Nursing competencies for spiritual care

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Abstract

Aim. This paper aims to answer the question: What competencies do professional nurses need to provide spiritual care?

Background. Nursing literature from The Netherlands shows little clarity on the qualities that nurses require to provide spiritual care. Although the international literature provides some practical guidance, it is far from conclusive on the required qualities of nurses.

Method. A qualitative literature review was conducted to draw together information from the nursing literature in order to formulate nursing competencies. A format developed for higher nursing education in the Netherlands was used; this consists of description of a general domain, specific competencies, vignettes, key focus and objectives.

Results. The resulting competency profile has three core domains (awareness and use of self, spiritual dimensions of the nursing process, and assurance and quality of expertise) and six core competencies (handling one’s own beliefs, addressing the subject, collecting information, discussing and planning, providing and evaluating, and, integrating into policy).

Conclusion. This literature review yields a competency profile that may help to structure future care, research and education in spiritual care by nurses. Implications of the work for future research and education are discussed.
Introduction

In its policy statement Professional Profile of Nursing, the Dutch National Centre for Nursing and Caring Professions explicitly includes spirituality as a key focus in nursing practice (Leistra et al. 1999, p. 12). It states that nursing care presupposes a holistic perspective that includes physical, mental, social and spiritual aspects of human functioning. In order to provide holistic care, nurses must be competent to intervene on a physical, mental, social and spiritual level. The competencies required to provide physical, psychological and social care have been clearly documented in the nursing literature. However, in the context of nursing in The Netherlands, it is unclear which nursing competencies are vital to providing adequate spiritual care.

Our study is a first attempt to remedy this situation (Van Leeuwen & Cusveller 2002). In this paper, we share the results of a literature review conducted in 2002 with the aim of pulling together the competencies nurses are supposed to possess for the provision of spiritual care. First, we clarify the definition of spirituality that we adopted. Secondly, we briefly describe the methodology of our project. Thirdly, we present the results of our literature review in a format developed for this purpose. Finally, we explore some implications for nursing research and education.

Spirituality: a functional approach: definition issues

In the nursing literature, authors define and use the term ‘spirituality’ in a number of different ways, such as searching for meaning, adhering to a religion, balancing energy or basic trust (Tanyi 2002). Hence, it is difficult to tie the concept to a single meaning. Rather than having one fixed meaning, the notion of spirituality seems to refer to a ‘family’ of different yet connected meanings. Therefore, to establish a working definition for use in our literature review, we did not attempt to define what spirituality is, or what forms or content belong to it ‘essentially’. Rather, we focussed on the variety of things that people do, or the variety of ways in which they function. It could be said that human beings have physical, mental and social functions, or function in physical, mental and social ways. By the same token, it could be said that they have a spiritual function, or function spiritually. This approach to human
spirituality could be called ‘functional’ rather than substantive: it focuses more on how a person makes meaning in their life rather than on what that specific meaning is (Fitchett 1993, p. 40).

In this spiritual function, the beliefs, practices and lives of human beings express their relationship to that which transcends the physical, mental, and social. It involves activities, convictions and attitudes relating to fundamental features of human existence, such as death, suffering, vulnerability, dependency, the inevitability of choices and the sacred. This is not to say that there is a common form or content to human spirituality; it represents the weaker claim that human beings express their common function of spirituality in different forms and content. For the purpose of our study, the notion of spirituality will be used to denote the religious and existential mode of human functioning, including experiences and questions of meaning and purpose (Jochemsen et al. 2002, p. 12).

Spirituality in relation to health and illness

How does spirituality relate to nursing? In the patient-nurse relationship, spirituality is expressed in various spiritual areas or themes (hope, growth, strength, authority, belief and so on), as well as in various forms and contents. More important for the nursing process, however, is how spirituality is manifested in relation to patients’ health and illness. When we take illness as distorted human functioning, we may define nurses’ professional responsibility as a supportive, palliative or preventive response to certain ‘dysfunctions’. It follows from this working definition that nurses’ professional responsibility for spiritual care depends on the relationship between a patient’s spiritual function and their health situation.

