworks. The open codes were words or sentences, and in some cases entire paragraphs (more so in cases where an in vivo code was used) in which the participants described concepts and gave examples. The open and in vivo codes were grouped into similar categories under the headings as identified in the interview guide. All the words and codes were scrutinised line by line, as in open coding, to ensure that no important message was missed and that the various perspectives on similar codes were accommodated. As a second cycle of coding, the longer passages of text and the in vivo codes were coded by the means of axial coding into condensed codes under specific principles that emerged throughout the research process. The links between the open and in vivo codes were summarised for each subsequent round of data collection as part of the latest draft version of the framework up until the final framework.

8.2.2 Strengths of the research findings

The qualitative case study approach followed in this research allowed for spiritual care within the health consultation to be examined in detail and in depth. The interviews were not restricted to specific questions as recorded in the interview guide and participants were able to direct what they considered as important concepts for quality and ethical spiritual care within health care.

The interviews revealed the complexities of offering spiritual care within a multi-cultural and multi-religious context, and the data generated from human experience obtained powerful and practical components for spiritual care that contribute to existing literature on spiritual care.

The final product of this research is presented as a framework. The codes generated from the participants' inputs explored and described the necessary competencies required to engage in a spiritual conversation as part of a health consultation in a meaningful way. The competencies were taken up into a framework recommended for practice as described in chapter 3. The uniqueness of the framework presented is that it maps out components for

quality spiritual care in detail. Principles are not only listed, but analysed for intent and approach. Each of the principles listed is described with quality requirements and recommendations for implementation. The practical components for implementing spiritual care at individual level that either serve as a catalyst or could be an impediment were taken up into the framework. The framework, as the final product of the research, is also described in the context of existing literature and spiritual health tools.

The rich narratives of the individuals that participated from various perspectives allow the health practitioner to view person-centric spiritual care from various stances, viz. scholar, health professional or patient. The narratives contributed new nuances and practical interpretations to existing content on this subject in the literature. The in vivo codes generated a descriptive perspective to position the health practitioner within the consultation and care context. The findings are presented recognising the voices of the participants, and through their voices to be able to learn from an expert, understand the approach that a health team member has to spiritual care and experience from a patient's perspective a preferred approach to addressing spiritual needs. Throughout the presentation of the research findings, the human experience is described as narratives, in different colours linked to the codes generated that contributed to the construct of the framework, allowing the reader to link theory to practice and personal context.

The findings of the research are transferable to other health settings and contribute to an approach to spiritual care that is applicable not only within the African context, but in other health settings.

8.2.3 Limitations of the research findings

The study has been subject to a number of limitations. The volume of data generated during the research made analysis and interpretation of results time-consuming. This also made the reporting of the findings difficult to present in a way that is easy to understand.

The researcher's presence during data gathering could have affected the participants' responses. The individuals interviewed by me were aware of the importance of spirituality in day-to-day care. In particular, the health experts were in the (fortunate) position that their practices were known for offering holistic care that included spiritual care and allowed time for patients to co-experience spiritual moments. The research does not account for people who might not be interested in receiving or offering spiritual care as part of a holistic health care approach.

The findings make recommendations on how spirituality in health care should be addressed in a practical way. They describe a practical approach for doing spiritual health screening and taking an in-depth spiritual history as per the framework presented in chapter 3. They do not, however, unpack in detail various types of spiritual care interventions or uncover which health professional should offer what type of spiritual care intervention. The importance of the inter-disciplinary team is also described in the research.

Further research needs to be done on developing spiritual treatment models that can be integrated into a bio-psycho-socio-spiritual care approach. This includes describing different spiritual care interventions and the role of different health professionals in offering such care.

8.2.4 Validating the research findings

Validity in qualitative research has a different connotation to it than in quantitative research (Creswell, 2009:195). With qualitative studies, because of their interactive and humanistic focus, consistency of responses is not expected to the same extent as with quantitative research. Validity determines whether the research truly measures that which it was intended to measure or how truthful the research results are (Joppe, 2000). Validity is an important feature of quality qualitative research that is used to determine whether the findings are accurate from the point of view of the researcher, the participants and ultimately the readers (Creswell & Miller, 2000).

In qualitative research the concept of validity is better articulated by the concept of trustworthiness. Trustworthiness ensures that no one view is privileged above any other; rather, multiple views are accepted and codes are developed by analysing the data systematically and accountably. The following strategies were applied to ensure the accuracy of the findings: Data were collected from different data sources in different settings, including those of health experts in the field, patients and an inter-disciplinary health team; these were used to build a coherent justification for the codes identified through triangulation of the data.

The research enquiry, data collection and analysis were performed over a prolonged period of time to assist the researcher to develop an in-depth understanding of the subject content and to convey in as much detail possible from the narrative accounts of the participants to contribute towards the credibility of the results of the study. Because the essence of qualitative research is humanistic and set in the context of real life (Creswell, 2009:196), different perspectives were discussed throughout the narratives and data presentation. The qualitative narrative was included in different forms, as recommended by Creswell (1998; Creswell & Miller, 2000), to include detailed descriptive accounts, analysis of cases and re-telling extended stories in text-embedded quotations. Participants' wording was consistently used to relay the in vivo codes that emerged throughout the research in the most authentic way possible. Quotations were intertwined with my own personal interpretations and the first person "I" was included in the narrative as recommended by Creswell and Miller (2000) when recording a narrative enquiry.

