Chapter 1

General introduction and outline
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Holistic nursing
As a nursing student I was taught to provide client-centred, so-called holistic nursing care to patients, and now as a lecturer I teach it to my own students. Taking a holistic approach means that all aspects of human functioning should be considered in assessing the individual patient’s needs and in planning nursing care for that patient. Someone admitted to hospital for open heart surgery, for instance, has health needs that are not restricted to the functioning of physical aspects. The patient may also have psychosocial problems or needs that may threaten the status of his or her health, for example, fear of the operation, or a stressful relationship with relatives. To maintain or enhance the health status of that patient nurses should pay attention to all the relevant aspects of the patient’s functioning. This holistic and health-related approach is emphasized in nursing models (Fawcett, 1995). Studies have also made clear that the health problems and needs of patients are related to many different aspects of human functioning (NANDA, 2007).

The holistic approach includes attention to the spiritual functioning of patients, because that may also affect a patient’s wellbeing. Professional nursing organizations such as the International Council of Nurses and the Dutch Nursing Organization emphasize that nurses should pay attention to the spiritual aspects of nursing care (ICN, 2007; Leistra et al. 1999). Patients who undergo open heart surgery may fear dying or may be worried about whether they will recover and what life will be like if full recovery is not possible. Patients may be religious and may need to talk to or to pray with a pastor to help them cope with this life-threatening situation.

Spiritual care as an under-utilized aspect of nursing care
Attention to the spiritual element of human functioning within nursing has been emphasized and demonstrated in different nursing studies, but the lack of it has also been observed (McSherry, 2006; Ross, 2006). Narayanasamy (2001) states that the spiritual aspect of human beings receives little attention in nursing and that spirituality is an under-utilized aspect of care. In his opinion, carers must become more aware of the impact of spirituality on a patient’s life and become more skilled in providing that care. McSherry (2006) states that the preoccupation with
technological and material developments in society and within health care has replaced the notion of holistic and individualized care. On the other hand, he also observes a refocusing on the spiritual dimension within health care and within society as a whole. This renewed attention to spirituality is also recognizable in Dutch society, where spiritual matters are more openly discussed and expressed than in the recent past (Van de Donk et al. 2006; Bernts et al. 2007). McSherry (2006) identifies barriers that hinder the provision of spiritual care in nursing, namely, barriers within the economic and environmental context (e.g. time, staffing, organization), in the health care professional (lack of knowledge or skills, too sensitive or emotional) and in the patient (too sensitive or emotional).

Some Dutch studies also clearly point to the absence of systematic attention to the spiritual aspect of patient functioning in the nursing process. Prins (1995) concludes that hospital nurses insufficiently assess the spiritual needs of patients. In their analysis of the nursing reports of 153 hospital patients, Achterberg & Coenen (2000) relate that no problems or needs were formulated regarding the spiritual functioning of those patients. They conclude that nurses cannot recognize those kinds of needs and problems, or that they have been unable to translate them into the nursing reports. In a study of community health in the Netherlands, Tiesinga (2006) reports that the main barriers to the delivery of spiritual care are a lack of time to provide that care and a lack of knowledge and skills. Other main factors include the fact that spirituality is not given priority within health care and that health care professionals consider spirituality as a private issue for the patient. Tiesinga & Post (2003) confirm this and in their discussion of spiritual care in nursing they conclude that this matter should be given more systematic attention within the nursing process. They also state that the interest that is found is too free of obligation.

Considering these aspects, one may conclude that spiritual care in nursing is deemed important and relevant, but it lacks systematic attention due to various factors. One of these factors is that nurses are not well prepared for their spiritual care role. A number of authors emphasize the importance of this educational gap (Highfield et al. 2000; McSherry, 2006). Ross (2006) concludes that more attention should be paid to research within the area of education to gain more insight into its effects. What should be taught and how should it be taught? In other words, which
competencies do nurses need to provide spiritual care? What educational methods are effective in developing those competencies? As a nursing lecturer I was very interested in finding answers to these questions. The observations mentioned above motivated me to start this study with the intention of contributing to a systematic embedding of spiritual care into nursing care and education.

