# Conversations of Spirituality: Spirituality in Family Systems Nursing—Making the Case With Four Clinical Vignettes

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*Nursing has a history of acknowledging the spiritual as a taken-for-granted dimension in health and illness. However, nurses and other health professionals have struggled to find meaningful ways to attend to the spiritual in practice. This article explores the notion that to inquire about spirituality is not neutral and not inquiring is also not neutral. In addition, four clinical vignettes are presented that illustrate ways of opening space to the spiritual in family systems nursing, within the framework of the Illness Beliefs Model. These include opening space for the following: the gift of listening, curiosity and surprise, inviting reflections, and the invocation of metaphor. This article also addresses how some constraining beliefs of the clinician can actually inhibit or close the door to possible exploration of spiritual experience.*

As a clinician with many years' experience in family systems nursing and a strong commitment to the spiritual and religious dimensions of life and care, I (first author, Deborah L. McLeod) was surprised by a conversation I recently had with a client. Lisa is a young woman with whom I had consulted for several sessions around issues related to childhood trauma and recent suicidal gestures. She was strongly linked to a supportive faith community and considered her relationship with God to be deeply meaningful. I was moved by her descriptions of "pure worship" that she encountered in her flute playing; thrilled when she discovered her "calling," to return to school and leave a dead-end job in which she had the sense of marking time; and laughed with her as she invoked images of "WWJD" ("What Would Jesus Do") by touching her pen on which these initials were inscribed when she became angry. The images invoked were of Jesus turning those with whom Lisa was angry into a pillar of salt or sending locusts or other plagues—the resulting laughter released the grip of rage and allowed Lisa to put things more into perspective (I had in fact added the locusts to the picture and my own laughter as we talked about the ways Lisa had discovered to keep rage from taking over). I had, in short, believed myself to be open to every aspect of Lisa's faith and the way it enriched her life, explicitly inviting conversations about her spirituality and related religious beliefs and themes (many of which I shared). So, I was surprised by the following conversation near the end of our fourth session. I explained to Lisa that I was working on a paper about spiritual and religious beliefs in therapy and asked if I could talk with her about her experience of the spiritual in our work together. She agreed and the following is part of our conversation.

Deborah McLeod (DM): I'm curious Lisa—have you been able to talk about your religious and spiritual beliefs as much as you would like to here?

Lisa: I think I've been a bit guarded.

DM: Oh [pause]. Is there anything that I could do to make it more comfortable for you—would it be helpful if you could talk more comfortably about your beliefs?

Lisa: Yeah it would.

DM: And what would need to happen in order for you to be more comfortable do you think?

Lisa: Just this.

DM: You mean this conversation?

Lisa: Yes. You see part of my self is really God centered. It's not just my voice that is here, because in Christianity we believe that the Holy Spirit is here and a lot of what I present as my self is actually God's voice telling me, "whoa—think about this."

DM: So how would it be helpful for us to talk more about God's voice in your life?

Lisa: Just because I want to acknowledge His presence in my life—His guidance.

DM: And it would be helpful to you to be able to acknowledge Him more fully?

Lisa: It helps me for one thing to connect more with Him—to be able to not be so afraid. We all have our own cliched thought of what God is. This way it makes Him more accessible—He IS part of my life—He is a positive force in my life.

DM: Are you saying it would strengthen your relationship with God to have conversations about God even more a part of our work together? [Lisa nods yes.] I'm curious, in our work together so far, have you talked as much about your spiritual beliefs as you thought you would?

Lisa: I've talked more than I thought I would.

DM: And how do you explain that?

Lisa: I just felt comfortable enough to share it. Like when I was rejoicing that I had found my calling, it was received with, "Wow that's wonderful!"

DM: Oh. OK—so the fact that I was excited for you helped. I'm curious about how you understand that you thought you would talk less about God here than you actually did?

Lisa: Well I guess, whenever you think about therapy, you think therapy is about me and my spiritual life is over here [spreading her two hands apart]. And here I'm learning that they're both together—like my spiritual life is not a separate entity from me. You know it's part of me—it's what guides my goals, guides my dreams, guides my behavior—just bringing those two together [joins her two hands together with fingers intertwined].

DM: And that's been helpful?

Lisa: Yes—absolutely.

