

## Integrating Spirituality into Nursing Practice.

### Abstract:

Spirituality is an important aspect of holistic care which is frequently overlooked owing to difficulty conceptualising spirituality and confusion about how to integrate it into nursing care. This article seeks to understand what is meant by spirituality and spiritually competent practice, it explores some of the attitudes towards spirituality and describes some of issues affecting integration of spirituality into nursing care.

### Key Words:

Spirituality, holistic care, nursing.

### Aim and intended learning outcomes:

The aim of this article is to explore the concept of spirituality, to examine health care practitioners' attitudes towards it and to present practical tips on how to integrate spirituality into nursing care. A case study is presented to offer practical guidance for integrating spirituality into day to day practice. After reading this article and completing the time out exercises the intended learning outcomes listed below should be achieved:

- To define spirituality and religion and make a distinction between them
- To discuss how spirituality can be incorporated into nursing practice
- To identify what skills are needed to integrate spirituality into practice
- To consider what facilitates and what inhibits the integration of spirituality in practice

### Introduction:

Spirituality has received heightened interest in the past few decades. Many in society are disillusioned with cultural pressure which leads to the need to be over busy, succeed by being the best and seek pleasure in materialism. An increasing number of people are

questioning whether this highly competitive and individualistic way of living and the resulting gross inequality is good for people (Wilkinson and Pickett, 2009). It may lead to burn out, relationship breakdowns and a deep sense of life being meaningless. Rohr (2003) suggested that the individualistic nature of society affects the ability of people to find any sense of peace or purpose. Spirituality is a way of finding hope, meaning and purpose in this frenetic world and is especially important when feeling vulnerable, for example when facing illness and crisis, whether as a patient or a nurse.

Good practice dictates that spirituality should be integrated into nursing care (NMC 2009, NMC 2014, ICN 2012). McSherry (2010) believed that not engaging with spirituality in nursing care “may be detrimental to the provision of high quality nursing care”. The NMC (2010) stated that nurses need to offer holistic approaches to care which includes assessment of spiritual needs to ensure a comprehensive care plan is developed. Holistic care encompasses the fundamentals of spirituality by offering a compassionate relationship with our patients which NHS Scotland (2009) suggests should “move in whatever direction is needed”. However for many nurses there is confusion between spirituality and religion, a level of ambivalence and anxiety about spirituality, and a difficulty in knowing how to integrate spirituality into nursing care. Exploring spirituality with patients may help them find hope and meaning during times of illness and crisis. In addition nurses may find spirituality helps them to find meaning and purpose in their work.

What spirituality means, how is it distinct from religion and its place is in nursing care:

Defining spirituality can be difficult and at times it appears to be a nebulous concept (Coyle 2002, Gilbert 2007, D'Souza 2007). In the nursing literature many contemporary discussion papers and empirical studies offer contradictory definitions of spirituality and use a plethora of terms when talking about spirituality i.e. spiritual care, spiritual dimensions, spiritual behaviour, spiritual needs and spiritual assessment which are often not defined (Stranahan 2001, Maddox 2001, Hubbel et al 2006, Helming 2009). Many definitions of spirituality include the concepts of what gives meaning, hope and purpose to an individual (Cook 2004, Narayanasamy 2002, Narayanasamy 2004) whilst others conflate it with religion (Koenig et al 2001, 2004, Stranahan 2001, Monroe et al 2003, Hubbell et al 2006). Clarke (2009) suggests that watering down the concept can make it vague and over-inclusive. On the other hand Swinton and Pattinson (2010) suggest that the vagueness around defining spirituality can be its strength and value. The danger of an over-inclusive definition is that it becomes cumbersome and defies operationalising for research and practice. The danger of not embracing spirituality within practice is that nurses miss the deep interpersonal compassionate connection with patients which epitomises the heart of nursing care. Milligan (2011) reminds us that spirituality is unique to each individual and that nurses needed to listen to patients to determine what was important to them.

