Spiritual care in nursing: a systematic approach

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Summary

Ian Govier suggests that patients will benefit if nurses adopt a systematic approach to assessing spiritual needs. However, it may be necessary to evaluate personal spirituality before applying this approach.

THE TERM holistic care in nursing is one that many nurses who have trained or undergone further nurse education in the past decade will be familiar with (Harrison 1993, Narayanasamy 1996, Oldnall 1996). Indeed, many nurses will probably claim to have a commitment to the concept of holistic care, in that they will recognise the importance of considering the physical, psychological/emotional, social, cultural and spiritual aspects of need and care (Dossey and Dossey 1998, Stoter 1995). There is evidence to suggest that the first four of these needs are recognised, taught and practised in nursing curricula and care (McSherry and Draper 1997, Narayanasamy 1993, Ross 1995 and 1996), but the area of spiritual care is one that is frequently overlooked and delegated to a religious leader. This is often addressed within the framework of nurse education by the hospital chaplain or occasionally a tutor with a particular interest in spiritual matters.

Although colleges of nursing are attempting to rectify this apparent omission by revising existing curricula and incorporating spiritual care, one may argue that many are still reluctant to recognise its relevance and importance (Govier 1999a, Harrison and Burnard 1993, Johnson 1998). The hesitancy displayed by nurse educationalists may suggest that a degree of suspicion, misconception and ambiguity still surrounds the spiritual dimension. Furthermore, given nursing's apparent preoccupation with establishing itself as a scientific and research-based profession, the metaphysical dimension of spiritual care is not one that lends itself easily to scientific scrutiny.

Considering that the dominant paradigm at this time supports the scientific model, it is not surprising that nursing has followed suit in its quest to gain greater credibility among the more established health disciplines which claim that practice is based on a rigorously tested theoretical foundation. Martsolf and Mickley (1998) highlight the void surrounding spirituality in nurse education and encourage continued theoretical development to further our understanding of the concept and ultimately guide practice. In response to this call to promote nurses' understanding of spiritual care, guidelines for the assessment of spiritual needs are presented as part of a systematic approach to nursing care.

Defining spiritual care

In an attempt to further clarify what is understood by spiritual care, and following extensive review of the literature, Govier (1999b) has summarised the concept as the 'five Rs of spirituality' (Box 1):
- Reason.
- Reflection.
- Religion.
- Relationships.
- Restoration.

Reason and reflection The search for meaning in life experiences has been viewed as an essential universal trait (Cobb and Robshaw 1998, Carson 1989, Highfield and Cason 1983, Murray and Zentner 1989, Stoter 1995, Thompson 1996). Indeed, the view of the renowned psychiatrist Viktor Frankl (1984) is that man's primary motivational force is the search to find meaning and purpose in life experiences, whether they be in ordinary or extreme circumstances. Patients and carers often find themselves in 'extreme circumstances' and might ask: 'Why is this happening to me or my loved one?'

It is through the nurse taking a sincere and active role, and recognising that the physical, psychological/emotional, social, cultural and spiritual realms are all interconnected, that he or she is in a position whereby he or she can help those who are suffering to reflect upon and find meaning in their experiences.

Religion Religion can serve as a vehicle for expressing spirituality through a framework of values, beliefs and ritual practices (Labun 1988, Langford 1989, Ross 1994) and for some, provides the answers to the essential questions surrounding life and death issues. What must be recognised is that some people have their own form of religion that may not always be encapsulated within institutionalised religion (for example, Christianity, Judaism, Islam, Buddhism). Nevertheless such beliefs demand the respect of the nurse who seeks to listen to and respect the views and practices of patients, without always agreeing with them.

Relationships Oldnall (1996) regards relationships with ourselves, others and God (or another influential focus) as being at the centre of the spiritual dimension. Labun (1988) identified meaningful, purposeful or creative work as an expression of spirituality and indicated that service to others might also fulfil spiritual needs. An influential theory put forward by Carson (1989) argues for both vertical and horizontal dimensions of spirituality. The vertical dimension involves a person's transcendent relationship with a higher being, often referred to as God, whereas the horizontal dimension is experienced in relationships with self, others and the environment.