Spirituality and health
The World Health Organization (WHO) defined health as ‘a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity.’ (WHO, 1992). Since its introduction the definition has been under discussion, one of the issues being the question of whether the spiritual domain should be added to it (Blok, 2004). The original definition has not changed as yet, but the debate continues. Other developments within WHO indicate that spirituality is indeed a health-related factor. WHO emphasizes the importance of attention to human activities in the area of spirituality in its International Classification of Functioning and also states that palliative care encompasses the spiritual aspects of patient care (WHO, 2001, 2007). The WHO Department of Mental Health recognizes aspects related to spirituality, religion and personal beliefs as aspects of the quality of life (WHO, 2002). From the perspective of health policy, spirituality and spiritual care seem relevant, which implies a relationship between spirituality and health and wellbeing. This notion is supported by studies regarding the relationships between spirituality, health and health care (Koenig, 2001; Ross, 2006). These studies show that research is being done among many different kinds of patient populations in physical, mental, chronic and palliative health care settings. This demonstrates the broad relevance of this subject to health and health care in general.

Growing attention to spirituality is also observable in the Dutch health care system. For a number of years specific studies have been published about the relationship between spirituality, religion and mental illness (Braam, 1997; Schreurs, 2001). These studies focus on the impact of religion on mental wellbeing and the attention it receives in treatment and therapy sessions. Studies in palliative care have also revealed the relevance and importance of spirituality (Jochemsen et al. 2002; Kuin et al. 2006).
With regard to the results of studies on the connection between spirituality and health, it seems evident that aspects of spirituality can be important to patients being treated for various illnesses or receiving terminal palliative care. However, there seems to be a lack of research in the field of somatic health care within the context of Dutch healthcare. Hence the focus of this thesis will be on that sector of health care. The second chapter will explore the connection between spirituality and physical health. Considering the number of relevant studies being published in mainly medical and nursing journals, the impact of spirituality on health and health care cannot be ignored by health care professionals. The results of these studies can provide insight into the importance of spirituality to patients. That insight is fundamental to assess whether patients should be given spiritual care.

**Spirituality and health care**

Acknowledging the connection between spirituality and health implies that health care professionals should attend to spirituality in the care they provide to patients. Waaijman (2002) notes that interest in spiritual issues in today’s health care sector is growing from two perspectives. Firstly, from the perspective of the patient: the patients must not be identified with their illness, people should not be medicalized, isolated, eliminated from or exploited by the treatment of their illness, their personal integrity should be respected. This is also stressed in recent Dutch studies on charitable care (Van Heijst, 2006) and presence in care (Baart, 2005) which provides a person-centred approach to health care.

Secondly, from the perspective of care: the spiritual life of the patient must be an explicit part of health care, nurses must be competently trained to address a patient’s spiritual needs. Waaijman (2005) argues that health care professionals should focus on a so-called primordial kind of spirituality which is related to ordinary processes of human life such as birth, corporality, primary relationships and the course of life. The first notion refers strongly to a holistic view of nursing that was referred to at the beginning of this introduction. The second notion implies also taking care of the patient’s spirituality.

Medical and nursing perspectives also emphasize that with respect to the spirituality of patients, interaction within the health care system should not be restricted to pastors, imams or hospital chaplains. Many authors have stated that
other health care professionals, particularly physicians and nurses, should also be involved (Koenig, 2002; Puchalski, 2006; Steven Barnum, 1996; O’Brien, 1999; Steemers van Winkoop, 2001; Narayanasamy, 2001; Johnston Taylor, 2002; McSherry, 2006). Many of these authors also state that the integration of spirituality and health care is not common today and still depends largely on the attitude of the individual health care worker.