For clarity a simple definition of spirituality from the nursing literature suggests that:

“spirituality is defined as the essence of being and it gives meaning and purpose to our existence” (Narayanasamy 2004). Cook offers an expanded definition:

“Spirituality is a distinctive, potentially creative and universal dimension of human experience arising both within the inner subjective experience of individuals and within communities, social groups and traditions. It may be experienced as a relationship with that which is intimately “inner”, immanent and personal within the self and others, and/or as a relationship with that which is wholly “other”,

transcendent and beyond the self. It is experienced as being of fundamental or ultimate importance and is thus concerned with *meaning and purpose in life, truth and values* (our emphasis)" (Cook 2004).

It should always be remembered that spirituality is unique to the individual (Milligan 2011) and that keeping the definitions flexible and vague may enable this to be understood better in practice (Swinton and Pattison 2010). In practice, considering and responding to whatever gives our patients hope, meaning and purpose in life will ensure spiritual needs are addressed

Religion and spirituality are distinct though for some they overlap. The Oxford English Dictionary (on line) gives the primary meaning of religion as "belief in a superhuman controlling power especially in a personal God or gods....". Wattis and Curran (2006), writing in a healthcare context, suggested that religion is connected with the beliefs and rituals found in many faiths and that it is often associated with power structures. They also include relationship with God in their definition of religion. Of course there can be some potential overlap between spirituality and religion; some will view their faith as the core of their spirituality. However many would assert that you can be spiritual without being religious and religious without being spiritual (Cook et al 2010).

A good starting point for being sensitive to the spiritual needs of patients is to be aware of our own approach to spirituality.

Time Out 1:

Consider what gives your own life hope, meaning and purpose and what informs your own personal values. What are the guiding principles of your life and where do they come from? Make a list of at least three or four of the things that are most important to you in this respect.

Feedback: Kang (2003), writing from an occupational therapy perspective suggests that there are six dimensions of psycho-spiritual integration (Box 1). Look at these and consider how they relate to your own list of what is important to you in this area.

Box 1:

Six Dimensions for addressing “psycho-spiritual integration”:

Becoming;	volitionally directed growth of the self through active doing
Meaning;	the sense of intrinsic purposefulness and vitality rooted in personal, collective or transpersonal spaces
Being;	a pervasive quality that forms the foundation of our existence as human beings
Centeredness;	an inner stability based on knowing and recognising what lies at the core of one’s being
Connectedness;	seeing the self as a “fluid process” embedded within a larger interrelational context
Transcendence;	this has two aspects. Firstly, the innate human drive to find ultimate meaning and happiness and secondly the goal which this drive seeks

( Kang, 2003)

Despite difficulties with the conceptualisation of spirituality, professional standards, including nursing standards (NMC 2009, 2010 and 2014, ICN 2012), expect us to pay attention to the spiritual needs of patients. In 2010 the largest UK survey of nurses' perceptions of spirituality and spiritual care was carried out with 4054 respondents (McSherry and Jamieson 2013). They found that nurses struggled to conceptualise spirituality even though they recognised it as being important to their patients. 92.6% of the nurses' surveyed felt spiritual care should be addressed but only 5.3% felt they could meet spiritual needs of patients all the time. A much higher number (92.2%) felt they sometimes could address spiritual needs: but it wasn't clear how they would do this and lack of training in this area was evident. A small survey of University teachers in healthcare professions found that whilst around 90% agreed or agreed strongly that spiritual values were relevant to their subject area and over half thought it was integral to teaching and learning, only 17% agreed it was actually integrated into their curricula (Prentis *et al*, 2014). Being clear about what spirituality means can make addressing this subject with patients much easier. Including spirituality within the nursing curriculum is an important way of ensuring nurses have the opportunity to explore what spirituality is and how to address it in practice.