The theoretical codes that emerged from the data were also compared to what was written in current literature. Throughout the research process, the draft ethical framework was updated and the latest version of the analytic yield up until each point of data collection was submitted to the views of the research participants. Thick and rich descriptive findings were discussed and included in the final framework and also the thesis to assist the reader to gain the most from the shared experiences and personal narratives of the participants.

Reliability is “Yielding the same or compatible results in different clinical experiments or statistical trials” (Shuttleworth, 2009). Creswell (2009) argues that qualitative researchers can, in a limited way, apply reliability to check for consistent patterns of codes and generalise certain facets of multiple case analyses of sources of data collection. Consistency of data was achieved in this study by verifying the steps of the research process through examination, careful notation and systematic analysis of raw data, systematic and exhaustive filtering of codes, and process notes to develop various draft frameworks after each data collection phase up until the final framework presented in this thesis.

My research supervisor also played an important role in peer debriefing (Creswell, 2009), asking questions throughout the research process to ensure that the research account is accurately described and would be easily understood by people other than myself, as the research had become a tangible component of myself throughout this experience. Contrary to quantitative research, in which bias is unwanted and eliminated as far as possible, bias in qualitative research is considered inevitable and a source of meaning that has to be accounted for in the processes of sampling, data collection and data analysis. The specification that participants have an “interest in the field” may be thought of as a bias in quantitative terms, but in qualitative terms this is purposeful sampling as to ensure that particularly people (patients and practitioners) who are keen to gain from the integration of spirituality into health care are given a voice. The study interest and meaning are particularly sought from this “biased” source. This sampling is considered a strength in qualitative research provided that claims and findings are explicitly limited to this selected population. Thus, claims and findings for the use of the framework among people who did not have an interest or had a disinterest in the field were not included in the study.

Furthermore, qualitative research takes an interest in singular or even extraordinary perspectives, whereas quantitative research generally has little if any interest in “outliers”. For this study, for example, extraordinary or singular responses may give a new direction in the articulation of an item and the refinement of the framework that is more apt or instructive than the more common views.

The findings of this research have some distinct differences from what is written in current literature in terms of what is happening in practice and where the line is drawn in terms of professional boundary with offering spiritual care (Puchalski, 2001). The participants discussed the importance of prayer for certain patient cases where this was acceptable to the patient and professional as a spiritual ritual to engage in. This is, however, in opposition to what is described as a professional boundary (Puchalski, 2001) in literature. Describing and including the discrepancies found in the research strengthened the credibility of the research (Creswell & Miller, 2000).

8.3 Implications of the study

The research implications discussed below explore the potential impact of the research on future research and on policy decisions in offering spiritual care within health care.

8.3.1 Implications and application for practice

The research contributes to existing literature on patients' spiritual needs by making recommendations on general guidelines and principles to apply in practice. All patients should be offered spiritual care to the extent that it is required to meet the patient's needs and is feasible within a health context. Although the health professional will not be able to offer spiritual care to every patient, it is possible to do a spiritual screen or history taking, and depending on the presenting complaint and individual patient scenario, the patient could then possibly be referred for specialised care. This requires that health practitioners are equipped and comfortable discussing spiritual matters with patients and are able to recommend a care plan or refer to a specialist spiritual carer for a need identified.

The study findings as described in the framework in chapter 3 provide practical steps on 'how to do' and 'what to do' in practice. Patients were clear that they wanted spirituality defined. Although the health professional body has focused on defining spiritual care amongst themselves over the last few decades, patients in the consultation may be uncertain how health practitioners define spiritual care and how this will be approached. It is recommended that spiritual care, from screening to treatment, be clearly defined within the South African, African and international health care environment for both patient and practitioner, upon which practitioner and patient can draw to make the communication about this clear during a consultation.

Health professional training in undergraduate years and as part of continuous professional development should include education on how to conduct a spiritual screen and/or history taking and how to incorporate the needs identified into a care plan. Health professionals should also be taught how spiritual care relates to their scope of practice within the specific care model in which they are functioning to accommodate the specific context of the communities that they serve. The framework may be of help to inform this training.

Health professionals should be equipped through health education and continuous professional development with skills and knowledge that are based on standardised competencies and assessments that are rigorous and meet evidence-based criteria to support spirituality in the clinical context. The competencies should be rooted in the incorporation of spiritual care within health care at the individual and inter-professional level as part of holistic, person-centric care.

Patient education on spiritual care may be equally as important as practitioner education. This has not been incorporated in preventative patient health education on a global scale as yet. Spirituality has a role to play in preventative health and the management of chronic and end-of-life conditions. Patients interviewed who suffered from a chronic condition or required a surgical intervention described having internal conflict about why this 'happened to them' or how God, their religion and spirituality are tied to this experience. Spiritual distress was also reported by patients interviewed to be secondary to having seen a loved one struggle with a debilitating illness. Health practitioners have a role to play in helping

patients voice these struggles and questions that may cause spiritual distress. One patient interviewed underwent orthopaedic surgery for an arthritic condition years ago. He noted that he still had unresolved conflict about whether he should have had the operation despite the good surgical outcome many years after the surgery. This was connected to his spiritual beliefs that he should have trusted God longer for a miraculous healing. Previous clinical studies have reported the benefits of including spiritual practices and counselling before and after surgery, including orthopaedic surgical interventions (Fitchett et al, 1999; McGraw, 2011).

The research also highlighted the importance of the approach by which spirituality is introduced in the consultation. This includes establishing rapport and communication that is meaningful. The health practitioner should be equipped to accommodate varied worldviews in a sensitive manner. The research affirms the value of spirituality as a resource to transcend health challenges and its importance in end-of-life care for patients and their families. Culture plays a vital role in how spirituality is expressed and how the offering of spiritual care is perceived.