It should also be noted, however, that the issue of spirituality and health care is still under critical debate. This ongoing debate places emphasis on what might be expected from doctors and nurses (Koenig, 2002; Baldacchino, 2006). Should they assess a patient’s spiritual needs and then refer the patient to a pastor, an imam or hospital chaplain, or should they provide some kind of spiritual care themselves? Tiesinga & Post (2003) wonder how the issue can be put on the health care agenda and how it can be freed from the idea that matters of meaning and purpose should be private and not for public discussion. The authors are also of the opinion that in times of growing individualization, rationalization, technical development and emphasis on legal aspects in health care, health care professionals should pay attention to spiritual aspects of care. However, they note the confusion about what might be expected from those professionals, questions about who is responsible for providing spiritual care and where the limitations are of that responsibility. Sloan (2006) criticizes the role of doctors when he states that doctors should always refer patients with spiritual needs or problems to a specialist (e.g. a pastor). In his view, a doctor is not a specialist in spiritual matters and could even harm the patient when attempting to address those needs or problems. Clearly the issue is controversial. In this thesis I explore the particular role of nurses in providing spiritual care.

Spirituality: conceptual framework

The concept of spirituality provokes different associations. It can be linked to religions, but there are also many non-religious forms of spirituality. It relates to all kinds of beliefs and world-views. This is illustrated by the 25th edition of World Spirituality, An Encyclopedic History of the Religious Quest (Cousins, 1985), a reference work on all kinds of religious and non-religious forms of spirituality including those occurring in Western society. Recent research in the Netherlands (van de Donk et al. 2006; Bernts et al. 2007) shows that people are tending towards
more non-religious forms of spirituality. This is expressed in statements such as ‘I think you should experience the truth inside yourself’ or ‘religion is something particularly personal for me and not something I would share in a group or community’. A general characteristic of today’s spirituality might be that it expresses a person’s individual belief system, which can be religious or non-religious. However, spirituality should not be completely uncoupled from established religions, because for many people their spirituality is related to their religion (Waaijman, 2002).

Spirituality must be characterized by its multidimensionality, which is important to finding a unifying definition of the concept. Within the context of this thesis it is important to clarify its meaning as a conceptual point of reference. McSherry et al. (2004) conclude in their systematic review of the nursing literature that many definitions are used within nursing, that they have different layers or meanings, and that spirituality can imply different things depending upon an individual’s personal interpretation or world-view. They also conclude that spirituality is a concept whose meaning is highly individualized and dependent on the value an individual attaches to it. They recommend the use of a spiritual taxonomy that contains all the different meanings of the concept of spirituality.

In line with this view, a distinction can be made between two approaches to the concept of spirituality, namely a functional and substantial approach (Van de Donk et al. 2006). In the functional approach, spirituality is interpreted in terms of the function it has for the individual (e.g. patients) as well as in society at large (Jochemsen et al. 2002, Bouwer, 2004). This approach implies that every person is, in a sense, spiritual, but people differ with respect to the content of their spirituality. Contrary to the functional approach, the substantial approach formulates spirituality in terms of certain views, experiences or traditions, especially those with a specific common meaning and structure. Christian spirituality differs in this way from a humanistic form of spirituality, and within Christian and humanistic spiritualities different forms of these substantial spiritualities can be recognized. This substantial approach of spirituality is expressed in the Encyclopedia of Spirituality (Cousins, 1985) and is similar to the approach in nursing described by McSherry (2006).

Both approaches are useful in nursing. On the one hand, nurses should realize that each patient has a spiritual dimension with a personal content, which becomes
apparent in specific personal needs, rituals and behaviour. As such, nurses should understand spirituality from the functional perspective. At the same time, individual patients may belong to a certain group or community with specific spiritual needs, rituals and behaviour. For example, Muslim patients express, to a certain degree, common needs and behaviours. Alternatively, patients show a more personal kind of spirituality that is unrelated to any other institutionalized form, such as a strong affinity with nature. Clearly, nurses should understand spirituality from the more substantial perspective as well. Hence, these two approaches are complementary in care practices.

The functional approach to spirituality is followed to in this thesis. This choice emphasizes the view that spirituality is an aspect of human functioning in addition to the physical, the psychological and the social aspects. This approach accords with the previously mentioned integral vision of human functioning implicit in the concept of holism. It also fits nursing models which make spirituality explicit (Neuman, 2002; Watson, 1998; Newman, 1994; Parse, 1995). Neuman (2002), for example, states that every person is spiritual in some way (consciously or unconsciously) and that spiritual needs or problems can arise during illness and its treatment. This functional approach includes all patients. The substantial definition does not include all patients in general as it entails opting for a particular spirituality which necessarily excludes some patients. The following definition of functional spirituality is used in this thesis: ‘The religious and/or existential mode of human functioning, including experiences and questions of meaning and purpose’ (Jochemsen et al. 2002, p. 6). This definition encompasses both religious and non-religious forms of spirituality.