One may then argue that a person who does not have a relationship with a higher being, might still experience spirituality on a horizontal plane. This position challenges the popularly held opinion that spirituality equates with a religious belief or association with a particular religious denomination. Indeed, the person experiencing horizontal spirituality could, in some cases, be considered more spiritually in tune than many who opt for a more vertical approach.

Carson (1989) observes the need for a continuous interrelationship between the inner being of the person (the person's vertical relationship with the transcendent/God or whatever supreme values guide the person's life) and the person's horizontal relationships with self, others and the environment.

Restoration Restoration refers to the ability of a person's spirituality to have a positive influence on the physical aspects of a person. Certain life events can cause an inability to 'restore' the body to a spiritual equilibrium, resulting in spiritual distress (Burnard 1986, 1987 and 1988). These may be displayed through a change in a patient's disposition manifested by his or her mood, emotions or physical being. Whatever the alteration, the nurse should be able to recognise signs of spiritual distress and draw on either personal or adjunctive means to assist the patient in restoring spiritual wellbeing.

A foundation for spiritual assessment

These five areas provide a useful foundation for the assessment of a patient's spiritual needs and refute the notion that spiritual care is only concerned with those of a religious persuasion. Assessment guidance, although not yet thoroughly tested in clinical practice, can be found in Box 2. These guidelines invite the nurse to enquire into intimate details of the patients' world. Caution is advised as the nurse needs to be equipped with the resources to either deal with the answers, or have the insight to recognise that referral to more able or appropriate professionals may be necessary. The assessment guidelines are in some ways unsuitable for certain clinical areas, such as acute or day wards, or other areas where patient interaction is either

brief or limited. However, long-stay, continuing care or rehabilitation areas where patients can spend protracted periods of time, may be appropriate settings in which to explore the issues related to spiritual care. Spiritual needs therefore, may be described as the deepest requirement of the self, and if met, make it possible for people to function with meaningful identity and purpose.

Box 1. The five Rs of spirituality

Reason and reflection – A desire to search for, or find, meaning and purpose in one's life; the will and reason to live; to reflect and meditate on one's existence (may be enhanced through art, music or literature)

Religion – A means of expressing spirituality through a framework of values and beliefs, often actively pursued in rituals, religious practices and reading of sacred texts; religion might be institutionalised or informal

Relationships – A longing to relate to one's self, others and a deity/higher being (may be expressed via service, love, trust, hope and/or creativity); the appreciation of the environment

Restoration – The ability of the spiritual dimension to positively influence the physical aspect of care (certain life events can be detrimental, resulting in spiritual distress)

Box 2. Guidance for spiritual assessment

Reason and reflection
Does the patient take time to reflect on life's experiences?
If yes, can he or she describe how?
What events in the patient's life have had an effect on him or her?
Are there any things that particularly motivate the patient?
If yes, what are they?
Has the patient thought why the illness/trauma has happened to him or her?
If yes, in what way?
Is there anything that frightens the patient about this illness/traumatic experience?
If yes, what is it?
Religion
Does the patient have a religion?
If yes, which one?
Is there a religious representative that the patient finds especially helpful?
If yes, who?
Would the patient like to see a hospital chaplain or religious representative during his or her stay in hospital?
Are there particular rituals or practices that are important to the patient?
If yes, what are they?
How can the patient's religious beliefs and practices be accommodated while in hospital?
Relationships
What are the most influential relationships in the patient's life?
Does the patient have a belief in God or a higher being?
If yes, can he or she describe this belief?
How does this belief in God or a higher being manifest itself?
Has the patient ever felt, or been, abandoned in a relationship?
If yes, how did he or she feel? Have these feelings been rectified?
Restoration
Has this illness/trauma affected the patient's spiritual beliefs?
If yes, in what way?
Does the patient feel at peace with him- or herself?
If no, what might be the reasons for this?
Are there any signs of spiritual distress?
If yes, what are they?