The complexity of practising corporate faith in a 'secular' clinical setting was raised by the inter-professional focus group. Research participants, both patients and professionals alike, cited the potential benefit of incorporating spiritual rituals within a clinical context in a group setting. This is, however, something that has to be well planned and implemented in such a way that different religions and faiths are accommodated or at least that no patient feels excluded. Patients should be able to express preferred spiritual practices within a health care setting. Opportunities could be created to accommodate varied religions with individual events. If patients should be able to practise their faith and express this in the clinical setting according to their perceived needs, then a person-centric approach should also accommodate the health practitioners participating in such activities and expressing their own spiritual and religious beliefs. This should however be done in a respectful manner that accommodates varied beliefs and does not infringe on the beliefs and rights of the patients.

The inter-professional group described approaching spirituality in the African health care setting as requiring the health professional to be informed about various religious beliefs and to enquire on these in a sensitive manner that is affirming of the patient and his/her context. The African context offers unique perspectives and beliefs that should not only be considered, but accommodated when offering health care. The theme of an 'African' interpretation of illness, health and spirituality is of particular relevance for the South African context (De la Porte, 2016): "In the African worldview, illness is not linked to bacteria, viruses and infection, but to a disruption of the system, the societal order and the web of life. The question *who* caused the illness is important in the African interpretation. Suspicion of underlying factors and the influence of evil powers are therefore present." A patient interviewed during this research reported having attended clinical sessions with her general practitioner where he followed a similar approach of enquiry, asking 'who' is wrong with you with the intent to understand the social and societal factors impacting on the patient's health.

Enquiring about a patient's underlying beliefs and fears becomes important if a health professional wants to meet the needs of patients holistically.

Participants conveyed through stories shared and principles recommended the importance of not looking down on someone because they do not share your worldview or spiritual belief. Traditional practices and medicine played a strong role in many cultures that influenced the uptake of recommended health and lifestyle choices. The research participants pointed out that it is only when the practitioner is able to respect the patient's beliefs, display empathy and understanding, that one is able to make recommendations that could be acceptable to a patient and have an influence on health outcomes. Spirituality and creating a space for a patient to not only share, but incorporate his/her beliefs within the health plan should be a cornerstone in practice to impact lifestyle choices and overall health.

8.3.2 Implications of the findings for future research

Medical ethicists argue that religion and spirituality form the bedrock of meaning and purpose for a majority of people (Foglio & Brody, 1988). Meaning-making and finding peace or acceptance of a current health state or diagnosis is an important component of a patient's health. Medical professionals have an important role to play in the patient's personal narrative. "Cure is not possible for many illnesses, but I firmly believe that there is always room for healing. Healing can be experienced as acceptance of illness and peace with one's life. This healing, I believe, is at its core spiritual" (Puchalski, 2001). The role of the patient's narrative and meaning-making within an African context that is focused on the collective good and not just the self needs to be further explored within a spiritual care context.

The research findings as reported in this framework and thesis make recommendations towards health care looking at spirituality within three dimensions of inquiry, which could be in the form of a brief spiritual screen, in-depth spiritual history taking or as part of ongoing care. The practitioner's approach should be appropriate to the situation. The three dimensions are: spiritual screening, spiritual history taking and ongoing spiritual assessment. The findings in this research unpack the practical components of care in the African context of *how* patients want to be approached and *what* health professionals recommend from personal experience to start the conversation with a patient. Future research needs to be undertaken to explore in greater depth the practical ways to implement spiritual care rituals and experiences in a health setting that accommodates various worldviews.

This study describes the importance of spiritual rituals in the health setting within the African context, including the value of nutrition and traditional medicine. This area has not been covered sufficiently in health curricula and continuous professional development of health professionals. Further research needs to be undertaken to explore these domains and map out a specific approach for health care.

The implications of this research include the need for health professional education on incorporating spiritual care in an appropriate and ethical manner. Person-centric care that supports the patient, practitioner and their individual social environments should receive

attention in research. Medical burnout and fatigue could be addressed if psycho-spiritual support programmes are implemented routinely in health settings. Health practitioners also face their own emotional and spiritual challenges in offering health care; this could be supported by incorporating spiritual care that is truly person-centric to the extent that both practitioner and patient are allowed to express their needs and have these addressed within a health care context. Currently there is still much research that needs to be done on how to incorporate this successfully into health education and health care practice.

8.4 Conclusion

Spiritual diversity within the African context could present a challenge when incorporating spiritual needs and care in a clinical and consultation setting. The role of cultural and traditional health practices in combination with individual expression of spirituality can seemingly oppose a more Westernised approach to care. Although this can be complex for the health team to manage and discuss with their patients, it does not mean it should be ignored or excluded from a holistic care approach.

The health experts' findings described the potential benefit of incorporating spirituality in the health consultation and care plan. "Spirituality is a physiological feature of mankind. With that concept in mind it is far easier to have just a human-to-human conversation with the safe assumption that spirituality is a physiological feature and that the conversation and language we use and have of spirituality may either be facilitating of the conversation or raise unnecessary objections. The realisation and perspective that this (spirituality) is an attribute of man, rather than a tool of therapy, is what I want to explore" – HE_1. An appropriate approach for spiritual care takes into account the value that is placed on spirituality and its exploration within the health care consultation.