Although interest in spiritual and religious aspects of family work has mushroomed over the past decade (Griffith, 1995; Walsh, 1999; Wright, Watson, & Bell, 1996), spurred on perhaps by the interest in other aspects of diversity, such as race, ethnicity, gender, and socioeconomic status (Adams, 1995; Bergin, 1991; Boyd-Franklin & Lock-wood, 1999; Lax, 1999; Lukoff, Lu, & Turner, 1992; Stewart & Gale, 1994; White & Tapping, 1990), my conversation with Lisa convinced me once again that as health professionals, we need to find more active ways of opening space to spirituality in our practices. A family's spiritual/religious orientation is as important a consideration in our work with them a s are other aspects of diversity, reflecting powerful ways of understanding, making meaning, or being in the world. In the context of working with families experiencing serious

illness, "the experience of suffering from illness becomes transposed to one of spirituality as family members try to make meaning out of their suffering" (Wright, 1999, p. 62). Yet, too often we do not make explicit our openness to having conversations about spiritual or religious experience. To be open, as I believed I was with Lisa, even asking about the meaning of her faith and involvement with her church community, is not sufficient. We (health care professionals) too often have inadvertently, or at times with intention, participated in a form of "professional oppression" (Griffith, 1995; Weingarten, 1992) with regard to spiritual and religious diversity. In relation to gender, Johnella Bird (2000) offered that to inquire is not neutral and to not inquire is also not neutral. Neutrality sometimes is taken to mean remaining silent on an issue. Such silence on the part of professionals may equate to rejection for families, marginalizing and silencing conversations that families may find healing. As health professionals, we need new understandings of how we wittingly and unwittingly oppress by sealing off our practices to the spiritual as well as how we might open space for spirituality in our practices. This article explores a variety of ways that space is opened to spirituality in a particular advanced clinical nursing practice in family systems nursing at the Family Nursing Unit (FNU), University of Calgary. The guiding model for family systems nursing at the FNU is the Illness Beliefs Model (Wright et al, 1996).

## THE ILLNESS BELIEFS MODEL

The Illness Beliefs Model (Wright et al., 1996) rests on the assumption of the biopsychosocial and spiritual nature of human beings. Illness beliefs (including religious and spiritual beliefs) are understood to be at "the heart of the matter" in the suffering as well as the healing that families experience in the face of illness. A belief is understood to
be a persisting set of premises about what is taken to be true. Among our most strongly held beliefs are those that are spiritual and religious in nature. These are especially forged in community with others such as families and faith communities. Walsh (1999) offers,

> Faith is inherently relational. . . . the most fundamental convictions about life are shaped in care-giving relationships. Caring bonds with partners, family members, and close friends nourish spiritual well-being; in turn spirituality deepens and expands our connections with others. It can be a spiritual experience to share physical and emotional intimacy, to give birth, to care for a frail elder, to befriend strangers, or to receive the loving kindness of others, (p. 22)

Although spirituality has been intertwined with nursing practices throughout history, and nursing has maintained a taken-for-granted acknowledgment of the importance of spiritual concerns in practice, understanding the meaning of spirituality and the nature of nursing practices in this domain has been elusive (Cusveller, 1998; Martsolf & Mickley, 1998; Reed, 1992).

## SPIRITUALITY IN NURSING PRACTICE

There seems to be consensus within nursing that spirituality is part of the focus of nursing; however, there remains confusion about the meaning of spirituality in our practices (Cusveller, 1998; Martsolf & Mickley, 1998; Oldnall, 1995). Much effort has been expended in the past decade in defining and conceptualizing spirituality (e.g., Burkhardt, 1989, 1994; Emblen, 1992; McSherry & Draper, 1998; Reed, 1992). For example, Emblen (1992) surveyed more than 30 years of the nursing literature to distinguish the concept of religion from that of spirituality by using concept analysis procedures. The following nine words appeared in defining spirituality: *personal, life, principle, animator, being, God, quality, relationship,* and *transcendent.* Six words were associated with religion: *systems, beliefs, organized, person, worship,* and *practices.* In analyzing the concept of spirituality emerging in nursing literature, Martsolf and Mickley (1998) identified the following attributes of spirituality: meaning, value, transcendence, connecting, and becoming. Although much work has been done, there has been relatively little clarity on the topic of spirituality, limiting direction for

**Table 1: Dimensions of Spirituality**

A way of being and experience that is embodied in:

1 A transcendent dimension, a belief in "something more," ranging from a belief in a personal God to a belief in a greater self.
2 A sense of meaning in life that values a quest for meaning and is confident that one's life has purpose.
3 A mission in life, a sense of purpose, vocation, a "call," a "destiny."
4 The sacredness of life. Life is not separated into the secular and the sacred but rather all of life is experienced as sacred and with reverence.
5 Ultimate satisfaction in spiritual values not material objects.
6 Altruism: Spiritual awareness moves people to respond to the needs of others.
7 Idealism that sees the potential of people, society, and the planet. It includes a commitment to the betterment of the world through prayer, meditation, acts of charity, or acts of social activism.
8 Realism that acknowledges the tragic realities of human existence, such as suffering, and increases commitment to make a difference.
9 Fruits of spirituality: Spiritual beliefs, attitudes, and activities bear fruit in compassion, courage, joy and positively influence one's relationships with other people, nature, self, and the transcendent reality.