First, there is the patient’s ‘customary’ or ‘everyday’ spirituality, which they might want to continue during a period of care. For instance, a patient used to praying, meditating, reading scripture or worshipping may want to continue doing so during their stay in hospital or during home care. As the nurse is, at least in part, responsible for making the patient’s stay possible, this customary spiritual function is part of the focus of nurses’ professional responsibility, which assumes the ability to support this function.
Secondly, there is a phenomenon that could be called the 'spirituality of illness or crisis'. People confronted by disease or handicap, giving birth, or imminent dying are vulnerable to changes or reactions in the way that they relate to their existence, habits, beliefs and way of life. For many, this is a 'healthy' response to a crisis. For some, these responses result in spiritual distress, a struggle with the meaning of life or a conflict related to faith. As these spiritual responses to illness are direct and urgent consequences of the reasons why patients were being cared for in the first place, the spiritual function is part of the focus of nursing and requires competence in this area.

Thirdly, a patient's spiritual function itself may be 'distorted', i.e. in need of treatment. Patients do not usually want a state of spiritual distress to continue during their stay. Nor is it always a direct and urgent consequence of the reason why a patient is being cared for. A patient who is hospitalised for bone fracture surgery may also suffer from certain despairing expectations about their marriage or work. This despair is not something that the patient would want to see continued during their hospital stay, nor is it related to their fracture, surgery or subsequent care. However, this patient’s moods, attitudes and decisions may affect the nursing process and the patient-nurse-relationship. In this case, the episode of spiritual distress itself needs to be addressed. Nurses’ responsibilities and competencies to deal with this form of spiritual distress may be limited, but the relationship between patients’ spirituality and nurses’ responsibilities requires them, at the very least, to work in a multidisciplinary team and support other health workers who can attend to such patients’ spiritual distress.

**Spirituality and professional responsibility**

Another preliminary aspect worth mentioning is that the varied nature of human spirituality will also include nurses’ own forms of spirituality. This is important, because they will always bring their own personal “frames of reference” to bear on practice, including the spiritual care provided. This means that there is room for a nurse’s personal convictions when providing spiritual care, in terms of talking about faith in the same way that they talk about other things. There may, however, be tensions between personal convictions and the interventions asked of them when
caring for patients’ spirituality. Again, the requirement is that nurses handle such conflict-provoking situations in a professional manner, and this demands competence in this respect.

Lastly, we would like to point out the general importance of good working conditions and an environment that facilitates nurses to provide adequate spiritual care. They do not only need to be competent on the level of the patient-nurse relationship, but also need an organizational context conducive to providing adequate spiritual care and the competence to make use of it.

In summary, we found reason to search the literature for material on nursing competencies in spiritual care as defined above. These are competencies relating to:

- nurses’ professional responsibility for direct patient care;
- handling the limitations of that responsibility;
- interacting with health care providers in a professional manner; and
- dealing with the contextual conditions for spiritual care.

Method

Research questions

The notion of ‘competencies’ denotes complex sets of skills used in a professional context, i.e. the clinical nursing process. Being competent depends on correct assessment of a clinical situation and on the ability to implement knowledge and skill in the right way at the right moment. Equivalents of this notion are capability and capacity.

The leading question for our literature review was: What are the competencies a nurse needs to possess for providing adequate spiritual care? We divided this question into four sub-questions that relate to the content and implications of this body of nursing literature:

- Which nursing interventions and activities relating to spiritual care are described?
- What are the requirements in respect of nurses’ professional attitudes to spiritual care?
• Which organizational conditions that might impact on spiritual care are described?
• Can a nursing competency profile for spiritual care be derived from an analysis of this literature?

