

Spiritual Care in a health care: state of the art

Lecture by

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I am grateful for the opportunity of giving this paper 'Spiritual Care – the State of the Art'. The literature on spirituality in health continues to grow as the leading journals regularly publish empirical and theoretical papers. This growth in the literature reflects a concern amongst practitioners that their practice should reflect spiritual concerns, and recognition amongst policymakers that spiritual care is an important component of wellbeing.

But it's important from time to time to step back and look at the 'big picture'. The literature may be growing in size, but what is its quality? What research methods are being used, and how substantial are the reported studies? How is the research distributed internationally? Are researchers in health taking note of what is happening in other disciplines? Has the growth in empirical research been matched by the development of theory? Is scholarship being driven by unrecognized underlying assumptions? These are some of the questions I'd like to touch on today, and I'd like to structure this presentation around four objectives:

- To give an overview of the recent literature on spirituality in healthcare
- To focus specifically on spiritual assessment, and evidence for the effectiveness of spiritual interventions, as these are perhaps the most important elements of 'spiritual care'
- To offer a critique of the 'evidence based practice' approach to spirituality
- To take note of recent developments in the theory of spirituality in healthcare

A good starting point is to compare the development of scholarship now, with a point in the recent past. We sometimes need to look back to see how far we have come. As we think about the 'state of the art' today, a good point of comparison is a paper written by Linda Ross, published in 2006. Ross's paper 'Spiritual care in nursing, an overview of the research to date' (Ross 2006), summarised research published between 1983 and 2005. As the title suggests, the focus was *nursing* research, but the paper is useful, not only because it summarises what was known at the time, but also because it provides a framework we can use to classify some of the research published since that date.

Ross found:

- Fourteen studies describing and exploring nurses' perceptions of patient/client/carer spiritual needs and nurses' responses to these needs
- Twenty-three studies exploring the meaning of spirituality and spiritual care to patients, clients and carers.
- Five studies, mostly North American, comparing clinician and patient/client/carer perspectives on the meaning of spirituality and spiritual care delivery.
- Nurse education (how, what where and when spiritual care should be taught). Three papers were found.
- 5 Instrument development: one study sought to develop a measure of spiritual coping strategies.

Ross summarized her evaluation of this research as follows:

- All of the research to date had been small in scale and mainly exploratory and descriptive with low response rates, and using purpose-designed instruments, which had often not been tested for reliability and validity.
- Ross recommended moving the research on by investigating spirituality in health in a coordinated and systematic way, with researchers across countries and disciplines collaborating to produce a research strategy to bid for large grants to support multi-centre collaborative research.
- Ross recommended moving practice on by better educating students and by fostering collaborative working.

The first thing I want to do in this paper is to bring Ross's work up to date. I have therefore reviewed the literature published since 2005, using a similar search strategy to hers, but with slightly wider parameters. I have looked at all health professionals, not just nurses and, using Cinahl, Medline and other search engines have identified papers with 'spiritual care' in the title or the abstract.

My search identified many types of literature ranging from book chapters to editorials, letters and systematic reviews, theoretical arguments and commentaries; but in the first instance I will focus on those papers with an empirical basis, either qualitative or quantitative, without being too 'picky' about the study design or sample size.

A large proportion of the current literature can be slotted into the categories that Ross developed, although there have also been interesting developments which I will discuss later.

1 (Nurses) (and other health professionals)

I identified 19 empirical studies exploring the attitudes, characteristics, and practices of nurses and other health professionals in relation to the provision of spiritual care. These refer to Ireland, Malta, USA, Australia, Singapore, Hong Kong, Uganda, Thailand, Sweden, UK, and Taiwan.

Slightly more studies used quantitative (11) than qualitative approaches (7) with one using mixed methods. The largest quantitative studies were Wong (Wong, Lee et al. 2008) who investigated the perceptions of spirituality and spiritual care of a convenience sample of 429 enrolled nurses in Hong Kong; and Yang (Yang 2006) who described the spiritual intelligence profile of 299 nurses in Taiwan.