Source: Elkins, Edstrom, Hughes, Leaf, & Saunders (1988).

both researchers and practitioners (Cusveller, 1998; Martsolf & Mickley, 1998; McSherry & Draper, 1998).

Bradshaw (1994) argued that attempts to define spirituality may result in fragmentation and loss of meaning as ideas are taken, piecemeal, out of context. Efforts to define and conceptualize to measure have been guided largely by the tenets of empirical science, contributing knowledge about the spiritual that largely rests on the position of subject and object. Rather than define and conceptualize spirituality, some authors have attempted to describe the meaning of spirituality by the way it invites us to live. Using a "theoretical-phenomenological" approach, Elkins and his colleagues (Elkins, Edstrom, Hughes, Leaf, & Saunders, 1988) described nine major components of spirituality (see Table 1). No one interpretation of spirituality may capture the meaning for all, with every interpretation necessarily opening space for some understanding while simultaneously closing down the possibility of other understandings. However, many of the definitions identified above and others point to aspects of spirituality that include connection with oneself, others, and a transcendent meaning that provides meaning and purpose in one's life.

## WHY INCLUDE SPIRITUALITY?

The Illness Beliefs Model (Wright et al., 1996) offers that the focus of nursing is the alleviation and healing of suffering. Wright (1997) further argues that

> Discourse of suffering frequently opens up a discourse of spirituality. Suffering invites us into the spiritual domain. A shift to and emphasis on spirituality is frequently the most profound response to suffering from illness. If nurses are to be helpful we must acknowledge that suffering and, often, the senselessness of it are ultimately spiritual issues
> (R. B. Patterson, 1994). The influence of family members' religious and spiritual beliefs on their illness experience has been one of the most neglected areas in family work. (p. 5)

The neglect of spirituality as an explicit focus in practice is not unique to nursing but has been identified in a number of health professions, including medicine (Benson, 1996; Dossey, 1993; Kristeller, Zumbrun, & Schilling, 1999; Larson, 1993; Levin, 1994; Mathews, Larson, & Barry,

1993), psychology (Bergin, 1991; Moore, 1992; Richards & Bergin, 1997), and family therapy (D. A. Anderson & Worthen, 1997; Becvar, 1996; Chubb, Gutsche, & Efron, 1994; Griffith, 1995; Prest & Keller, 1993; Stewart & Gale, 1994; Walsh, 1999). Such neglect is gradually diminishing as society and the health professions are gradually becoming sensitive to diversity in all its aspects. Substantial bodies of literature are accumulating that attest to the importance of spiritual and religious beliefs to health and illness (e.g., Benson, 1996; Dossey, 1993; Gartner, 1996; Koenig, 1995; Mathews et al., 1993; Mickley, Carson, & Soeken, 1995; Weaver, Flannelly, Flannelly, Koenig, & Larson, 1998). As might be expected, there is a substantial body of nursing literature in the context of life-threatening illness that reveals a positive relationship between spiritual and religious variables and a wide variety of health-related outcomes. Recent studies examine the associations between a religious or spiritual variable and the following outcome variables: feelings of health and well-being (Fehring, Miller, & Shaw, 1997; Fryback & Reinert, 1999; Kurtz, Wyatt, & Kurtz, 1995), coping (Dein & Stygall, 1997; Feher & Maly, 1999; Fredette, 1995; Jenkins & Pargament, 1995), quality of life (Brady, Peterman, Fitchett, Mo, & Cella, 1999; Ferrell et al., 1996; Gioiella, Berkman, & Robinson, 1998; Wyatt & Freidman, 1996), meaning and hope (Ballard, Green, McCaa, & Logsdon, 1997; Feher & Maly, 1999;
Fryback & Reinert, 1999), social support (Feher & Maly, 1999), and demands of illness (Fernsler, Klemrn, & Miller, 1999).

This body of literature is not without difficulties. Most of the studies cited above are correlational in design, limiting the conclusions one might draw. Spiritual and religious variables for the most part are operationally defined and measured using existing instruments with reasonable psychometric properties, but many of the instruments have been criticized for not being culturally relevant (Mytko & Knight, 1999). However, the preponderance of research interpreted within the empirical tradition overwhelmingly demonstrates the relevance of spiritual and religious dimensions of life for health and well-being. In addition, there are accumulating numbers of studies guided by qualitative approaches that also support the importance of spirituality in health and as a resource in illness and healing (e.g., Burkhardf, 1991; Chiu, 2000; Dunbar, Mueller, Medina, & Wolf, 1998; Humphreys, Lee, Neylan, & Marmar, 1999; Learn, 1993; Smucker, 1993).