Research procedures

The literature review was qualitative, semi-structured and explorative. Results were documented in an analytical framework (Table 1) consisting of the stages of the nursing process, to which we added contextual aspects and referral to other disciplines (as this appeared to be of particular importance in the case of spiritual care). Thus, the analytical framework contained the following elements, derived from the Dutch Professional Profile for Nursing (Leistra et al. 1999):

• Patient-related interventions and activities, consisting of: monitoring/observing, assessing, helping/coaching, teaching/advising, prevention and co-ordination of care;
• Co-operation with other experts; and

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<th>Analytical framework</th>
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<td><strong>Patient-related tasks</strong></td>
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<td>• Observation/assessment/diagnosis</td>
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<td>• Continuity and co-ordination of care</td>
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<td><strong>Organisation-related tasks</strong></td>
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• Organizational and personal conditions in the clinical context.

An on-line literature search was carried out using the databases Invert and Picarta (in Dutch), as well as Medline and CINAHL (in English). Search terms used were: nursing, spiritual care, competence, nursing interventions and nursing education. When searching in English, care was taken to retrieve literature originating from different countries rather than just the United States. Secondly, key internationally acclaimed works were included (Benner Carson 1989, Stevens Barnum 1996, O’Brien 1999, McSherry & Cash 2000, Narayanasamy 2001, Taylor 2002). In addition, special attention was given to Dutch and German sources, as they relate to the Dutch culture in both nursing and spirituality. Lastly, care was taken to include literature that focussed on clinical interventions in nursing practice, rather than philosophical reflection.

RvL prepared written summaries of each relevant article or chapter. BC and the advisory committee checked these summaries for accuracy. In addition, BC prepared summaries of six randomly selected articles and compared them to RvL’s summaries. No substantial differences appeared. Following this, we categorized relevant skills, roles and activities related to spiritual care independently, using an analytic framework sheet for each summary. RvL then combined the data from each analytical framework sheet in a single cumulative analytical framework. During this process, overlapping sets of skills were labelled together as one competency. Again, BC and the expert committee checked the results of this step for accuracy and found them to be satisfactory. No new information emerged from the last few articles with summaries. After combining 29 articles and chapters it was decided that the sample had been sufficient to cover the issues involved.

Results

Table 2 shows how the findings of the literature review were related to the elements of the analytical framework. It became clear that spiritual care pertained to all facets of a nurse’s professional competencies with the notable exception of prevention and health education, on which no clear findings could be reported.
### Table 2  Results presented within the analytical framework

<table>
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<th>Observation/assessment/diagnosis</th>
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<td>• Asking questions about spirituality, faith, religious background. Checking which practices, rituals, symbols and traditions support the patient. Probing the meaning of faith and meaning for the patient (Pieper &amp; Van Uden and Van Uden, 2000; Steemers, 2001; Rijkse &amp; Van Heijst, 1999; Driebergen, 2001; Wehner, 2001; Jochemsen et al., 2002)</td>
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<td>• Making use of tools: queries, interview techniques, instruments (Stoll, 1979; Rijkse &amp; Van Heijst, 1999; Eliens &amp; Frederiks, 2002; O’Brien, 1999)</td>
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<td>• Communication skills: active listening to religious biography, life story, non-verbal expressions (Prins, 1996; Rijkse &amp; Van Heijst, 1999; Greenstreet, 1999; Steemers, 2001; Ganzevoort, 2000)</td>
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<td>• Recognising the patient’s symbols/symbolic language (Weher, 2001)</td>
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<td>• Clarifying by asking for additional information, checking first impressions, and structuring information (Rijkse &amp; Van Heijst, 1999)</td>
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<td>• Formulating existential questions with the patient, ‘diagnosing’ spiritual distress; determining the patient’s position on the continuum of spiritual well-being, and opportunities to meet needs and solve problems (Rijkse &amp; Van Heijst, 1999; Westnik &amp; Van Leeuwen, 1999; Van Leeuwen &amp; Hunink, 2000; Steemers, 2001; Driebergen, 2001)</td>
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<td>• Distinguishing spiritual needs and problems from pathology (Campinha-Bacote, 1995)</td>
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<td>• Creating conditions (time, room, resources) for access to the patient’s spirituality and spiritual needs (Greenstreet, 1999).</td>
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### Coaching