REFERENCES(Wong, Lee et al. 2008, Yang 2006, Belcher, Griffiths 2005, Bush, Bruni 2008, Chan 2010, Chism, Magnan 2009, Chung, Wong et al. 2007, Hubbell, Woodard et al. 2006, Kale 2011, Lundmark 2006, Noble, Jones 2010, Tanyi, McKenzie et al. 2009, Bailey, Moran et al. 2009, Baldacchino 2006, Lundberg, Kerdonfag 2010, Nagai 2008, Seccareccia, Brown 2009, Smyth, Allen 2011, Wehmer, Griffin et al. 2010)

2 Patients / clients / carers

I found 15 empirical studies exploring spirituality from the perspectives of patients / clients / carers. The larger proportion of these studies was qualitative, and had a very small sample size. Of 11 qualitative studies, only 3 had a sample size of 20 or greater.

Two of the studies focused on the spirituality of people with no religious affiliation. Smith-Stoner (Smith-Stoner 2007) surveyed 88 members of 2 atheist organisations about their spiritual preferences at the end of life. They found that participants' view of a good death included respect for non-belief and the withholding of prayer and references to God. There was also a strong preference for physician-assisted suicide, and evidence based interventions. Participants expressed a deep desire to find meaning in their own lives, to maintain connection with family and friends, and to continue to

experience and appreciate the natural world. In a small, qualitative study (n=11), Creel (Creel 2007) reported that some people felt alienated by nurses and sometimes this was related to nurses' failure to be sensitive to their beliefs.

The literature investigated fields as diverse as renal dialysis, emergency care to the care of older people, but the bulk of the research addressed spiritual needs of people at the end of life or receiving palliative care, replicating the pattern Ross found. What I find particularly interesting is that the research is beginning to address specific spiritualities such as the spirituality of those who are not from Western cultures, or those who implicitly or explicitly reject religious frameworks. This raises both the issue of cultural sensitivity, and the possibility of comparing and contrasting different spiritualities.

References (Smith-Stoner 2007, Creel 2007, Alcorn, Balboni et al. 2010, Bull, Gillies 2007, Davis 2005, Hanson, Dobbs et al. 2008, Lang, Poon et al. 2006, Mok, Wong et al. 2010, Nixon, Narayanasamy 2010, Selman, Higginson et al. 2011, Shih, Lin et al. 2009, Tan, Braunack-Mayer et al. 2005, Tanyi, Werner et al. 2006, Taylor, Mamier 2005, Yardley, Walshe et al. 2009)

3 (Nurses) and patients

I was able to find no new studies describing or comparing clinician and patient/client/ carer perspectives on the meaning of spirituality and spiritual care delivery.

4 (Nurse) education

5 empirical studies investigated aspects of nursing and other health professional education.

References(Bentur, Resnizky 2010, Taylor, Mamier et al. 2009, van Leeuwen, Tiesinga et al. 2008, Wasner, Longaker et al. 2005).

Bentur (Bentur, Resnizky 2010) described the development and implementation of spiritual care training in Israel. Although it is a small-scale study (12 students and 3 programme directors), it is an interesting paper about the development of an occupational role specifically directed to spiritual care.

Two studies investigated specific approaches to teaching. Taylor (Taylor, Mamier et al. 2009) evaluated a self-study programme teaching nurses how to talk with patients about spirituality, finding significant differences between before and after scores for attitude, ability, spiritual experience and knowledge; and Van Leeuwen (van Leeuwen, Tiesinga et al. 2008) used the Spiritual Care Competence Scale to evaluate a six-week course for nursing students.

Thus, there is a small but rigorous body of evidence beginning to evaluate the impact of professional education for spiritual care. This research also hints at the importance of local context, as the provision of spiritual care varies from country to country, and suggests that a range of teaching methodologies can be applied.