Survey findings in Canada highlight the importance of religious and spiritual beliefs to Canadians, with approximately three quarters of the population professing Christian beliefs and association with a Christian denomination *(MacLeans* magazine survey, 1993, cited in Swenson, 1999) and between 73% to 93% of the population professing a belief in God (depending on the region of the country) (Bibby, 1987). Surveys have identified that up to 40% of individuals would consider it very important for their physicians to address spiritual issues with them if they were seriously ill (H. Gallup, 1997), and up to 77% of inpatients in another study wanted their physicians or counselors to address their spiritual needs (King & Bushwick, 1994). Moadel and colleagues (1999), in a sample of 248 ethnically diverse people living with cancer, identified a variety of spiritual/existential needs. Patients indicated they wanted help with overcoming their fears (51%), finding hope (42%), finding meaning in life (28%), and finding spiritual resources (39%) or someone to talk with about finding peace of mind (43%), the meaning of life (28%), and dying and death (25%). In another Gallup poll (G. Gallup, 1996), 66% of respondents stated that in a counseling situation they would prefer their caregivers to represent spiritual values and beliefs, and more than 81% would prefer a caregiver who enabled them to integrate their values and belief system into the counseling process. Griffith (1995) reported that clients "want to reflect on spiritual experiences in therapy, and ... feel fragmented by attempting to delegate psychological, relational issues to conversations with their therapist and spiritual issues to conversations with their priest, rabbi, or pastor" (p. 124). These findings provide some indication of how important these issues might be to families experiencing serious illness.

## SPIRITUALITY IN FAMILY SYSTEMS NURSING

In the context of clinical work with families at the FNU, University of Calgary, spirituality emerges in practice in a variety of ways. A clinical nursing team of faculty and graduate students collaborates and consults with families experiencing serious illness. The focus of the advanced

practice nursing that is taught at this outpatient clinic is the alleviation and healing of suffering, including physical, emotional, and/or spiritual suffering.

Spirituality and religion are understood to be distinct from one another, though not necessarily disconnected one from the other. Within this practice, spirituality is embodied in taken-for-granted ways of being in the world and is consistent with the dimensions identified by Elkins and colleagues (1988). The etymological roots of *spirit* include the Latin, meaning soul, courage, vigor, and breath and the Hebrew *rauch* and the Greek *pneuma,* both of which also point to breath, or breath of life (Barnhart, 1988). Religion is understood to refer to an organized, institutionalized belief system that includes shared values and beliefs and involvement in a faith community (Wright et al., 1996). Some understand the relationship between spirituality and religion as being very separate; others see the connection more as praxis, transforming experience to a way of living life. Capra and Steiendl-Rast (1991) suggested,

> You can have spirituality without religion, but you cannot have religion, authentic religion, without spirituality. .. . So the priority belongs... to spirituality as *experience, a* direct knowledge of the absolute Spirit in the here and now, and as *praxis,* a knowledge that transforms the way I live out my life in this world.... Institutionalization is one of the consequences when an original spiritual experience is transformed into a religion . . . religion brings out the intellectual dimension of spirituality, when it seeks to understand and express the original experience in words and concepts; and then it brings out the social dimension, when it makes the experience a principle of life and action for community, (pp. 12-13)

The etymological roots of religion mean "connection" (Capra & Stindl-Rast, 1991) and in the Native American tradition are loosely translated as meaning "the way you live" (Spretnak, 1991). At the same time, the limitations of these descriptions are acknowledged. Although the intent is to be inclusive, not all will feel included by these descriptions. Some might prefer to think in terms of existential, moral, or ethical meaning. Some understand their spirituality to be unrelated to any religion, and some that are religious do not relate particularly to spiritual experiences. In our attempts to interpret these ideas for the sake of illustration and some understanding, we necessarily limit other understandings. As Max Jacobs, a French, Jewish-Christian mystic noted, "You must live things, not define them" (cited in H. Anderson, 1999, p. 157).

Therapeutic conversations that evolve within the clinician/family relationship provide a frame for healing and embody the spiritual. It is hoped that through the following illustrations of living and breathing spirituality in the midst of therapeutic conversations, new understandings may emerge to guide clinical nursing practices. The following case vignettes from the FNU illustrate the opening of therapeutic conversations to spirituality. Doors through which spirituality is received in the therapeutic process include the gift of listening, curiosity and surprise, reflection, and the invocation of metaphor. Con-Straining beliefs that may limit a clinician's sensitivity to the spiritual in therapeutic conversations are also discussed.