Systematic approaches to spiritual care

Prior to the widespread introduction of models of nursing into the UK, the nursing process, also known as a problem-solving or systematic approach to nursing care, appeared to operate in isolation from any underpinning conceptual frameworks. It is a familiar nursing tool and identifies four key stages when organising nursing care:
■ Assessment.
■ Planning.
■ Intervention.
■ Evaluation.
The nursing process was primarily developed in the profession by nurse theorists Yura and Walsh (1982). They argued against a wholly intuitive approach to nursing and for a more systematic and analytical approach to care. A response to this argument might be that, although this approach can be extremely effective and is adopted by other professions, and in everyday living activities, intuition also plays an important part in nurses' interactions with patients. This is especially true as they gain increased knowledge and experience, and seek to apply these in a multitude of clinical settings.

First, by emphasising the importance of patient assessment, the nursing process allows the nurse to identify, in partnership with the patient, actual as well as potential problems. This systematic assessment will be enhanced if based on an appropriate conceptual framework which will subsequently inform and assist this stage of the process. If it is to be holistic in its approach, it will include a physical, psychological/emotional, social, cultural and spiritual assessment and identify associated problems. Johnson (1998) firmly states that spiritual needs are inextricably linked with physical and psychological needs and will have an influence on all of the areas in a holistic framework.

Second, the relevance of planning helps to specify how certain behaviour will help to achieve goals that will be set in response to identified problems. By identifying goals, nurses place themselves in a position to make suitable interventions or nursing actions (the third stage of the nursing process) to assist the patient in achieving them.

Finally, by recognising and emphasising the role of ongoing evaluation, the nursing process encourages the practitioner to appraise actual behaviour in response to nursing actions deemed appropriate to meet set goals. The nursing process is cyclical in nature, in that the successful or even unsuccessful completion of each stage provides useful information for the next. In wider terms, Christensen and Kenney (1990) claim that the nursing process can also enhance accountability to patients and employers, and might even be used to demonstrate cost effectiveness, especially in these times of scarce resources.

Conceptual models and spiritual care In relation to conceptual frameworks, Fawcett (1995) summarises the nursing process as emphasising the:

■ Assessment of a person's health status.
■ Setting of goals for nursing action.
■ Implementation of nursing actions.
■ Evaluation of a person's health status after nursing intervention.
However, each conceptual model of nursing will adapt the nursing process, depending on what the model has to say about the nature of the person, nursing, health, environment and the specified goals of nursing action. In very simple terms, one model of nursing might have very patient-centred, self-care goals, when compared with another with an orientation to nurse-dependence. Only a small number of the major theorists (Neuman 1995, Newman 1989, Parse 1992, Watson 1985) identify the spiritual domain in an explicit manner, but in Oldnall's (1995) view, none actually provides guidelines to help direct the nurse in the process of spiritual assessment.

Assessing spiritual care

Before attempting to respond to a spiritual need, it must first be recognised and assessed (Stoter 1995). It would also seem appropriate that if spiritual needs are to be met, nurses must not only have some appreciation of the significance of patients' spiritual needs, but also some framework of assessment to identify specific spiritual problems accurately (Harrison 1993). An early form of assessment guidance was written by Stoll (1979) a US academic, who readily admitted to the more elusive nature of the spiritual dimension and the discomfort experienced by nurses in tackling this social and seemingly taboo nursing subject. Professor Stoll developed a 'spiritual history' guide that highlighted four areas of concern (Box 3).

The four areas of spiritual concern in the assessment guide appear biased towards the believer or religious person, with Stoll openly declaring her involvement as a volunteer hospital chaplain, although not admitting affiliation to any particular denomination. An additional criticism, accepted by Stoll, might be that the values and beliefs expressed in these areas may or may not be manifested by a person through conventional religious language and rituals. Furthermore, some people might find the content areas ambiguous, verbally incongruent with their behaviour and even threatening to discuss.