5 Instrument development

You will recall that Ross found a single paper on instrument development. The present review shows an increase in activity. We can see that instruments have been developed for a number of purposes:

Primary author and date	Purpose of instrument	Site of research	Reliability and validity discussed
Chan (2010)	Nurses attitudes to providing spiritual care, and factors associated with nurses attitudes	China	✓

Chism (2009)	Measurement of spiritual empathy in nursing students	USA	√
Chung (2007)	Nurses Spirituality and Delivery of Spiritual Care (NSDSC)	Hong Kong	√
Van Leeuwen (2009)	The validity and reliability of an instrument to assess nursing competencies in spiritual care	The Netherlands	√
Yakushko (2011)	Development of a measure to assess feminist religious and spiritual attitudes: the Women's Spirituality Instrument	USA	√

(Chan 2010, Chism, Magnan 2009, Chung, Wong et al. 2007, van Leeuwen, Tiesinga et al. 2009, akushko 2011)

Other instruments have been developed to measure aspects of spirituality in patient / client assessment, but these will be discussed shortly.

Let's take stock of where we are in comparison to the 'state of the art' as described by Ross.

- There continues to be a pattern of small-scale exploratory and descriptive work, much of which uses qualitative methods and small sample sizes.
- There is little evidence that spirituality in health is being investigated in a coordinated and systematic way characterised by multi centre research across countries
- However, research is being conducted in a wider range of countries, creating the conditions both for collaborative and comparative work
- There is evidence that researchers are investigating spirituality in different countries / different client groups / different cultural contexts / different ideological perspectives. This focus on context and culture is good.
- There is evidence of systematic research into nursing students and nursing education

My observations thus far are essentially based on a replication of Ross. I took this approach to enable us to compare the current situation with that she described. Now I want to drill down a bit further into the research by asking some questions that Ross did not ask.

What do we mean by 'spiritual care'?

For nurses brought up in my generation, 'care' is understood through the structure of the nursing process and has the following elements:

Assessment

Diagnosis

Planning

Implementation

Evaluation

Today I will focus on the two stages that seem to me to be key: assessment, and implementation.

There is a great deal of interesting in the practice of spiritual assessment. As usual, the literature varies in quality. At the bottom of the pyramid are editorials and opinion pieces simply encouraging professionals to assess spiritual needs and suggesting how this might be done.

(Don't use rigid approach for spiritual assessment. 2008, Dunn 2008, Loustalot 2008, Warner 2005).

Then there is literature describing the practices of groups of professionals.

(Tanyi, McKenzie et al. 2009, Smyth, Allen 2011, Curlin, Roach 2007, Elliott 2011, Higginbotham, Marcy 2006)

There are models of assessment based in theory / practice / informal literature review

(Galek, Flannelly et al. 2005, Luk, Kwong et al. 2007, Oakes, Raphael 2008, Power 2006, Richards, Bartz et al. 2009, Richards, Hardman et al. 2007, Skalla, McCoy 2006, Tanyi 2006, Timmins, Kelly 2008)

And useful book chapters have been written on the topic:

(Pargament, Krumrei 2009, Richards, Bergin 2005)

But I want to focus on approaches to assessment that have been tested through qualitative or quantitative evaluation, or systematic review:

(Yakushko 2011, Cole, Hopkins et al. 2008, Faull, Hills 2007b, Faull, Hills 2007a, Hall, Reise et al. 2007, Hodge, Limb 2010b, Hodge, Limb 2010a, Lewis 2008, Rubin, Dodd et al. 2009)

So lets take stock of the 'empirical' literature on patient assessment. You will notice that some of these articles came up when we discussed research on the measurement of spirituality, but there are others too. I found seven groups of researchers working in this field:

