Let me begin with a question. In the context of our changing society, how well prepared are nurses to care for the whole person?

Nursing theory today will readily admit to the importance of endeavoring to meet all dimensions of a person’s need. Why? Because nursing acknowledges that the essence, and indeed the goal of the holistic care we speak so much about is to attain or maintain wholeness in all dimensions - physically, mentally, emotionally and spiritually. At the same time we know that the less tangible areas of need are all too likely to be neglected, either because they remain unrecognized or because of the demands of time and the tyranny of the urgent.

Now let me recount a real life scenario

Robert Burns is scheduled for coronary bypass surgery in the morning. Sally a nurse on evening shift is reviewing pre-operative instructions with him when she notices that he is paying little attention. She gently points out that he doesn’t appear to be listening to her, to which Mr Burns replies, "You are just wasting your time I'm afraid. I'm not going to make it tomorrow. This illness is my own fault. I've been a heavy smoker for many years, eaten the wrong things and really abused my body. I am going to be punished for that, I just know it".

How does the nurse respond? She knows that when Mr Burns goes to surgery tomorrow, he will have the benefit of all the latest technology in bypass surgery and one of the top surgeons in the field; while after surgery he will be expertly cared for in a specialist coronary care unit which is state of the art. She will most likely tell him all these things, but if she under pressure of time, or does not feel prepared to go any deeper, that is all she will tell him. But it may be that the Sally will discern that Mr Burns is expressing emotional and spiritual needs, and will respond appropriately at this point.

Most of us know only too well that there are dimensions of human need which cannot be met by scientific nursing and medicine alone - needs that while not physical, have a bearing on physical health and illness. If Sally is
not only discerning of the deeper need that has just been revealed, but convinced of its significance, she is likely to give more priority to going a bit deeper with Mr Burns. In doing so she will be following a long nursing tradition - a concern for all dimensions of a person's need. Florence Nightingale, who brought to nursing not only her traditional Christian values, but also some very modern nursing values such as autonomy and professionalism, was a firm believer in holistic care. She once said, "The needs of the spirit are as critical to health as those individual organs which make up the body".

A much later nursing theorist Joyce Travelbee speaking on the interpersonal aspects of nursing said, "A nurse does not only seek to alleviate physical pain or render physical care - she ministers to the whole person. The existence of suffering, whether physical, mental or spiritual is the proper concern of the nurse". (1971)

But while nursing has traditionally led the way in a more integrated and personal approach to caring for the sick, we are forced to admit that the more intangible needs have frequently been given a much lower priority than needs which are more obvious and more easily measurable. Perhaps the most neglected area of need has been that which we have usually considered to be the most intangible of all - the needs of the human spirit.

It is a bit of a paradox actually. For the most part, nursing today continues to maintain that caring for psychosocial and spiritual needs is as important to a person's well being, as meeting their physical needs. In fact the last ten years have witnessed a dramatic increase in studies of spirituality, health, and well-being. There has been much research and discussion about links between spirituality and health, and ways practitioners can integrate spiritual resources into health care. There is recognition that health practitioners including those in the mental health field can address spiritual problems that pose barriers to health care.

But to return to our question, how well prepared are we deal with these less tangible aspects of need? Are we beginning to move from research to practice? How do we assess, meet, and document, the needs of the spirit?
I would like to suggest an approach that can make these intangibles, a little more concrete and tangible. To explore this thoroughly is outside the scope of this short paper and is the business of a full scale workshop such as NCF presents on Spiritual Care in Nursing Practice. However we can look at some approaches and principles. Before we return to Mr Burns in order to illustrate this, let us consider the nature of spiritual needs and the context in which we will provide care. 

We are living in an increasingly multi cultural and multi religious society. So naturally in our health care setting, we encounter a diversity of cultures, philosophies and religious traditions. There are also many people have no particular religious belief or world view. Spiritual needs which are expressed less overtly, or outside a religious framework, or even a different framework to our own are unlikely to be identified.