## CASE VIGNETTES

### Vignette 1: Opening Space for the Gift of Listening

> The gift is to the giver, and comes back most to him—it cannot fail. —Walt Whitman (1881, p. 188)

> In circling twice in this way the gift itself increases from bread to the water of life, from carnal food to spiritual food. —Hyde (1979, p. 11)

The Campbell family[1] was referred to the FNU for help in coping with the aftermath of leukemia and a stroke that the father, Mr. Campbell, had experienced as a result of the chemotherapy treatments. Mrs. Campbell's concern for her husband and his associated depression precipitated her call to the FNU. During the second interview, the conversation turned to Mr. Campbell's "difficulty accepting" the way his life had been changed. As Mr. Campbell spoke of his struggle, the team noticed that whenever Mr. Campbell wept in the session or spoke of his anguish, his wife tried to cheer him by expressing her beliefs that he was "on a different path now;

God has something different for you; God didn't bring you back for no reason." Following a phone-in from the faculty supervisor commenting on this emerging pattern, the clinician joined with Mrs. Campbell and suggested they both sit quietly and hear all that Mr. Campbell had to say. What followed was a full 5 minutes in which Mr. Campbell, haltingly at first, then with more fluidity and anguish, expressed some of the pain he was experiencing in relation to the losses he had suffered.

> Some days I just feel—[sighing deeply]—well it's really hard; it's really hard accepting the way things are. I tell myself that I should—that I should be thankful that I am alive—that these things have happened to me—and I've got to accept them, but I just can't do things like I used to. I trip over things; I understand that my brain doesn't work the way it used to [pause, sighing]. 1 sit on my balcony and I see people walking and riding, walking their dogs without looking like a gimp, and I am a gimp [weeping]. I don't know what I am going to do—I think a lot about that. I can't take each day as it comes, and I live life being thankful that I—you know—I didn't die. I have my wife here with me and—but so much is unknown. I know this sounds silly because there's always the unknown, but at least my wife knows she's going to work.... You— you come here and talk to us. . .. You've got some kind of schedule to your life—like my doctor said she'd die to have 2 weeks off. I don't know what my future's going to hold, and I think a lot about that. Maybe I shouldn't—I don't know [sighing]. If I could do something beneficial—you know I don't want to spend my time getting up, making the bed, doing the laundry; it's not like I mind doing that, it's not like I hate it, but there's got to be something more [pause, weeping]. And it's going to take time, well I know its going to take time [deep sighing]—am I making any sense?

"The inviting, listening to, and witnessing of illness stories provides a powerful validation of a profound human experience. . . . [Within these stories a] domain of spirituality is encountered" (Wright, 1999, pp. 67, 75). Listening to such stories is profoundly difficult work in which both clinician and family struggle with ultimate meaning and purpose and the unknown. The gift of listening in the face of such suffering is given with anguish also. To think of what one might "do" or how one might "intervene" in such encounters is to diminish the profound nature of the topic. "When listening becomes a task, instead of a gift, then stories are not witnessed and honored but rather become 'clinical material/ demanding manipulation and change." (Frank, 1998, p. 199). To offer "deep listening" (Stein, 1998, p. 213) or "empathic witnessing" (Kleinman, 1988, p. 10) allows a story to be told that cannot be told unless someone listens (Frank, 1998). "Meaning of life" questions demand the gift of such listening. Telling stories of suffering and spiritual searching helps us to make meaning in the midst of chaos. Telling such stories uncovers the meaning that people attach to their suffering for both listener and speaker. Yet, the listening called for in such places with families demands that we hold the belief that the story (and the teller) needs no change (Frank, 1998).

Listening as an act of the spirit acknowledges the need for mutuality in the encounter with spiritual questions. The clinician does not listen to "intervene," nor does he or she invite family members to listen from such a place, but rather to honor the mysteries of life that illness often brings. In the context of family work, the nurse creates space for the telling and witnessing of stories (Wright, 1999). For Mr. and Mrs. Campbell, the story of suffering opened the spiritual domain in which her beliefs ("you are on a different path") silenced his anguish ("I can't accept this—there has to be more"). Although this "meaning of life" story was anguished and difficult to listen to, the telling of it was accompanied by deep sighs—a letting go of something that had been held for too long. When the family and the clinician could reflect on their witness of this story, Mrs. Campbell was able to comment on her fears of depression and suicide, both of which had touched their family in significant ways in the past. Acknowledging that a story is a child of a relationship (Stein, 1998), not a thing to be manipulated, invites the clinician and family members to a reflection on the meaning of life for all of us, a position in which the family and clinician both may experience spiritual connection and mystery. In Mr. Campbell's story are heard the many discourses that have silenced him with "you need to accept," as well as the release of anguish in the sighs as he speaks of those things he cannot accept. When families can provide the gift of listening to each other, the gift cannot fail to come back as the possibilities are opened up for new meanings to emerge in their own time.