The timing and suitability of the spiritual needs assessment, as well as the ability of the nurse to be sensitive towards each individual, will determine the success of such an important nursing action and, if nurses are to adopt this assessment approach, they should do so cautiously. It is important that nurses explain the basis for their enquiry (Cobb 1998), including what they plan to do with the information obtained, which is ultimately to increase the knowledge of patients' sources of strength, and to offer and provide the best care possible and help attain and maintain peace of mind (Kitson 1985). Otherwise, the information remains of little use, fulfils the pur-

Box 3. Areas of concern in spiritual assessment

■ The person's concept of God or deity.
■ The person's source of strength and hope.
■ The significance of religious practices and rituals to the person.
■ The person's perceived relationship between his or her personal beliefs and his or her state of health.
(Stoll 1979)

pose of 'form-filling' and contributes to an increasing volume of perfunctory paperwork.

Harrison (1993) claims that Stoll's assessment process is time consuming to complete and, therefore, unrealistic in practice. She also expresses the view that because the guidelines were developed in the US, where attitudes towards discussing such intimate and personal details are possibly more open, they may not sit comfortably with the innate reservedness of nurses and patients in the UK. If this is true, and the area of spiritual need assessment is to be a key part of holistic nursing practice in the UK, adapted and workable guidelines must be developed to address this omission in nursing care. Narayanasamy (1996) and Cobb (1998) assert that information based purely on religious needs is insufficient for spiritual care and does not allow the nurse to explore feelings about the meaning and purpose of life, love and relationships, trust, hope and strength, forgiveness and expressions of beliefs and values – the concepts that form the foundation for Stoll's (1979) assessment guide.

Spiritual needs are not solely the prerogative of the believer and the assessment process must consider and embrace the needs of those who do not have any particular religious beliefs, or who question or dismiss the existence of a higher being altogether. Newshan (1998) advocates a more open technique when assessing patients' spiritual needs. She encourages the use of open-ended questions, not in a regimented and routine manner, but rather in a sympathetic way. 'Active listening' becomes the key to noticing verbal and non-verbal cues, especially the facial expressions that indicate fear, doubt, depression or despair which are indicators of spiritual distress. Guidance using the 'five Rs of Spirituality' (Govier 1999b) is presented to assist the practitioner in exploring this aspect of holistic nursing care (Box 2).

Despite the petitions from nurse educationalists and practitioners to include spiritual matters in the assessment of patients, certain precautions should be considered, especially for those novice clinicians who wish to 'test the water'. Nurses should consider whether the assessment is practicable for the type of patients being assessed and whether the language (Labun 1988) and concepts being used are appropriate for all patients. Finally, nurses performing the assessment must consider their own professional ability to conduct such an appraisal and whether they are prepared and capable of dealing with the immediate consequences of what the assessment may evoke.

Some of the reluctance to become involved in assessing the spiritual needs of patients may lie with nurses who might themselves have little insight into their own spirituality. Newshan (1998) proposes that nurses should begin their own spiritual journey before becoming intimately involved with others, and suggests reflection upon several questions (Box 4). She suggests that before nurses can readily minister to the spiritual need of others, they must achieve an awareness of an inner life. This could be promoted in an

Box 4. Personal spirituality: questions for reflection

- What do I believe in?
- What gives my life meaning?
- What do I hope for?
- Who do I love and who loves me?
- What do I understand by the term spirituality?
- How am I with others?
- What would I change about my relationships?
- Am I willing to heal the relationships that trouble me?

(Adapted from Newshan 1998)

educational or a clinical setting, but unless there is a sincere desire to explore this most intimate area of one's self, the approach to the assessment of someone else's spirituality will remain superficial and duty-based.

Planning spiritual care

It has been claimed that planning care is the key to attending to patients' spiritual needs (Carson 1989, Narayanasamy 1991), with Johnson (1998) emphasising the importance of effective communication not only between the patient and members of the healthcare team, but also with family, informal carers and friends who may know the patient well.

The care plan should reflect the needs identified by the assessment and might include the provision of support, active and non-judgmental listening, comfort, empathy and the time to attend to these activities.

Attending to someone's spiritual need is time consuming and presents a challenge to the nurse who is over-stretched by under-staffing and the routine demands of a busy hospital ward or community setting. Interestingly, it has been the author's experience that many of the conversations with people in hospital concerning matters of the spirit have been discussed at night time, when they often feel most vulnerable and alone.

This is also a time when a nurse might have less demand on his or her time, as he or she is often freed from many of the daily practical and routine tasks that might prevent effective communication with those for whom he or she cares.