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<td>• Watching over the patient after receiving bad news (Prins, 1996)</td>
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<td>• Supporting those with longterm illness in terms of self-awareness, accepting, coping, and enjoying the good moments (Steemers, 2001)</td>
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<td>• Creating conditions for spiritual guidance, prayer, meditation, reading and listening to music (time, room, availability, being present, sense of security, enhanced patient mobility) (Leetun, 1997; Ross, 1996; Stevens Barnum, 1996; O’Brien, 1999; Greenstreet, 1999; Narayanasamy, 1999; Steemers, 2001; Van Veluw, 2001; Driebergen, 2001)</td>
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<td>• Being near, being present, adequate use of touch (Taylor et al., 1995; Stevens Barnum, 1996; O’Brien, 1999; Greenstreet, 1999; Steemers, 2001; Van den Berg, 2001; Wehner, 2001)</td>
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<td>• Focusing on faith, worldview, spirituality, meaning and religion from the patient’s perspective, and interventions such as pastoral and spiritual care, reducing anxiety and offering comfort. Addressing questions of life and meaning against a background of religious biography. Helping to put life events in perspective, Promoting meaning, self-respect and hope. Clarifying perspective on life and identifying inconsistencies. Taking note of thoughts and feelings evoked by handicap, illness, suffering or death. Supporting patients in their quest for meaning. Addressing issues relating to coping with illness,</td>
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Nursing competencies for spiritual care

dying and the meaning of life. Supporting self-actualisation. Stimulating conversation and communication about painful experiences and events, anxiety, insecurity and future plans with others. Encouraging enjoyment of the everyday. Being a companion. Offering supportive opportunities to make changes and decisions. Encouraging patients to define values, goals and personal opinions. Not giving false hope, but enabling patients to express themselves. Gaining access to motives and mental images of the patient and family, to their existential experiences, of temporality and the downsides of life (Taylor et al., 1995; Stevens Barnum, 1996; Leetun, 1997; Pieper & Van Uden, 2001; Rijken & Van Heijst, 1999; Westrik & Van Leeuwen, 1999; Narayanasamy, 1999; O’Brien, 1999; Steemers, 2001; Van Veluw, 2001; Driebergen, 2001; Weiher, 2001; Jochemsen et al., 2002).

• Evaluating if the nurse has focussed adequately on the patient’s story, if the fundamental problem has been identified adequately, if the method used has been attuned to the patient’s situation and how the indicator ‘spiritual integrity’ played a role (Rijken & Van Heijst, 1999; Narayanasamy, 1999; Steemers, 2001)

• Taking care that patients can express their faith and/or spirituality by way of celebrations, rituals and conversations, with or without nurses’ support (Steemers, 2001)

• Exhibiting communication skills: asking and listening actively, noticing non-verbal behaviour, using silences, reflecting content and emotions, making the problem concrete, summarising, connecting to goals, reflecting aloud and concluding. Communicating with patients from different cultural backgrounds, and reflecting on cultural differences (Taylor et al., 1995; Stevens Barnum, 1996; Prins, 1996, Leetun, 1997; Westrik, 1999; O’Brien, 1999; Greensstreet, 1999; Narayanasamy, 1999; Steemers, 2001; Van Veluw, 2001; Van den Berg, 2001; Driebergen, 2001)


• Helping to apply techniques: meditation, counselling, relaxation exercises, therapeutic touch, visualising, writing letters, repatterning and alternative interventions not available in regular care (Leetun, 1997; Stevens Barnum, 1996; Driebergen 2001; Eliën, 2002).

• Involving the family in spiritual care. Coaching the patient in relations and social ties in the terminal phase. Noticing obstacles in communication. Coping with bereavement. Arranging visits (Leetun, 1997; Ross, 1996; Eliën & Frederiks, 2002; Narayanasamy, 1999; Weiher, 2001; Jochemsen et al., 2002)

• Providing terminal spiritual care: bringing a close to an evaluation of one’s life and/or life goals, to life itself, material matters. Promoting courage, hope and growth. Tending to religious practices and rituals. Coping with emotions, wishes for death and/or requests for euthanasia (Jochemsen et al., 2002).