### Vignette 2: Curiosity and an Openness to Surprise

> Knowing how to act "is a dance ... a conversation between what is said and what could be, an openness to passionate sorrow and surprise, a play between understanding and perception."
>
> —Phelan (in press)

Within the Illness Beliefs Model, maintaining curiosity and explicitly inquiring about religious and spiritual beliefs provide openings for spirituality in therapeutic work with families. Such inquiry emerges out of therapeutic conversations as the clinician listens for cues in the language or themes the family offers in their stories. Part of a respectful and culturally sensitive practice is curiosity and maintaining the mind of a beginner (Epstein, 1995). A lapse in curiosity often precedes the closing down of conversations about spiritual experiences and beliefs. As the clinician embraces the mind of a beginner, the family is invited to teach the clinician about their beliefs, faith, or spiritual experiences. Curiosity is sometimes more difficult to maintain when the clinician shares the same faith, as we may be inclined to make more assumptions. Holding the belief that each family (and individuals within the family) makes sense of their spirituality in varying ways and, that in a very real way, no two people share exactly the same spiritual understandings (even within the same faith community) may help the clinician maintain curiosity. Although conversations are not aimless, there is a sense that when curiosity and openness to learning from families are high, that one is conducted by the topic as much as one is the conductor. In such conversations we do not talk at cross-purposes, seeking to understand so that we can make predictions (in which the clinician is distanced and "objective"). Nor do we seek to understand the meaning that relates to me (a social conversation). We listen, rather, with the other for the way in which what the other is saying is "right" (Gadamer, 1989). We seek to understand what the topic (spirituality) might have to say to all of us, clinician and family together. Out of such hermeneutic listening new understanding and possibilities for healing may emerge.

In a therapeutic conversation with a man living with multiple sclerosis, the clinician's curiosity helped to maintain an openness to the spiritual in the conversation as the client, Brian, described his spiritual experiences at the funeral of his brother. The clinician remained curious about the ideas Brian had, the language he used, the meanings he drew from these experiences, and the relationship between his beliefs and his suffering related to feelings of guilt about the last conversation he had with his brother. The following conversation picks up as Brian is describing his experience of his brother's presence at the funeral home and, later, the funeral.

Brian: There's something else out there—it's not ghosts but—your spirit is made out of an energy; you can't destroy energy so where does it go?

Clinician (C): What do you think?

Brian: I—there's something else out there—whether it be another plane, whether it be, something—I don't know—but there's something else out there.

C: Because what did you experience that convinced you of that?

Brian: Well, try a 5 or 6 hour conversation with my [dead] brother that night—and it wasn't just me. My wife had it too. [Brian goes on to describe the sense of his brother's presence that came and went during this time.]

C: So have you found it a comforting experience or disturbing?

Brian: It made it easier to deal with.

C: It did? In what way?

Brian went on to describe the comfort he gained from the sense of his brother's presence and the way he became convinced through this that his brother's death was not a suicide but an accident.

A belief about change reflected in the Illness Beliefs Model is that change must be languaged to

be real. "Like other 'realities', change is brought forth through the distinguishing of it" (Wright et al., 1996, p. 92). "The act of indicating any being, object, thing or unity involves making an act of distinction which distinguishes what has been indicated as separate from its background" (Maturana & Varela, 1992, p. 40). Change is brought forward and solidified through the therapeutic conversations that evolve between the clinician and the family. Spiritual meanings emerge and evolve in the context of conversations that are characterized by curiosity and mutuality. Maintaining a curious openness to the spiritual seemed important to Brian in easing the suffering that he was experiencing at the loss of his brother. The clinician's willingness to adopt the mind of a beginner (Epstein, 1995) and be taught by the client's experience maintains an openness to the expression of the spiritual in human experience.

**Vignette 3: Inviting Reflection on Spiritual/Religious Beliefs**

In family work, sometimes the more difficult encounter for clinicians is with families who hold strong religious views (Prest & Keller, 1993; Stewart & Gale, 1994). The assumption that religious beliefs are rigid and unlikely to change closes down conversations and goes against the call for deep, hermeneutic listening that stories of spiritual quest, strength, and meaning demand. The more conservative religions seem particularly vulnerable to monolithic stereotypes (Stewart & Gale, 1994). Many of us do not reflect deeply on the religious beliefs, stories, and teachings of our faith traditions until confronted with a question. Often, such teachings have a taken-for-grantedness that does not invite questioning. Within a given faith community, however, there is often (if not always) more than one way to understand a given idea, belief, or scripture. One might even argue that with reflection, no one understands such teachings in exactly the same way. New understandings often do evolve in the midst of the questions that we have not yet confronted, individually, as a family, or even as a faith community.