The patient narrative plays a vital role in empowering the patient in a multi-cultural context. The inter-disciplinary focus group stressed the importance of enquiring about the health of a patient that includes the spiritual dimension within the patient's current context and life story: "Holistic care includes the incorporation of the spiritual component in a manner that is acceptable and relevant to the patient. I believe we are different parts. We are body, we are mind, we are soul. So, I think the health care isn't complete until all the aspects have been addressed." Understanding the spiritual and social beliefs of a person can also be harnessed to positively influence their health and lifestyle behaviour. Louw (1998) argues that all human behaviour is rooted "in cultural contexts in which attitudes, values, customs, and rituals play an important role."

Quality spiritual care is as much about how this is approached and in what setting as about what the discussion centres on. Patients indicated that they periodically had specific spiritual needs that they wanted to discuss with a health professional. This often did not happen. Quality spiritual care includes enquiring about such needs with patients and introducing management plans that support the patients within their psycho-socio-spiritual context. Patient interviews revealed the personal importance that patients placed on incorporating

spirituality in health care: "It is important to create a human experience. It's not a clinical experience. You have to stay the clinician but you also have to be a human being." Patients described the value of spiritual care in meaning-making and managing their health: "Having a condition or diagnosis does not ultimately define who you are as a person. Framing a diagnosis as a smaller component of who the person is, what the significance of his/her life is and how to life a meaningful life despite this is part of the goal of spirituality."

Spiritual care could be incorporated into the daily treatment plan. The perceived value of this emerged in the patient interviews and is affirmed in the literature. Possible spiritual rituals that can be combined with the health plan include mental imagery, prayer, traditional medicine and herbs, homeopathy, therapeutic touch, natural diet practices and exercise programmes, to name but a few. The question of how spirituality should be included is inevitably linked to worldview and the current experience of the individual within his/her context. It is also linked to what is achievable from the perspective of the health professional within his/her practice, context and health care system. Health practitioners need to be equipped to enquire with skill and comfort into a patient's narrative, to assess and introduce the correct spiritual care tool and to know when to refer to which member of the health professional team as per the spiritual care triad (author's own model, 2019).

Specialised spiritual care, beyond enquiry, will often require an inter-disciplinary approach. Health practitioners should collaborate within a care team to identify team members that will be able to address patients' specific spiritual needs. This being said, the inter-professional team should also be strengthened by including ministers of faith and traditional healers to refer to when a specific spiritual need is identified. In the South African and African context, the need for spiritual rituals (be they Christian, ancestral worship or based on some other system – and even a combination of the aforementioned) is a reality that health practitioners should be comfortable addressing and skilled at orchestrating.

Person-centric care includes the care of the health practitioner. Spiritual care should extend beyond the needs of the patient to address the overall health and well-being of the health team to the benefit of both patient and practitioner.

List of references

Albertyn CH. 2001. Family medicine – A luxury for the poor? *SA Family Practice*, 23(6):5–7.

Anandarajah E & Hight E. 2001. Spirituality and medical practice: Using the HOPE questions as a practice tool for spiritual assessment. *American Family Practice*, 63:81–88.

Astrow AB, Puchalski CM & Sumasy DP. 2001. Religion, spirituality, and health care: Social, ethical and practical considerations. *American Journal of Medicine*, 110:283–287. [Available from: https://www.amjmed.com/article/S0002-9343(00)00708-7/pdf. Last accessed 1 April 2019.]

Barnard A. 2011. Using communication skills for difficult conversations in palliative care. *Continuous Medical Education Online*, 29(7). [Available from: http://www.cmej.org.za/index.php/cmej/article/view/2185/1879. Last accessed July 2019.]

Bowers H & Rieg LS. 2014. Reflections on spiritual care: Methods, barriers, recommendations. Journal of Christian Nursing, Jan-March 2014: 47-51.

Boylan M. 2012. Health as self-fulfillment, in the Philosophy and Medicine Newsletter, 12:4. Reprinted in Boylan, M. (2014) *Medical ethics* (2nd edition), pp. 44–57. Malden, Massachusetts: Wiley-Blackwell.

Callahan AM. 2013. A relational model for spiritually-sensitive hospice care. *Journal of Social Work in End of Life & Palliative Care*, 9(2–3):158–179.

Canfield C, Taylor D, Nagy K, Strauser C, Van Kerkhove K, Wills S, Sawicki P, Sorrell J. 2016. Critical Care Nurses' Perceived Need for Guidance in Addressing Spirituality in Critically Ill Patients. *American Journal of Critical Care*, 25(3):206-2011.

Carter N, Bryant-Lukosius D, DiCenso A, Blythe J & Neville AJ. 2014. The use of triangulation in qualitative research. *Oncol Nurs Forum*, 41(5):545–7. [Available from: https://www.ncbi.nlm.nih.gov/pubmed/25158659. Last accessed June 2019.]

Centre for Research and Evaluation. 2012. Tobacco Control Evaluation Centre. Tips & tools #20: Writing analytic memos for qualitative research. [Available from:

https://tobaccoeval.ucdavis.edu/documents/Tips_Tools_20_2012.pdf. Last accessed 13 April 2019.]

Charmaz K. 2006. *Constructing grounded theory: A practical guide through qualitative analysis*. London, UK: Sage.

Chilisa B & Kawulich B. 2012. *Selecting a research approach: paradigm, methodology and methods*. Chapter 3. [Available from: https://www.researchgate.net/profile/Barbara_Kawulich/publication/257944787_Selecting_a_research_approach_Paradigm_methodology_and_methods/links/56166fc308ae37cfe40910fc/Selecting-a-research-approach-Paradigm-methodology-and-methods.pdf. Last accessed Aug 2019.]