It is the concern with hope, meaning and purpose in life, truth and values that is important in practice. A person-centred approach emphasises that "the key to providing spiritual care is to understand what spirituality means to the person you are caring for" (Gordon *et al*, 2011). This is really the only approach to take in a multi-cultural, multi-faith society where some people think "science has disproved God" and find their meaning and purpose outside of religion whilst others find meaning and purpose through embracing religious faith. One review of the concept of spirituality in occupational therapy practice (Jones 2014) concluded that it

was easier to *describe* spiritually competent practice than to *define* spirituality. This description can be modified to apply to nursing and other healthcare professions as follows:

“Spiritually competent practice engages a person as a unique spiritual being, in ways which will provide them with a sense of meaning and purpose, connecting or reconnecting with a community where they experience a sense of wellbeing, addressing suffering and developing coping strategies to improve their quality of life. This includes the practitioner accepting a person’s beliefs and values whether they are religious in foundation or not and practicing with cultural competency.”

Illness, especially life-threatening or disabling illness may challenge the understanding that patients have built for themselves about the meaning and purpose of their lives (Puchalski 2001). Serious illnesses often involve losses, including loss of income, abilities and role. They may even result in a feeling of loss of meaning and purpose and readjustment of life goals. One of the functions of the spiritually competent nurse is to recognise these challenges and to support patients in responding to them. Many robust studies have shown that spirituality is fundamental for patients (Burkhardt 2007, D’Souza 2000, Ellis et al 1999, Ellis et al 2004, Koenig et al 2001, Koenig 2004) in helping them regain hope, meaning and purpose in the midst of illness.

#### Spirituality in Practice:

Nurses strive to practice holistic care when faced daily with those coping with illness, pain, distress, vulnerability and death. Illness and admission to hospital often lead patients to consider the meaning and purpose of their own lives (Puchalski 2001). Patients often ask deeply spiritual questions and invite us into their questioning; “why me?”, “what does this mean?”, “How can I deal with this?” These questions are all opening questions to exploring spiritual needs; our responses can help patients to find a sense of meaning and purpose during illness. There is growing evidence to show that addressing spirituality improves

comfort levels (emotionally and physically) and has a positive effect on patients' responses to illness and treatments (Koenig 2004). Failing to deal with these issues may expose patients to more suffering.

When people are unwell they often may signal their desire to discuss spiritual issues. Being sensitive to and responding to these signals is a good way to open up discussion of spiritual issues; but how can they be approached if the patient does not raise them directly? In all cases a sensitive and individualised approach is indicated. For this reason some sort of questionnaire is not necessarily the best way to approach the issue. However, some questions may be useful to "open" discussion in the spiritual area. The following are suggestions from practical experience: "How has this illness affected you? ... your relationships?... and your activities? Has your illness brought any special concerns with it? Has it caused you to question things that you previously took for granted? What has helped/might help you to cope? What has being ill meant to you? How has it affected your family?...your work? " Generally it is best to avoid questions beginning with "why". These are often perceived as critical or attributing blame. Other general probing questions such as "What is behind that?" can serve the same purpose in a less threatening way. These questions should lead to discussions about how the patient can be supported in addressing the needs identified which can then be included in the care plan.

This requires a degree of cultural competency and an ability to discern what is important to someone who, because of age or upbringing, may have a different set of values, different hopes and expectations and different ideas about the meaning and purpose of life to yourself. Often the best way to approach these issues is to let the patient tell their own story and to listen empathetically with suitable prompts to give the patient an opportunity to discuss what illness means for them and to understand how it may be disrupting their sense of purpose in life.

Time out 2:

Write a short narrative from your own experience of how you supported a patient with the spiritual challenges of finding meaning and purpose in their life. Use Kang's PSI framework if it is helpful.

Feedback:

The following fictional narrative gives an example of how this can be done.