Spiritual care in nursing
Because of the connection between health and spirituality, nurses should attend to spirituality in the care they provide to patients. This care can be conceptualized as spiritual care. Within the scope of this thesis it is important to make clear what is meant by the concept of spiritual care. Spiritual care is understood as the care nurses provide so as to meet the spiritual needs and/or problems of their patients. Some authors state that the care nurses provide is spiritual in itself (Bradshaw, 1994). This position holds that the nurse develops (or possesses) the kind of character that embodies the virtues and values of patience, kindness, compassion,
unselfishness, loyalty, conscience and honesty. This view of nursing is close to the opinion that nursing is a vocation, an opinion which must be seen as a result of the religious roots of nursing. According to McSherry (2000), changes in society, especially through the processes of secularization, individualization and professionalization have resulted in nurses entering the profession not out of a vocation but because of a desire to have a career and to earn a secure income. According to this view, nursing care is no longer intrinsically a spiritual affair, which would assure that attention is paid also to the spirituality of patients. Attending to patients’ spiritual needs and care should thus be made a more explicit component of professional nursing.

The basic assumption in this thesis is that spiritual care is a part of the professional function of nurses and thus it is their task to care to some extent for the spiritual needs and problems of patients. This assumption is supported by professional nursing organizations (ICN, 2006). The Dutch Professional Profile of Nursing states that nursing care presupposes a holistic perspective that includes physical, mental, social and spiritual aspects of human functioning (Leistra at al. 1999). The profile also states that in the future, questions of meaning and purpose will take a more prominent place in nursing-care practices, similar to questions about patient autonomy, insecurity, neglect, despair and suffering. The Nursing Code of Ethics (ICN, 2006) declares that the nurse should provide care to the patient as far as possible according to the cultural and spiritual identity of the patient.

According to these general statements one might expect the tasks undertaken by nurses in practice to be clear in terms of spiritual care and the skills required for executing them. However, there seems to be a gap between what is expected of nurses in theory and what is actually practiced (McSherry, 2006; Ross, 2006; Tiesinga & Post, 2003). This raises questions about how the task of spiritual care in nursing can become clearer, and the level of expertise which should be expected from nurses. In this thesis the nurses’ role in spiritual care will be further explored and described in terms of the competencies required to provide spiritual care.

**Education in spiritual care**

When it comes to the expertise nurses need to possess to provide spiritual care, it appears that health care professionals feel inadequately prepared. There thus
seems to be a role for nursing education. In a recent review of research on spiritual care in nursing, Ross (2006) states that there is much debate in the nursing literature about how, what and when spiritual care should be taught to nurses. According to the studies she investigated, it appears that nurses receive little education in the spiritual dimension of care. The hypothesis is that by obtaining a more structured form of education nurses will become more competent in providing spiritual care. The evidence to support this hypothesis is still limited. This thesis will contribute to this aspect of the discussion about spiritual care in nursing by exploring the content of spirituality and spiritual care in nursing education and by investigating the learning effects of a certain education received by a group of nursing students (see Chapters 7 and 8).

The scope of this thesis and the research model

This thesis examines the relationship between spirituality and health and the nurses’ role in providing care for the spiritual needs and problems of patients, the competencies required to provide that care and the effects of spiritual care education on the competencies of nursing students. The first step will be to explore the relationship between spirituality, health and health care from a Dutch health care perspective, specifically from the perspective of the disciplines of oncology, cardiology and neurology. The following step will be to conceptualize the competencies required by nurses to provide spiritual care to patients and to develop an assessment tool to enable the measurement of those competencies. The final step will be to investigate the effect of education on the development of those competencies and to evaluate the hypothesis that education is an important predictor of the ability to provide spiritual care (see figure 1).