Ciarrocchi JW, Schechter D, Pearce MJ & Koenig HG. 2014. Religious cognitive behavioral therapy for depression in clients with chronic physical illness (Christian version): Therapist workbook. This workbook is a variant of the treatment protocol originally designed by AT Beck, M.D. [Available from: file:///C:/Users/u20030861/Downloads/rcbt_therapist_workbook_christian_version_3-14-14%20(1).pdf. Last accessed 4 April 2019]

Cloninger CR. 2004. *Feeling good: The science of well-being*. New York: Oxford University Press.

Cloninger CR. 2013. What makes people healthy, happy and fulfilled in the face of current world challenges. *Mens Sana Monographs*, 11(1):16–24. [Available from: http://www.msmonographs.org. Last accessed 22 Jan 2015.]

Cloninger CR & Zohar AH. 2011. Personality and the perception of health and happiness. *J Affect Disord*, 128:24–32.

Cloninger CR, Zohar AH & Cloninger KM. 2010. Promotion of well-being in person-centered mental health care. *Focus*, 8:165–179.

Cole W. n.d. The five principles of Functional Medicine. [Available from: https://www.mindbodygreen.com/0-6014/The-5-Principles-of-Functional-Medicine.html. Last accessed 30 April 2019.]

Creswell JW. 1998. *Qualitative enquiry and research design: Choosing among five traditions*. Thousand Oaks, CA: Sage Publications.

Creswell JW. 2009. *Research design: Qualitative, quantitative and mixed-methods approaches*. London: Sage Publications.

Creswell JW & Miller DL. 2000. Determining validity in qualitative inquiry. *Theory into Practice*, 39(3):124–130.

Cronje FJ. n.d. See his teaching on the spiritual roots of diseases [Available from: http://www.drfjcronje.com/#!spiritual-roots-of-disease/c1g83.] Also of relevance to the topic is the following: PHYMSH study (25 min) [Available from: https://www.youtube.com/watch?v=BH4uIn4_NoQ.]; Integrating spirituality in healthcare [Available from: https://www.youtube.com/watch?v=E7zRYi6LYOwN and https://www.youtube.com/watch?v=itj9XeB7jl.] There is also a link on his webpage Frans Cronje to the study conducted with Duke University, Religious cognitive behavioral therapy for depression in clients with chronic physical illness (Christian version) Therapist Workbook [Available from: https://www.spiritmindbodyconnection.com/duke-university.html. Last accessed 3 April 2019.]

Daaleman TP. 2012. A health services framework of spiritual care. *Journal of Nursing Management*, 20(8):1021–1028. [Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC3763824/. Last accessed June 2019.]

De la Porte A. 2016. Spirituality and healthcare: Towards holistic people-centred healthcare in South Africa. *HTS Teologiese Studies/Theological Studies*, 72(4):a3127. [Available from: https://hts.org.za/index.php/hts/article/view/3127/7526. Last accessed 5 May 2019.]

Demirsoy N. 2017. Holistic care philosophy for patient-centered approaches and spirituality. *Patient Centered Medicine*, Omur Sayligil, IntechOpen, DOI: 10.5772/66165. [Available from: https://www.intechopen.com/books/patient-centered-medicine/holistic-care-philosophy-for-patient-centered-approaches-and-spirituality. Last accessed July 2019.]

Department of Health (UK). 2001. The National Service Framework for Older People. London: Department of Health.

Department of Health (UK). 2003. The National Service Framework for Long-term Conditions. London: Department of Health.

Department of Health (UK). 2005. The National Service Framework for Long-term Conditions. London: Department of Health.

De Wet H. 2014. 'Your spirit and your health' – in Afrikaans: Jou gees & jou gesondheid. *Leef Tydskrif*. An interview with Dr F.J. Cronje on the spiritual roots of diseases. pp. 46–49 & p. 102.

Dogar IA. 2007. Biopsycho-social model. *A.P.M.C.*, 1(1):11–13. World Health Organisation. [Available from: http://applications.emro.who.int/imemrf/Ann_Punjab_Med_Coll/Ann_Punjab_Med_Coll_2007_1_1_11_13.pdf. Last accessed 17 Dec 2014.]

D'Mello C & Swain MG. 2011. Liver–brain inflammation axis. *American Journal of Physiology: Gastrointestinal and Liver Physiology*, 301(5):749–761.

Du Bray W. 2001. *Spirituality and healing: A multicultural perspective*. New York Writer's Club Press.

El Hussein MT, Kennedy A & Mount BO. 2017. Grounded theory and the conundrum of literature review: Framework for novice researchers. Royal University, Calgary, Alberta, Canada. *The Qualitative Report*, 22(4):1199–1210.

Ellis C. 2007. Telling secrets, revealing lives: Relational ethics in research with intimate others. *Qualitative Inquiry*, 13(1).

Fitchett G & Risk JL. 2009. Assessing spiritual needs in a clinical setting. Department of Religion, Health and Human Values, Rush University Medical Center, Chicago, IL. [Available from: http://www.ecrsh.eu/mm/Fitchett_-_Keynote_ECRSH14.pdf. or http://bishopandersonhouse.org/wp-content/uploads/2013/07/Spiritual-Screening.pdf. Last accessed 29 March 2019.]

Fitchett G, Rybarczyk BD, DeMarco GA & Nicholas JJ. 1999. The role of religion in medical rehabilitation outcomes: A longitudinal study. *Rehabilitation Psychology*, 44:333–353.

Foglio JP & Brody H. 1988. Religion, faith, and family medicine. *Journal of Family Practice*, 27:473–474. [Available from: https://www.ncbi.nlm.nih.gov/pubmed/3193064. Last accessed 13 May 2019.]