*Narrative: Janet, coping with bereavement and loss of role.*

*Janet a 73 year old single lady with a history of anxiety consulted the advanced nurse practitioner (ANP) at her GP surgery after her 94 year old mother died. Janet had been the main carer for her mother, moving in with her for the last few years of mother's life and never marrying. She rarely went out and took intermittent medication for severe anxiety. Her mother had been very domineering and critical of Janet.*

*Janet was socially very isolated and had noticed that her anxiety had risen. She felt there was no purpose to her life. The ANP spent a number of consultations with Janet listening to her concerns and fears about her anxiety and her life.*

*Janet used to enjoy gardening but this stopped when she moved into her mother's flat to care for her. The ANP introduced Janet to a local Mind worker who taught pottery at a community project. Janet started going to the group and also found out about a gardening group which met at the same centre twice a week.*

*Over a number of months Janet started to become more involved in pottery and gardening and started to gain confidence in relating to others and going out of the flat. After 6 months she became a volunteer at the centre serving at their community cafe.*

*Janet found a sense of hope, meaning and purpose through the community projects and also working as a volunteer. She told the ANP working with Mind has given her new insight*

*into how to deal with her anxiety and she realised how isolated she had become and how her self-esteem had suffered because of her mum's behaviour.*

Kang (2003) suggests a practitioner should pay attention to six dimensions in assessing addressing spiritual needs (Box 1). Using this framework to look at this case illuminates a number of issues. When her mother died, Janet's sense of meaning and purpose for her life almost died with her. Her life, previously centred on her mother had no continuing "focus" and she was uncertain of her own sense of being. Essentially Janet needed to develop a new focus for her life, centred within herself and a new sense of meaning and purpose. She was helped to do this by connecting with the attentive ANP who listened to her story and then suggested ways of re-connecting Janet with activities; especially gardening that had previously been important to her. The MIND volunteer provided another connection and through a process of becoming Janet learned how to manage her anxiety and developed a new sense of centredness and being which included her role as a volunteer. This involvement with helping and supporting others could be seen as a form of transcendence.

As well as Kang's (2003) dimensions, it may also be helpful to consider specific competencies such as those contained in of the Marie Curie Cancer Care (2003) self-assessment tool on spiritual and religious care competencies (Box 2). The majority of the Marie Curie competencies can be viewed as more or less generic: things that might be expected of any competent nurse or health care professional. We have selected from these the competencies in box 2 that we think apply most directly to spirituality. These include knowledge (k), skills (s) and action (a) competencies.

Box 2

- spiritual self-awareness (K)
- understanding the nature of spiritual assessment (K)
- understanding the skills that other members of the team have in relation to spiritual

care (K)

- an ability to describe and evidence a working definition of spiritual and religious needs (S)
- an ability to refer effectively and articulately to other spiritual care resources (S)
- appropriate documentation of referrals following a spiritual assessment (A)

(adapted from Marie Curie Cancer Care, 2003)

The first, second and fourth of these competencies have already been dealt with: the third will depend on local circumstances and the fifth and sixth should follow logically from the others.

Time out 3: Audit of personal competencies in spiritual care

Using the spiritual competencies listed in box 2, audit your own position. You can do this by reflecting on the different competencies and rating where you feel you stand on a scale of 0 - 4 where 0 indicates complete lack of confidence and 4 indicates complete confidence in your own ability in each of these areas. When you have done this consider how you might strengthen and use the areas where you are confident and consider what you might do to improve confidence in other areas. Make an action plan to do this.

Feedback:

This is probably an area where you can get the best feedback from colleagues, including other members of clinical teams that you work with.

What resources are needed to integrate spirituality in practice and what barriers stand in the way?

In order to practice in a spiritually competent manner nurses need to consider what resources are needed. These can be summarised as:

- personal attributes,
- development and education, and
- system and organisational resources

The main resources are the personal qualities of nurses and their education to develop spiritual competency. However, systems of care which encourage the more humane aspects of care and which allow nurses time to build rapport with patients are also essential. The RCN survey (McSherry and Jamieson, 2013) found that integrating spiritual care included those personal qualities of care instilled in all nurses during training; offering care, being kind and compassionate, listening and being cheerful. Nurses need to provide supportive relationships for people who may be going through a period of perplexity and pain as they get to grips with what their illness means for them and those around them. Integrating spirituality into care is not laborious or complicated and for many the ways of doing this are already integral to their practice. What may be different is conceptualising it as spiritual competence.