One is left to ponder whether some patients' physical ailments would be alleviated if nurses spent more time dealing with spiritual issues, which in turn would help to resolve physical or psychological problems.

Implementing spiritual care

Amenta and Bohnet (1986) suggest the use of four 'spiritual tools' to assist nurses in implementing spiritual care. These are the:

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- Need to listen in an authentic manner.
- Actual presence of the nurse.
- Ability of the nurse to accept what the patient says.
- Use of judicious self-disclosure.

Other tools would include intuition and appropriate behavioural interventions. These require a high degree of self-awareness from the nurse, especially in the use of self-disclosure. The nurse must be able to distinguish the need to share personal experiences as a means of positively helping, from just disclosing information to make conversation or as a means of imposing personal beliefs. Carson (1989) suggests that two principles be incorporated when implementing spiritual care. She reminds nurses that if someone claims a relationship with a higher being, it can be both complex and individual. Therefore, it is not possible to write a list of 'standing orders' for each person and care should reflect individual requirements. Secondly, she supports the notion of a nurse becoming more self-aware of his or her own spiritual needs before he or she can become deeply involved with others.

Narayanasamy (1996) and Burkhardt and Nathaniel (1998) ask carers to observe certain protocols when delivering spiritual care and highlight the importance of a caring nurse-patient relationship which should not include the imposition of personal beliefs.

It must also be recognised that although a nurse might become involved in addressing spiritual needs, he or she may play the role of facilitator and seek the assistance of those qualified to provide for this significant care need.

To those who argue that a nurse has no role in spiritual care and should leave this obligation to hospital chaplains and other trained representatives, they are reminded that if nursing is to be truly holistic, nurses must embrace the spiritual dimension of care. However, a nurse must recognise his or her own limitations and involve other professionals, where and when appropriate. The nurse, in partnership with the hospital chaplain, can play a vital role in supporting the spiritual needs of patients and will hopefully recognise that spiritual care goes beyond the realm of religious affiliation.

Evaluating spiritual care

To complete the cyclical nature of the nursing process, evaluation of care must be undertaken by determining whether outcome criteria or goals have been met. This can be somewhat difficult and imprecise due to the subjective nature of the spiritual dimension and, unfortunately, evaluation of spiritual care is not always simply a case of cause and effect. For example, it cannot be compared to receiving analgesia in response to a specific injury and waiting for the pain to be eradicated. It is far more complex and therefore more difficult to evaluate. Discussing outcomes with the patient seems to be the most obvious manner in which to evaluate the efficacy of spiritual care. Cues should be taken from patients, with Johnson (1998) stating that these cues will take the form of expressing a feeling of wellbeing, being in control or simply not feeling anxious about their care or situation.

Conclusion

A problem-solving approach to the organisation and delivery of spiritual care allows the nurse to perform his or her role in a truly systematic manner, while still maintaining the ability to use intuitive processes. The nursing process, especially the assessment stage, used in conjunction with a conceptual framework or appropriate guidelines, will enhance spiritual care in nursing and promote the recognition of spiritual care needs in the formulation and delivery of care plans. This expanded role of the nurse presents immense challenges, with a move away from the refuge of the body and all things physical to a role that includes the recognition and acceptance of things spiritual. The challenge to nurse educators and practitioners is to avoid the stereotypical view of spirituality as being purely religious and tied to a higher being, as well as recognising that spirituality affects and embraces all that we are and do. Spiritual care, although mostly subjective and often complex, can be developed, practised and refined by the nurse, especially when adopting a systematic approach to the dimension of spiritual care.

It would be an erroneous claim that there are no examples of systematic approaches to spiritual care, but when these exist, they remain in the minority. Spiritual care is an essential component of nursing practice and often the arbiter of how someone responds to his or her illness and associated life experiences. It would appear that when people encounter certain life events like serious trauma and illness, fundamental spiritual issues emerge that question their very existence. If medicine involves the recovery of the body, spiritual care involves a recovery of the patient as a person. These areas do not sit in contention, but aim to complement each other and remind us that: 'There is no profit in curing the body if in the process we destroy the soul' (Anon)