Frankl VE. 1959. Man's search for meaning. Beacon Press Books. Republished in 1962, 1984, 1992, 2006, 2014, 2017. [Available from: www.beacon.org. Last accessed 19 July 2019.]

Freeman JT. 2005. A definition of holism. *Br J Gen Pract*, 55(511):154–5.

Gallicano T. 2013. An example of how to perform open coding, axial coding and selective coding. *The PR Post*: July 22. [Available from: https://prpost.wordpress.com/2013/07/22/an-example-of-how-to-perform-open-coding-axial-coding-and-selective-coding/. Last accessed 10 Sep 2018.]

Gibson B. 2007. Accommodating critical theory. In A Bryant & K Charmaz (Eds.), *The Sage handbook of grounded theory*, pp. 1–28. London, UK: Sage.

Glaser BG. 1978. *Theoretical sensitivity*. Mill Valley, CA: Sociology Press.

Glaser BG. 2005. *The grounded theory perspective III: Theoretical coding*. Mill Valley, CA: Sociology Press.

Goldberg RM. 2009. How our worldviews shape our practice. *Conflict Resolution Quarterly*, 26(4):405. [Available from: https://www.nottingham.ac.uk/research/groups/ctccs/projects/translating-cultures/documents/journals/how-our-worldviews-shape-our-practice.pdf. Last accessed July 2019.]

Hays DG & Singh AA. 2012. *Qualitative inquiry in clinical and educational settings*. The Guilford Press.

Hernandez CA. 2009. Theoretical coding in grounded theory methodology. *Grounded Theory Review*, 3(8). [Available from: http://groundedtheoryreview.com/2009/11/30/theoretical-coding-in-grounded-theory-methodology/. Last accessed 3 Sept 2019.]

Hope R. 2004. *The ten essential shared capabilities: A framework for the whole of the mental health workforce*. London: Department of Health.

Hospivision. n.d. For more information about the organisation and the approach followed for spiritual health care visit their website. [Internet: http://hospivision.org.za/. Last accessed 2 April 2019.]

Hospivision. 2014. For more information on the conference on Spirituality and Health Care: Caring for the life of the whole person, email friend@hospivision.org.za.

Hvidt NC. 2018. Spiritual care interventions in Secular Health Care. International Conference: Forgiveness in Health, Medicine and Social Sciences. Symposia IX, 19 May

2018, Coventry (England) as part of the 6th European Conference on Religion, Spirituality and Health and the 5th International Conference of the British Association for the Study of Spirituality. [Available from: https://www.ecrsh.eu/ecrsh-2018. Last accessed 12 April 2019].

Institute of Functional Medicine. 2014. Functional Medicine Matrix. [Available from: [https://www.google.com/search?q=functional+medicine+matrix+pdf&safe=off&rlz=1I7GGLD_en-GB&tbm=isch&source=iu&pf=m&ictx=1&fir=4vJpxY9z2M3diM%253A%252CaBq-YCa8hKV1YM%252C_&usg=__FqswqyLS40fVRt7wvyEW8wvDlKs%3D&sa=X&ved=0ahUKEwiXl5XyvtvWAhXMAMAKHeO4AN8Q9QEINDAC&biw=1366&bih=648#imgrc=4vJpxY9z2M3diM. Last accessed 5 October 2017.]

Institute of Functional Medicine. 2017. Functional Medicine Timeline. [Available from: http://welllifefm.com/wp-content/uploads/2017/04/ifm-timeline-clinical.pdf. Last accessed 5 October 2017.]

Joppe M. 2000. The research process. [Available from: http://www.ryerson.ca/~mjoppe/rp.htm. Last accessed 15 Dec 2014.]

Josefsson K, Cloninger CR, Hintsanen M, Salo J, et al. 2013. Maturity and change in personality: Development trends of temperament and character in adulthood. *Dev Psychopathol.*, 25(3):713–27.

Kasilo OMJ, Trapsida JM, Mwikisa CN & Lusamba-Dikassa PS. 2010. An overview of the traditional medicine situation in the African region. World Health Organisation. African Health Observatory. Regional Office for Africa, Brazzaville. *African Health Monitor*, 13. [Available from: http://www.aho.afro.who.int/en/ahm/issue/13/reports/overview-traditional-medicine-situation-african-region. Last accessed 6 May 2019.]

Khandkar SH. n.d. University of Calgary, Department of Computer Science: Open coding. [Available from: pages.cpsc.ucalgary.ca/~saul/wiki/uploads/CPSC681/open-coding.pdf. Last accessed 3 Sept 2018.]

King DE. 2002. Spirituality and medicine. In MB Mengel, WL Holleman & SA Fields (Eds.), *Fundamentals of clinical practice: A textbook on the patient, doctor and society*, pp. 651–659. New York, NY: Plenum.

King DE. 2012. Faith, spirituality, and medicine: Toward the making of the healing practitioner. In Koenig HG, King DE & Carson VB, *Handbook of religion and health* (2nd edition), p. 13. Oxford, UK: Oxford.

Koenig HG. 2004. Religion, spirituality, and medicine: research findings and implications for clinical practice. *Southern Medical Journal*, 97(12):1 194-200.

Koenig HG. 2007. *Spirituality in patient care: Why, how, when and what*. Philadelphia: Templeton Foundation Press. Chapter 2.

Koenig HG, Hooten EG, Lindsay-Calkins E & Meador KG. 2010. Spirituality in medical school curricula: Findings from a national survey. *International Journal of Psychiatry Med*, 40(4):391–398.