First author, date	Client group	Purpose of paper	Comment
Faull 2007	People with chronic conditions	To develop and test a spiritually based measure of holistic health, the QEHS	QEHS is reliable and valid
Hall 2007	Not specified	The Spiritual Assessment Inventory – a theoretically based measure of spiritual development for use by clinicians and researchers	The scale suitable for clinical and research use, but development continues
Cole 2008	People diagnosed with cancer	To assess spiritual transformation following a diagnosis of cancer	The Spiritual Transformation Scale is reliable and valid
Lewis 2008	African-Americans	A review of 35 studies using 5 measures	There is a lack of culturally appropriate measures for this population
Rubin 2009	Adolescents and their parents	Evaluation of 2 adult scales, the SIBS and SWBS, for use with adolescents	SIBS and SWBS are not sensitive to change in adolescent spirituality
Hodge 2010	Native-Americans	Qualitative evaluation of 5 models of spiritual assessment	Appropriateness of assessment depends on context
Yakushko 2011	Women	To evaluate Women's Spirituality Instrument	Instrument is reliable and valid

There are some important points I'd like to bring out here:

- There is evidence that scales developed for one population are inadequate for use in another population, either because they are insufficiently sensitive, or because they are culturally inappropriate, or both
- Consequently, specific approaches to spiritual assessment are being developed for a range of different populations including ethnic groups, genders, young people and people with different health needs, and these are being found to be reliable and valid
- In some contexts, qualitative evaluation is appropriate
- This reflects an underlying attitude to spirituality as being specific to a number of contexts, and again leads us to consider that it is perhaps more appropriate to speak of 'spiritualities' than 'spirituality'?

Now let's look at research evaluating specific interventions in people's health. I found 5 such studies.

Brown (Brown, Pavlik et al. 2007) works in the field of addiction using an approach called '12 steps recovery'. This study evaluated a behavioural intervention to facilitate patients' integration of spiritual beliefs into their treatment plan. A pre-test post-test study found significant increase in spiritual involvement and belief over the 12 week measurement period, and a significantly greater spirituality score in those maintaining total sobriety (n=26).

Koszycki (Koszycki, Raab et al. 2010) evaluated a multi-faith spiritually based intervention (SBI) for generalized anxiety disorder. The SBI focused on spiritual well-being and growth. In this pilot, the SBI produced robust and clinically significant reductions in symptoms, and was comparable in efficacy to CBT (n=22)

Margolin's study (Margolin, Beitel et al. 2006) was another to investigate a spiritual intervention in the field of addiction. The Spiritual Self-Schema (3-S) is a manual-guided intervention for increasing motivation for HIV prevention, integrating a cognitive model of self within a Buddhist framework. A correlation study found that 3-s clients reported significantly greater increases in spiritual practices and motivation for HIV prevention, and that these variables were negatively related to HIV risk behaviour (n=72).

Murray-Swank (Murray-Swank, Pargament 2005) evaluated a programme called 'Solace for the soul', a non-denominational intervention based in a theistic spiritual worldview consonant with 5 major monotheistic religions. This was evaluated with 2 female adult survivors of sexual abuse, using a single-case interrupted time series design. Both clients increased in positive religious coping, spiritual well-being, and positive images of God (n=2)

Tarakeshwar (Tarakeshwar, Pearce et al. 2005) evaluated a spiritually based intervention designed to enhance coping and mental health, in adults living with HIV/AIDS. At post-intervention, participants reported higher self-rated religiosity, greater use of positive spiritual coping, lower use of negative spiritual coping, and lower depression (n=13).

In summary, 5 small-scale studies have evaluated spiritually based interventions in a range of mental health issues including addiction, coping, recovery from sexual abuse, and living with HIV/AIDS. Each of these studies is small, and none demonstrates the highest level of evidence of effectiveness, but they constitute the beginnings of a case for spiritually-based interventions in health care.

The approach I have taken to this point in my paper has loosely been based on the method of the systematic literature review.

In the first instance, I structured the findings of the review around Ross's categories, as this seemed useful to be a useful way of getting a sense of what progress, if any, has been made in the last five years. I then developed the review a bit further, defining spiritual care according to a 'nursing process' model which prioritises effective interventions based on the prior, objective assessment of patients' spiritual needs.

In the final part of this presentation, I want to point out some of the limitations of this approach, taking the word 'limitation' to mean boundaries rather than shortcomings. Then we can look at what lies within the boundaries, as we think about the strengths and weaknesses of spirituality as a field of investigation as represented in the literature we have seen today; and we can also outline emergent ways of thinking about spirituality that lie beyond these boundaries.