**Figure 1** From exploration through conceptualization and operationalization to evaluation

- explore the connection between spirituality, physical health and health care
- conceptualization of nursing competencies to provide spiritual care
- developing a tool for measuring nursing competencies to provide spiritual care
- evaluation of the effects of education on competencies to provide spiritual care
This model results in the following research questions:
1. How has the connection between spirituality and physical health been investigated and what are the results of that investigation?
2. What role does spirituality play in patients during physical illness and treatment?
3. What competencies do nurses need to provide spiritual care?
4. How do nurses handle spiritual aspects in health care practice and can nursing competencies for spiritual be identified in their conduct?
5. How can nursing competencies regarding the delivery of spiritual care be assessed?
6. What are the effects of a newly developed educational programme for student nurses on the development of their competencies in spiritual care?
7. What are the learning effects of the educational method of thematic peer review on the development of competencies for spiritual care provision?

This study uses qualitative and quantitative research methods. For the exploration of the experience of spirituality and spiritual care a qualitative approach was appropriate. For the assessment of the development of competencies and the effects of an educational method, quantitative and qualitative methods were applied. In this integrative approach both methods are seen as complementary, which enhances insight into the phenomenon of spirituality and spiritual care in nursing and contributes to the validity of this research (Polit & Hungler, 1997).

Outline of the thesis

Chapter 1 provides a general introduction.
Chapter 2 describes the connection between spirituality and physical illness. It reports the outcome of a systematic review of studies on this subject published from 1992 to 2002 in the international medical and nursing literature. It analyses the conceptual and methodological aspects of that research and gives recommendations for future research in this area.
Chapter 3 focuses on the relationship between spirituality and health. It describes the results of an explorative study of the spiritual aspects of illness within the context of the Dutch health care system. For this purpose patients, nurses and hospital chaplains within the fields of oncology, neurology and cardiology were interviewed in focus groups. From the analysis of the interviews, spiritual themes
have emerged that seem relevant to patients in terms of illness and treatment of their illness, as well as during the process of dying.

Chapter 4 contains the results of an extensive review of international literature concerning the tasks, or competencies, that nurses need to deliver spiritual care. This review results in the description of a competence profile identifying six nursing competencies in the area of spiritual care with reference to the nurses’ self handling (in chapter 4 mentioned as use of self), attention to spiritual care in the nursing process and attention to spiritual care in quality assurance and policymaking within the healthcare institution.

Chapter 5 describes the results of focus group interviews with patients, nurses and hospital chaplains in oncology, neurology and cardiology regarding the care nurses deliver according to the spiritual needs and problems of the patients. This chapter gives an indication of nursing practice in this area. Aspects of nursing competencies derived from the theory (Chapter 4) can be recognized in practice, but it also becomes clear that spiritual nursing care does not seem to have a systematic place within that practice. Factors possibly related to that conclusion also become apparent in the interviews.

Chapter 6 deals with the development of the Spiritual Care Competence Scale (SCCS), a tool to measure nursing competencies in providing spiritual care. The competencies described in Chapter 4 were used as the items of the tool. In this chapter the psychometric quality of this tool is evaluated, resulting in a valid and reliable tool containing six dimensions of competencies concerned with spiritual care, which are able to be used at a group level in nursing and educational practice.

Chapter 7 describes the effects of a course in spiritual care given to a group of nursing students from two nursing schools in the Netherlands, with respect to the development of their competencies in providing spiritual care. The quantitative approach of the study employed a statistical analysis of the students’ self-assessments on the Spiritual Care Competence Scale (SCCS). In addition, it analysed the teachers’ scores of student analysis of the vignettes. The study shows the effects on the development of student competencies to provide spiritual care.

Chapter 8 describes the qualitative effects of the course in spiritual care on the development of students’ competencies. For this purpose student reports from reflective group sessions were qualitatively analysed and different themes emerged from that analysis regarding the content of the reflective group sessions and their learning effects.
Chapter 9 discusses the results of the different studies, with a special focus on the impact of education on the development of nursing competencies for the delivery of spiritual care.
References


Bradshaw A (1994). Lighting the lamp: The spiritual dimension of nursing care. Scutari Press, Harrow


Chapter 1


http://www.who.int/classifications/icf.


WHO (2007). Palliative care is an essential part of cancer control and can be provided relatively simply and inexpensively, www.who.int/cancer/palliative.