Koenig HG. 2012. Religion, Spirituality, and Health: The Research and Clinical Implications. *International Scholarly Research Notices Psychiatry*, 2012:278730.

Koenig HG, King DE & Carson VB. 2012. *Handbook of religion and health* (2nd edition). Oxford, UK: Oxford.

Koenig HG, Larson DB & Larson SS. 2001 Religion and coping with serious medical illness. *Ann Pharmacother*., 35:352–359.

Koopsen C & Young C. 2009. *Integrative health: A holistic approach for health professionals*. Chapter 2: Health and the human spirit. pp. 31–60.

Kumar-Sinha A & Kumar S. 2014. Integrating spirituality into patient care: An essential element of modern healthcare system. *Indian Heart Journal*, 66(3):395–396. [Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4121749/. Last accessed 28 March 2019.]

LaRocca-Pitts M. 2012. FACT: A chaplain's tool for assessing spiritual needs in an acute care setting. *E-Journal of the Association of Professional Chaplains*, 28(1):25–32. [Available from: http://www.professionalchaplains.org/files/publications/chaplaincy_today_online/volume_28_number_1/28_1laroccapitts.pdf. Last accessed 30 April 2019.]

Leaf C. 2016. *Think and eat yourself smart*. Bakers Books.

Loeb Classical Library. 1923. *Hippocrates Vol 1.* English translation by Jones WHS. [Available from: https://archive.org/stream/hippocrates01hippuoft/hippocrates01hippuoft_djvu.txt. Last accessed July 2019.]

Louw DJ. 1998. *A pastoral hermeneutics of care and encounter*. Wellington: Lux Verbi.

Louw DJ. 2014. Wholeness in spirituality, health and hope care. On nurturing the beauty of the human soul. A hand-out as part of a presentation by Prof DJ Louw, Faculty of Theology, Stellenbosch University, as presented at the Spirituality and Health Care Conference: Caring for the life of the whole person, 13–15 Nov 2014, Pretoria, South Africa.

Magrath P. 2016. Spiritual care in nursing. Diversity Nursing Blog. [Available from: http://blog.diversitynursing.com/blog/spiritual-care-in-nursing. Last accessed Aug 2019.]

Manning J. 2017. In vivo coding. In J Matthes (Ed.), *The international encyclopaedia of communication research methods*. New York, NY: Wiley-Blackwell. Retrieved from (PDF) In Vivo Coding. [Available from: https://www.researchgate.net/publication/320928370_In_Vivo_Coding. Last accessed 3 Sep 2018].

Massey K, Fitchett G & Roberts PA. 2004. *Assessment and diagnosis in spiritual care*.

Maugans TA. 1996. The SPIRITual history. *Archives of Family Medicine*, 5(1):11–6. [Available from: https://www.ncbi.nlm.nih.gov/pubmed/8542049. Last accessed 31 March 2019.]

McGraw JJ. 2011. Orthopaedics Today. Spirituality and the practice of orthopaedic surgery: The links between faith and health. [Internet: https://www.healio.com/orthopedics/business-of-orthopedics/news/print/orthopedics-today/%7B5c8e2fca-d782-4598-bce4-88b84c414fed%7D/spirituality-and-the-practice-of-orthopedic-surgery-the-links-between-faith-and-health. Last accessed 7 March 2019].

McSherry W, Cash K & Ross L. 2004. Meaning of spirituality: Implications for nursing practice. *Journal of Clinical Nursing*, 13(8):934–941.

Méndez M. 2013. Autoethnography as a research method: Advantages, limitations and criticisms. *Colombian Applied Linguistics Journal*, 15(2). Print version: ISSN 0123-4641. [Available from: http://www.scielo.org.co/scielo.php?script=sci_arttext&pid=S0123-46412013000200010. Last accessed 22 Sept 2018.]

Monod S, Rochat E, Bula C & Spencer B. 2010. The spiritual needs model: Spirituality assessment in the geriatric hospital setting. *Journal of Religion, Spirituality and Aging*, 22(4):271–282. [Available from: http://www.tandfonline.com/doi/abs/10.1080/15528030.2010.509987. Last accessed 15 May 2017.]

Myers M. 2000. Qualitative research and generalizability question: Standing firm with Proteus. *The Qualitative Report*, 4(3/4). [Available from: http://www.nova.edu/sss/QR/QR4-3/myers.html. Last accessed 1 Dec 2014].

Nakamura A. 2008. 'Forest therapy' taking root. *Japan Times*, 2 May 2008. [Available from: https://www.japantimes.co.jp/news/2008/05/02/national/forest-therapy-taking-root/#.XICrzFwzZPY. Last accessed 7 March 2019].

Narayanasamy A. 1999. A review of spirituality as applied to nursing. *International Journal of Nursing Studies*, 36(2):117–125.

Oxford Dictionary Online. 2014. [Available from: http://www.oxforddictionaries.com/definition/english/spiritual. Last accessed 17 Dec 2014].

Pargament KI. 1997. *The psychology of religion and coping: Theory, research, practice*. New York: The Guilford Press.

Pargament KI, Koenig HG, Tarakeshwar N & Hahn J. 2001. Religious struggle as a predictor of mortality among medically ill elderly patients: a 2-year longitudinal study. *Arch International Medicine*, 161(15):1881–1885.

Pargament KI, Smith BW, Koenig HG & Perez L. 1998. Patterns of positive and negative religious coping with major life stressors. *Journal for the Scientific Study of Religion*, (37):710–724.