Many nurses perceive spiritual need to be as one suggested, "a vague indefinable entity that cannot be accurately measured, much less met" Others define it only in terms of religiosity. And at one level we would have to agree that psychosocial and spiritual needs are complex and abstract, and not always immediately obvious. Is it possible to make them more tangible? I believe so.

In the nursing literature there remains a lack of consensus as to what spirituality actually is. Maybe that will always be the case. Yet it is important that we develop some general definitions which can help us to recognise spiritual needs when we encounter them in our clients, including those who do not have a religious faith. A modern definition that I think reflects a typical secular view of spirituality is this one, found in a 2010 issue of Family Doctor Journal.

“Spirituality is the way you find meaning, hope, comfort and inner peace in your life. Many people find spirituality through religion. Some find it through music, art or a connection with nature. Others find it in their values and principles.” (Family Doctor, Editorial, 2010)

But it was in the 70s and 80s that some definitions emerged which I still find helpful both for defining spirituality, and for differentiating between spirituality and religious or psychosocial needs.

"The spiritual dimension of human beings is that which transcends physical and psychosocial dimensions." (Victor Frankl, 1971) Many more
recent definitions also speak of spirituality as *transcending* other dimensions

Slide Barbara Simsen, a Christian nurse who researched spiritual needs in the 80s said, "The spirit is that part of man which is concerned with the ultimate meaning of things and with a person's relationship to that which transcends the material." (Simsen, 1985)

**Spiritual need** has been defined in both religious and non-religious ways, Slide e.g. "Any factor that is necessary to support the spiritual strengths of a person or to diminish the spiritual deficits." (Simsen 1985) Slide "The lack of any factor or factors necessary to maintain a person's dynamic relationship with God (as defined by that person)." (Stallwood, 1976)

Slide The North American Nursing Diagnosis Association (NANDA) approved list of nursing diagnoses includes 'Spiritual Distress', which is described as: "Distress of the human spirit; disruption in the life principle that pervades a person's entire being and integrates and transcends one's biological and psychosocial nature".

Slide " The important thing to remember is that spirituality may or may not be expressed within a religious framework. Spirituality is not limited to religious affiliation and practices, but is a much broader concept. Slide Another difficulty in identifying spiritual need is that we can fail to make the distinction between spiritual needs and emotional needs, since they are not always opposites, and may in fact overlap. Nurses therefore need to be able to differentiate between spiritual needs and psychosocial needs.

Slide The distinctions become clearer if we think of persons as integrated beings with different dimensions or capabilities for relating to the world around and within. Nursing theory often looks at persons in this way as a basis for a holistic approach to nursing care. A model I find useful describes three dimensions: Slide the physical or biological dimension which relates to the world around us through our five senses; Slide the psychosocial dimension which relates to self and others, and involves our emotions, moral sense, intellect and will; Slide and the spiritual dimension which transcends physical and psychosocial dimensions and has the capacity to relate to a higher being. (Stallwood, 1975)
Here is a model that illustrates this. Slide (MODEL 1) These three dimensions interact. Our experience and observations tell us that we cannot put them into sealed and separate compartments. A crisis or illness affecting our physical body will invariably affect the other dimensions. Yet we need to recognise that some people may not acknowledge the spiritual aspect of their nature, while others, though recognising a spiritual dimension, may not express this in religious terms or practices.