Monroe et al (2003) and Helming (2009) found that one of the difficulties in addressing spirituality was the daily demands of achieving targets which can leave little time for holistic care. With the reduction of nurses in practice and the pressures faced, there is often limited time to sit and talk to patients. In many areas the basics of care are provided by healthcare assistants. It was often during the basics of care, for example washing a patient, making beds or helping a patient eat, that nurses would begin to build a relationship with their patient and spend time listening to their concerns. Nurses (and others working in healthcare) need to consider how, within the limitations imposed by present-day systems of care, they can find time to integrate spirituality. Systems that dehumanise care must be identified and changed.

In undergraduate training, the discrepancy between the importance attached by teachers to spiritual aspects of care and the relatively small number who felt it was integrated into their curricula has already been noted (Prentis *et al* 2014). Qualitative findings from the same

study confirmed that teachers understood spirituality in the context of the importance of self, personhood, being, direction, meaning and purpose in life and that they conceived of it as practical, affecting how people lived and acted towards each other and the outside world. Their strategies for addressing spirituality in education involved using particular contexts such as palliative care and ethical issues where spiritual values were seen as particularly relevant. They also commented that specific methods of teaching encouraging self-awareness, reflective learning, sharing, modelling, an emphasis on empathy and compassion and the use of narratives, discussion and even poetry helped to open up the spiritual side of nursing but that these methods were time-consuming in a tight curriculum. The main theme to emerge in relation to professional considerations was that personal values should not be imposed on students (in exactly the same way that nurses' personal values should not be imposed on patients).

Other studies confirm concern about not imposing one's own values and relate to a fear of projecting one's own belief onto a patient which is seen as ethically wrong (Ellis et al 2002, Monroe et al 2003, Ellis et al 2004). Many will recall the nurse who was suspended for offering to pray for a patient in 2009 (BBC 2009) and this may have increased reticence to explore spirituality for fear of being accused of proselytising. However spirituality is not about sharing our faith or trying to convert patients to a specific religious belief which is in breach of our code of conduct; it is about following patients' leads when they ask us to connect with them and help them find hope, meaning and purpose in their suffering.

The emphasis on "evidence-based" nursing has tended to lead educators to focus on the technical, measurable aspects of nursing. In Western culture scientific knowledge tends to be privileged over other kinds of knowledge, reflected in the findings by Prentis *et al.* (2014) that virtually all respondents in this admittedly small-scale study believed "the intellect is more important than spirituality". This reflects the way in which the scientific and economic, supposedly measurable aspects of living are generally privileged over more intuitive "right brain" ways of knowing based on narrative, poetry and (some would say) common humanity.

Yet there is good scientific evidence, often based on qualitative research, for the importance of factors like empathy, compassion, person-centred care and integrity. This emphasis on “hard”, measurable facts follows from the great divorce between “science” and “the humanities” that occurred in the “Enlightenment” period of Western history which led to the “modern” age. Not all cultures share this split. Some (possibly minority) Christian and Islamic cultures, for example, do not support the great divide between the scientific way of knowing and other equally valid ways of understanding truth. This also needs to be borne in mind when supporting people from those cultures.

Other cultures, such as the dominant political, economic, and organisational cultures affect the ability of nurses to offer good spiritual care. The tendency for care to be fragmented, patients moved around in hospital and sometimes sent home early because of pressure for beds to be vacated and “industrialised” models of care, based on short term contracts using personnel with minimum training, can all militate against spiritually competent care.