Patton MQ. 2002. *Qualitative research and evaluation methods* (3rd edition). Thousand Oaks, CA: Sage Publications.

Peltzer K. 2006. *Collaborating with traditional healers for HIV prevention and care in sub-Saharan Africa: Suggestions for programme managers and field workers.* Geneva: UNAIDS.

Pike J. 2011. Spirituality in nursing: a systematic review of the literature from 2006–10. *British Journal of Nursing*, 20:743–749.

Puchalski CM. 2001. The role of spirituality in health care. *Baylor University Medical Center Proceedings*, 14(4): 352–357. [Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1305900/. Last accessed 13 May 2019.]

Puchalski CM, Blatt B, Kogan M & Butler A. 2014. Spirituality and health: The development of a field. *Academic Medicine*, 89 (1)10–16.

Puchalski CM & Ferrell RN. 2010. *Making health care whole: Integrating spirituality into patient care*. Conshohocken, PA: Templeton Press.

Puchalski CM & Romer AL. 2000. Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine*, 3:129–137. Copyright: Puchalski CM. 1996. [Also see: https://smhs.gwu.edu/gwish/. Last accessed 15 May 2017.]

Puchalski CM, Vitillo R, Hull SK & Reller N. 2014. Improving the spiritual dimension of whole person care: Reaching national and international consensus. *Journal of Palliative Medicine*, 17(6):642–656. [Available from: https://www.ncbi.nlm.nih.gov/pmc/articles/PMC4038982/#a003. Last accessed 10 April 2017.]

Ruder S. 2013. Spirituality in nursing: Nurses' perceptions about providing spiritual care. *Home Healthcare Nurse*, 31(7): 356–367.

Saldana J. 2009. *The coding manual for qualitative researchers* (1st edition), p. 68. Sage Publications. [Available from: http://stevescollection.weebly.com/uploads/1/3/8/6/13866629/saldana_2009_the-coding-manual-for-qualitative-researchers.pdf. Last accessed 10 Sept 2018.]

Schwandt TA. 2001. *Dictionary of qualitative inquiry* (2nd ed.). Thousand Oaks: Sage.

Seaward L. 2013. Spiritual wellbeing: A health education model. *Journal of Health Education*, 22(3):166–169. [Available from:

https://www.tandfonline.com/doi/citedby/10.1080/10556699.1991.10614606?scroll=top&needAccess=true. Last accessed 12 April 2019.]

Selman L, Speck P, Gysels M, Agupio G, Dinat N, et al. 2013. 'Peace' and 'life worthwhile' as measures of spiritual well-being in African palliative care: A mixed methods study. *Health and Quality of Life Outcomes*, 11(94):1–12.

Shuttleworth M. 2009. Definition of reliability. [Internet: https://explorable.com/definition-of-reliability. Last accessed 26 Nov 2014].

Simpson VL, Hyner GC & Anderson JG. 2013. Lifestyle behavior change and repeat health risk appraisal participation: A structural equation modeling approach. *American Journal of Health Promotion*, 28(2):128–35. [Available from: https://www.ncbi.nlm.nih.gov/pubmed/23621625. Last accessed 2 April 2019.]

Stephen J, Gentles SJ, Jack McMaster SM, Nicholas DB et al. 2014. A critical approach to reflexivity in grounded theory. *The Qualitative Report*, 19:1–14. [Available from: http://www.nova.edu/ssss/QR/QR19/gentles25.pdf. Last accessed 22 Sept 2018.]

Strydom MK. 2013. *Healing begins with sanctification of the heart* (4th edition). Eagles Wings' Ministries. See also her website: www.eagleswings.co.zw.

Sulmasy DP. 2001. Addressing the religious and spiritual needs of dying patients. *Western Journal of Medicine*, 175(4):251–254.

Sulmasy DP. 2002. A biopsychosocial-spiritual model for the care of patients at the end of life. *The Gerontologist*, 42(Special Issue III):24–33. [Available from: https://bit.ly/2JXlJsR (shortened URL). Last accessed 1 April 2019.]

Taylor EJ. 2012. *Religion: A clinical guide for nurses*. New York, NY: Springer Publication Company.

Taylor SC. n.d. Health care ethics. Internet Encyclopaedia of Philosophy. [Available from: https://www.iep.utm.edu/h-c-ethi/#H1. Last accessed July 2019.]

University of Southern Denmark. 2017. Denmark's first professor of Spiritual Care with special focus on cancer appointed at SDU. [Available from: https://www.sdu.dk/en/om_sdu/fakulteterne/sundhedsvidenskab/nyt_sund/danmarks_forste_professor_i_eksistentiel_ogandelig_omsorg. Last accessed 10 April 2019.] For more information, email Prof Hvidt at nchvidt@health.sdu.dk.

Van Dover L & Pfeiffer JB. 2007. Spiritual care in Christian parish nursing. *Journal of Advanced Nursing*, 57(2):213–221.

Walker A & Breitsameter C. 2017. The provision of spiritual care in hospices: A study in four hospices in North Rhine-Westphalia. *Journal of Religion and Health*, 56(6):2237–2250.

Wright HW. 2005. *A more excellent way: Spiritual roots of disease, pathways to wholeness*. Thomaston, Georgia: Pleasant Valley Publications.

Yach D. 2008. Report from the World Health Organization: Closing the gap in a generation: Health equity through action on the social determinants of health. [Available from: http://en.wikipedia.org/wiki/Social_determinants_of_health. Last accessed 28 March 2019.]

Young C & Koopsen C. 2005. *Spirituality, health and healing*. Sudbury, MA: Jones and Bartlett.