Slide The spiritual dimension is sometimes seen as having two axes - horizontal and vertical. (MODEL 2) Slide The horizontal axis represents a person's consciousness of the values that mark faith, aim, lifestyle, social relationships. This does not need to have any religious connection. Slide The vertical axis represents that transcendent dimension - a person's relationship to God/ Supreme Being/ Something outside one's self [as the person defines it]. Seen in this way spirituality is an integrating strength to the whole personality, giving consciousness of meaning, values and purpose in life. Spiritual growth does not necessarily involve both axes. Slide It is possible to develop the horizontal and not the vertical dimension. (Carson, 1989)

Slide Spiritual needs such as the need for relationship love and relatedness, or meaning and purpose, hope and forgiveness may be fulfilled to some extent on a horizontal level, but ultimately they are fulfilled we believe on this vertical axis in the context a relationship with God our creator and the redemption he has provided for humankind. I have developed other models that overlay this one to illustrate this more fully within a longer time frame. Slide

Let us now return to Sally and Mr Burns. Slide

We will assume that she has spent some time with her patient to explore his statement further, assess his needs and plan some appropriate care. Let's take a look at the case notes to see how she has documented this.

Slide ASSESSMENT Mr Burns appears withdrawn, and anxious. Was unable to concentrate and showing no interest in pre-op education. (the objective data) Stated that illness was self inflicted and expressed the belief that he would not survive surgery because God was angry with him and would punish him. (the subjective data)
**Slide**  *NURSING DIAGNOSIS*
Spiritual distress related to feelings of guilt and the perception that God is angry with him

**Slide**  *DESIRED OUTCOMES (goals)*
1. Restoration of spiritual and emotional well being through relief of guilt, restoration of hope, and positive relationship with God.
2. A positive expectation concerning the outcome of surgery, and cooperation in self care.

**Slide**  *NURSING INTERVENTIONS (Steps to achieve outcomes)*
1. Chaplain's visit arranged for this evening at patient's request. Ante room made available for privacy during the visit.
2. Arrangements made to meet request for prayer prior to surgery.

Nursing notes and handover report elaborated on interventions further. Chaplain not available to pray with patient in early am. But RN..... is happy to attend to this when she arrives on duty at 7 am.

**Slide**  *EVALUATION*
1. Patient's response to intervention: Expressed gratitude for chaplain's visit, and stated that he felt more able to discuss his concerns with someone outside own church community.
2. Nurse's observations: Seems more peaceful and attended well to pre-operative instruction later this evening.

**Slide**  You will notice that this expressed need of the patient has been placed within the kind of framework used for assessing, planning and documenting physical needs. That framework may vary in different settings but regardless can be easily adapted to responding to spiritual needs. This will:

- **Slide** make it more tangible and achievable
- ensure better ensure continuity of care
- **Slide** utilise a team approach to care. Members of the team who, for some reason, do not feel comfortable about providing that care themselves, will be able to use referral.
Meeting the Challenge

How can we become better prepared to meet this challenge? Slide As with all other aspects of nursing, providing quality care in this dimension requires Slide that we are continually increasing our knowledge and developing our skills. Interacting with colleagues, liaising with hospital chaplains, reading relevant literature or attending ongoing education courses and workshops dealing with this aspect of nursing, can all increase our awareness of spiritual needs and our ability to integrate spiritual care into our nursing practice and education. We can also develop a good resource system so that we know who the available chaplains are and how to contact them; understand the requirements of different faiths and how best to meet them; and become aware of the resources and expertise of other staff members.

Another factor which will affect our confidence and competence in providing spiritual care is a recognition of our own beliefs and values, and the degree to which our own spiritual needs are being met. It is difficult to respond to spiritual needs of others if we ourselves are experiencing unresolved spiritual concerns or distress. Sometimes we will need to seek out help and support for ourselves so that we are more able to help others.

Having prepared ourselves as well as possible to meet the challenge, we will begin to find considerable satisfaction in ensuring that this intangible dimension of need, is not a neglected dimension of our nursing practice.

Above all let us always remember that in all it’s dimensions... Slide Nursing is not just a science. It is also an ART. May I encourage you to practice that art in caring for the spirit.

© Margaret G Hutchison
November 2010

Presented at the 2010 conference of Nurses Christian Fellowship Australia in NSW. University of Notre Dame Australia
REFERENCES