Research clearly shows that patients want us to talk about spirituality with them (Ellis et al 2002, Ellis et al 2004) and nurses say that spirituality is important in their work (Stranahan 2001, McSherry and Jamieson 2013). An open, accepting and compassionate attitude makes it easier for patients to “open up” about their deep concerns. Several papers suggest listening attentively for patient cues will naturally lead into spirituality discussions (Ellis et al 2004, Helming 2009). Nurses can help by fostering a positive attitude to spirituality, recognising that patients do want to talk about these matters and understanding that they are important in recovery. Ellis et al (2004) found that patients would not begin to talk about their spiritual needs unless they felt honoured and respected. If spirituality was not addressed some patients believed that it would adversely impact the healing process. Those clinicians who already integrate spirituality into their own practice appear to be those who are aware of their own spirituality and do listen to patient cues (Treloar 2000, Stranahan 2001, Ellis *et al* 2002, Hubbell et al 2006). Treloar (2000) states that the breadth and depth of the spiritual care offered reflects the nurse’s own spiritual maturity.

Practising holistically is also an important resource. The bio-psycho-social model of practice is where spirituality comfortably finds its place. Truly holistic care embraces what gives patients hope, meaning and purpose. McSherry and Jamieson (2013) found that spirituality for many nurses is a fundamental and integral aspect of holistic nursing.

Finally being confident about integrating spirituality is a resource nurses need to develop. The staggering high statistic of 92.2% of nurses feeling that they only sometimes met their patients' spiritual needs (McSherry & Jamieson 2013) implies nurses do not feel confident. A clearer understanding of spirituality in education and practice leads to recognition that some of the ways of integrating spirituality are already part of nurses' core practices. This, in turn can lead to increased confidence in practice.

Time Out 4: How can nurses promote spiritually competent care?

Consider the headings of personal factors, educational and developmental factors and systemic and organisational factors. How can you ensure you are personally well prepared to deliver spiritually competent care? If you are a nurse educator how can you ensure undergraduate and postgraduate teaching prepares nurses for spiritually competent practice? If you are involved in management what can you do to create conditions in which good holistic nursing care, including a spiritual component, is possible?

Feedback: We hope that having worked through this article you feel competent to answer these questions AND to put the answers into practice!

### Conclusion:

In this article we have considered what is meant by "spirituality" and "spiritually competent practice" in nursing (and healthcare more generally). We have offered a narrative of what spiritual care "looks like". We have discussed what encourages and what discourages spiritually competent nursing. There is clearly a need for more systematic research and educational activity in this area. What also needs to be said is that, like other healthcare

professions, nursing has its own sense of meaning and purpose and its own values. These professional values underpin our ethics and our sense of purpose can sustain us as nurses and make us more resilient in difficult times. Conceptualising spirituality for yourself and considering how you can integrate this into your practice will lead to more holistic care, better recovery and coping with healthcare issues and an increased therapeutic connection with patients. In addition to the benefits to patients, nurses integrating spirituality into practice may re-engage with the meaning and purpose in their work.

#### Top Five Tips for promoting spiritually competent care

1. Be aware of your own spirituality, of where your own sense of meaning and purpose and values come from
2. Listen for, and be attentive to patients raising issues of what their illness means for them
3. Be fully present, paying attention to the person, when undertaking practical tasks with patients so that they understand you respect them as valued fellow human beings
4. Promote person-centred rather than task-centred ways of nursing for yourself and for others
5. Reflect every day on how well you have dealt with patients and colleagues in a compassionate and mindful way.

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practice. It examines attitudes to spirituality, describes factors that might affect the integration of spirituality into nursing care and offers practical guidance to equip nurses to incorporate spirituality into their practice. Authors. Melanie Rogers Senior lecturer, University of Huddersfield, Huddersfield, England. John Wattis Visiting professor, University of Huddersfield, Huddersfield, England. Correspondence to: m.rogers@hud.ac.uk. Keywords. Attitudes, holistic care, nursing care, religion, spirituality, spiritual care