The Walsh family presented at the FNU with questions about how to manage the serious illnesses of their son, Brad, who was 10 years old and the father, Jeff, who was 49. Brad had been diagnosed with a serious brain tumor shortly after birth. The tumor had caused significant developmental delays, and the family believed he would not live beyond his adolescence. In addition, Jeff had recently been diagnosed with a degenerative brain disease. The family also expected that Jeff's life would be shortened, though they were uncertain by how much. Their presenting concern was Brad's behavior that his mother, Susan, described as "out of control" at times, with temper tantrums, screaming, and demanding behavior. The neurologist had told Brad's parents that his tumor likely would affect his behavior and that at times Brad would have difficulty controlling his impulses and emotions. The family described themselves as conservative Christians. Part of Susan's suffering was the conflict she experienced about how to discipline Brad. Her Christian beliefs supported the idea that discipline was the responsibility of all godly, loving, and responsible parents. Godly parents discipline their children—to spare the rod would mean spoiling the child and would negatively affect Susan's relationship with God, to whom she felt accountable. Susan was also experiencing criticism from her parents and friends who admonished her to discipline Brad and correct his behavior.

As is a common practice in the FNU, a reflecting team (Wright et al., 1996) offered their thoughts to the family toward the end of a session. One idea that was offered the family was the notion that the word *rod* in the original Hebrew could also be translated "shepherd's hook" and that a shepherd's hook is used for shaping and guiding the path of lost sheep. Perhaps one way to understand their work as Christian parents might be to think of guiding this little boy as a form of discipline. For the family, this notion was very powerful and invited them to think of discipline in a different, gentler way by offering a possible alternative understanding of Scripture. Such an offering invited new possibilities for this family as they reflected on the enactment of their faith in their parental role. Maturana and Varela (1992) offered the notion that

> reflection is a process of knowing how we know. It is an act of turning back upon ourselves. It is the only chance we have to discover our blindness and to recognize that the certainties and knowledge of others are, respectively, as overwhelming and tenuous as our own. (p. 24)

Invitations to a reflection emerge out of therapeutic conversations. In working with religious families, maintaining deep listening, curiosity, and a position of listening for what the other is saying that might be right facilitates open, reflexive conversations. Believing that one's understanding of his or her faith evolves and deepens over time may invite the clinician to ask questions silently or out loud and may allow new understandings to emerge. Questions such as, "How else might this be understood?" and "How do others in your faith community understand this?" can be helpful in the invitation to reflection.

**Vignette 4: The Invocation of Metaphor**

Religious meaning and experience are carried in the metaphors of rituals, stories, songs, and symbols of a faith. The invocation of metaphor in clinical work with families is an open door to the spiritual and often emerges in conversations about meaningful experiences, stories, or scriptures. The word *invoke* means to call on or to summon into presence (Barnhart, 1988). Such metaphors embody the divine in the midst of our work with families. The spiritual is invited to be present to families as they share the stories of their faith. As we listen, we participate with families as new meaning emerges. In the telling of oral stories, Ong (1981) offered that

> the singer is not conveying "information" in any ordinary sense of a "pipeline transfer" of data from singer to listener. Basically the singer is remembering in a curiously public way—remembering not a memorized text, for there is no such thing—nor any verbatim succession of words, but the themes and formulae that he has heard other singers sing. He remembers these always differently, as rhapsodized or stitched together in his own way on this particular occasion for this particular audience. . . . The song is an interaction between him, his audience, and his memories of songs sung. (pp. 17-18)

For many families, the telling of faith stories through therapeutic conversations, even though they may rest at times on "memorized text," is often told "as stitched together ... on this particular occasion for this particular audience," for the experience of stories depends on the particularities of this time and this place. The telling of such stories can be profoundly healing of spirit.

The Lange family attended the FNU following the death of first their brother and then, a year later, the death of their father/husband. The family was involved with their religious community and considered their faith important to them. In the second session, the clinician explored their religious beliefs, and these beliefs are expressed through stories of faith. As the clinician listened, there was a sense for the observer that the family as a whole was strengthened by listening to the son speak of his own faith and their faith as a family. This was witnessed in the side comments of his sister and the nods, tears, and smiles of his mother as she listened. There is a sense, too, of an invocation of spirit carried in the stories and a renewing of faith as the stories are told in this place and time and to these particular witnesses.

Clinician (C): The first time we met we talked some about the events at your church and the way you felt betrayed. At times of loss, families sometimes find that they really start to question their faith; I'm wondering—has your spirituality—your beliefs in God brought you comfort or brought you pain?

Son: It's kept us sane!

Mother: Yes—I would say that's really been the anchor of my soul.

Son: What we experienced in the church before, it was like a precursor of now. . . .

Daughter: It was a foreshadowing of death.