We should begin by acknowledging that neither the 'process' model of nursing care, or the method of the systematic literature review, is value-neutral. Each has its context and history, and is based upon particular assumptions. Borrowing a term from Foucault, we could say that they are part of the 'discourse' of contemporary health care – a discourse characterised by the term 'evidence-based healthcare'. Practitioners working within this discourse are encouraged to undertake only those interventions for which good evidence of effectiveness can be found. The best evidence is taken to be the evidence of randomized controlled trials, and the systematic review is how this evidence is harvested and evaluated. The 'Holy Grail' of evidence based practice is to develop reproducible interventions which have a measureable benefit, demonstrated experimentally.

There are good reasons for this approach. Many of us will be able to remember specific historical instances of useless but expensive therapies. This is both ethically and financially problematic. This is why Speck argued 'there is a need therefore to develop systematic approaches to assessing and researching the most effective forms of intervention required to meet identified religious and spiritual needs' (Speck 2005).

If, on the basis of the literature I have summarized today, I were to evaluate progress towards this objective, using the lens of 'evidence based practice', I would say that the evidence is mixed. There is no doubt that progress has been made in that a significant volume of research has taken place, but much of it represents small scale, qualitative investigations and there is little sign of multi-centre work or international collaboration. Some interventions have been tested, but R.C.Ts are rarely used, and I doubt that much of the research would make its way into a rigorous systematic review.

But I wonder how this body of work might look if we were to inspect it through a different lens? Lets begin by thinking about the adequacy of the 'nursing process' as a model for the delivery of spiritual care, and here I draw upon an interesting paper by Barbara Pesut and Rick Sawatzky (Pesut, Sawatzky 2006). Pesut and Sawatzky distinguish between 'descriptive' and 'prescriptive' approaches to the nursing process. The goal of a descriptive approach is simply to make visible the nursing actions to provide spiritual support (retrospectively), whereas a prescriptive approach entails influencing and in some cases reframing the spirituality of patients. Pesut and Sawatzky find this ethically problematic as it extends the nursing role beyond appropriate professional boundaries. In the 16th century, in England, Queen Elizabeth said she had no desire to 'make windows into men's souls'. Elizabeth was not commenting on spiritual assessment in healthcare, but in the context of an historical conflict between different parts of the church. But her phrase is interesting, and serves to remind us of the ethical aspects of spiritual care. I suggest the ethical aspects of spirituality should be debated more often.

But what if we look beyond the boundary as it is currently placed, and think of spirituality in a very different way? I would like to draw your attention to a paper by John Swinton and Stephen Pattison, 'Moving beyond clarity: towards a thin, vague and useful understanding of spirituality in nursing care' (Swinton, Pattison 2010). Swinton and Pattison argue that 'spirituality' is part of a critical discourse within health care. Its function is to point to absences and inadequacies in care. It also provides a vocabulary for those people whose experience of health and illness has led them to an existential crisis.

A related way of conceptualizing spirituality is to understand it as an ethical position.

'Spirituality can be seen as the essential part of the humanity of all people. It is at its root, relational and thus forms the basis of the altruistic care healthcare professionals are committed to. Spirituality has to do with respecting the inherent value and dignity of all persons, regardless of their health status. It is the part of humans that seeks healing, particularly in the midst of suffering. Spiritual care models are based on an intrinsic aspect that calls for compassionate presence to patients as well as an extrinsic

component where healthcare professionals address spiritual issues with patients and their loved ones. Currently in the healthcare system, evidence-based models are the criteria for practice recommendations. Yet spirituality may not be amenable entirely to strict evidence-based criteria'

(Puchalski 2007) 34-35

In this paper we have:

- **Reviewed the recent literature on spirituality in healthcare**
- Focused specifically on spiritual assessment, and evidence for the effectiveness of spiritual interventions
- Outlined a critique of the 'evidenced based' approach to spirituality
- Taken note of recent developments in the theory of spirituality in healthcare

Thank you

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