Son: And we experienced it; I believe we experienced it and we took it very hard and we took it in different ways and it reaffirmed everything that we were taught since we were little—so it made it [our faith] stronger ... that has been the only thing that has been able to keep us sane— because it's true—if I didn't have the things, the simple things that I know in my heart, I know to be true, I wouldn't have a hope in the world. I would be lost. It would be like walking

around with a toque on my head; [with my faith] I can still see a trail—it's a little obstructed but I can still sec some light.

C: If you were to offer some advice to other families going through this—to make their pain less—what would you say?

Son: You can't make the pain less. You just have to remember the things that you know in your heart to be true. And for me the things that I know in my heart to be true are that I'm only passing through. I was able to have a relationship with two people; there's a verse in the bible—"He who has started a good work in you will be faithful to complete it"—it goes on to talk about how it may not be in our frame of time, it may not be when we want it to happen, we will know though; it's just a matter of on whose time frame. My hope now is in my family and in my beliefs.

C: Can you tell me what those beliefs are—what you believe in?

Son: [Speaks at some length of God as comforter and of His unconditional love.] For me, that's what I've been raised with since I was little— and my experiences since through my life have reaffirmed that—it's a reality I live with.

C: Those sound like very comforting beliefs.

The telling of these stories, coming as they do after the loss of two members of this family, invokes new and comforting images and meanings for this particular time. Told as they are in the midst of family who are both speakers and witnesses invites a healing, a reaffirmation of faith, that for this family seemed powerfully healing.

## CONSTRAINING BELIEFS

A variety of beliefs may constrain spirituality in our nursing practices. Some health professionals feel unprepared to deal with spiritual themes and issues in their practices and may not themselves have considered such topics important in their own lives. A lack of personal reflection and education specifically on spirituality in practice may contribute to this discomfort and the constraining belief that "I don't have the expertise or previous experience" to address spiritual issues. If we believe that conversations are coevolved with families (Wright et al,, 1996) and that the clinician can learn from families about their particular spiritual experiences and beliefs, the belief that the clinician must have expertise is challenged. A colleague offered the notion that because she had absolutely no family experience herself in religion or spirituality, she particularly felt unable to incorporate spirituality into her practices. As she stated, "I simply have no questions that might open up conversation." This is more about a lapse in curiosity than about a lack of expertise. Clinicians who want to develop their practices in this area may benefit from reading about spirituality and different faiths (J. Patterson, Hayworth, Turner, & Raskin, 2000), with the understandings gained perhaps contributing to increased curiosity and exploration with families.

Clinicians sometimes believe that inquiry about spirituality can be dangerous, intrusive, or disrespectful. Some may even believe such topics are not relevant to our practices. Clearly, the research and survey findings cited previously reflect the importance of these topics to health and illness and the interest of many people in having their spiritual experiences and beliefs respected through inclusion in their health care. Provision of culturally respectful care requires that we become open to the spiritual in our practice, not simply by "being" open but by finding ways to explicitly include spirituality in our practices.

Finally, clinicians are sometimes constrained by their beliefs that they "know" what the family believes when they name their religion (or denomination). Such stereotyping always closes down conversations and possibilities for healing whether the stereotypes are about ethnicity, race, class, or religion. "A generic approach to 'religious' clients will not do, any more than a generic approach to 'ethnic' clients or 'middle-class' clients will do. *What* religious clients believe is more important than the mere fact *that* they believe" (Stewart & Gale, 1994,

p. 17). Challenging such constraining beliefs often occurs through learning from families who hold a variety of spiritual or religious beliefs or through conversations with colleagues who hold different beliefs (or the same beliefs differently!).

## PRAXIS OF SPIRITUALLY SENSITIVE PRACTICE

> The power of narrative to nurture and heal, to repair a spirit in disarray, rests on two things: the skillful invocation of unimpeachable sources and a listener's knowledge that no hypocrisy or subterfuge is involved. —Lopez (1989, p. 19)

It is neither neutral to inquire nor neutral to not inquire about spirituality in our work with families. Both may be considered political acts. Either could invite oppression—the former potentially through the imposition of certainty; the latter through marginalization and oppression by silence (Griffith, 1995). We, as nurses, cannot be neutral in our work with families, for we cannot *not* hold the beliefs that we do. However, we can be thoughtful about the ways in which our beliefs are at play in our practices. Most important, we are ethically bound to respect the family's beliefs as central to the therapeutic process. Holding the family's beliefs as central requires that I, as a nurse, continually evaluate how my own spiritual and religious beliefs, or lack of belief, might be at play in the things that I choose to inquire about, those that I attend to, those that I choose to ignore. We are obliged to be aware of what we are potentially opening up, closing down, and imposing. We continually do all of these in our conversations with people, but to do so with a lack of awareness may constitute culturally disrespectful practices. The clinical vignettes highlighted in this article illuminate some possible ways of embracing the spiritual in our work with families.

## NOTE

1. Pseudonyms have been used to protect the anonymity of the families.

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