• Arranging visits by consultants and experts (Jochemsen et al., 2002).
Information and advice

• Informing the patient about pastoral care and availability for conversations. Avoiding alienating patients with questions about religion/faith during admission (Prins, 1996; Driebergen, 2001)

• Offering information on daily routine and rules, facilities, support within the institution, availability of chapels and rooms to retreat to (Driebergen, 2001)

• Informing the patient and family about night accommodation for family and significant others (Jochemsen et al., 2002)

Prevention and education

No clear findings

Continuity and co-ordination of care

• Creating continuity in spiritual care, especially with patient transfer and discharge, recording data and agreements, making use of patient files (Jochemsen et al., 2002).

• Careful planning of work, using the patient’s care plan for spiritual care, attuning to the patient’s individual situation, setting realistic goals and defining existential questions, care goals, methods and criteria for evaluation (Ross, 1996; O’Brien, 1999; Narayanasamy, 1999; Greenstreet, 1999; Rijksen & Van Heijst, 1999; Driebergen, 2001; Jochemsen et al., 2002).

• Evaluating the adequacy of assessments of existential questions and the method used (Rijksen & Van Heijst, 1999).

Multidisciplinary co-operation

• Referring the patient, when wanted, to a pastoral caregiver or counsellor for questions relating to faith and meaning. Overseeing the patient’s total well-being. Being available for specific rituals (Prins, 1996; Stevens Barnum, 1996; Westrik, 1999; Pieper & Van Uden, 2000; Van den Berg, 2001; Driebergen, 2001; Jochemsen et al., 2002)

• Seeing to it that a contact with the pastor or counsellor is arranged. Informing and referring the patient (Prins, 1996; Steemers, 2001)

• Facilitating informal contacts with the pastor or counsellor (Prins, 1996)

• Consulting the pastor or counsellor and addressing the patient’s needs in interdisciplinary communication (Ross, 1996; Van den Berg, 2001)

• Referring the patient, if needed and wanted, to a nurse with the same faith or to a member of his own faith-community (Westrik, 1999; Driebergen, 2001)

Fostering institutional conditions

• Including spirituality in quality assurance policy (Stevens Barnum, 1996)

• Enhancing integral spiritual care in treatment, policy and vision. Enhancing the role of management and institutional culture. Persuading management of the importance of
spirituality (Borsjes et al., 2001; Steemers, 2001; Jochemsen et al., 2002).

- Working from a shared framework, not depending on individual interests or workload (Prins, 1996)
- Participating in nursing audit and inter-colleague coaching in spiritual care (Jochemsen et al., 2002)

**Attitude and personal qualities**

- Showing respect for the patient’s outlook and way of life. Accepting patients of a different persuasion to that of the nurse. Making the distinction between one’s own faith and that of the patient. Avoiding imposing one’s own perspective on the patient. Avoiding last-minute evangelism (Eliens & Frederiks, 2002; Rijksen & Van Heijst, 1999; Greenstreet, 1999; Westrik, 1999; O’Brien, 1999; Steemers, 2002; Borsjes et al., 2001)
- Reflective use of one’s own worldview or religion. Recognising the positive effects of expressing one’s own worldview (Borsjes et al., 2001)
- Reflecting on one’s own limitations and being able to set limits for oneself in providing spiritual care. Accepting that some may not have an ability/wish to provide spiritual care. Coping with limited abilities, interest and experience. Knowing how to refer when not competent. Knowing when referral to a pastor or spiritual counsellor is needed (Taylor et al., 1995; Ross, 1996; Prins, 1996; Greenstreet, 1999; O’Brien, 1999; Driebergen, 2001)
- Knowing pitfalls in spiritual care that inhibit adequate recognition of spiritual questions and needs, such as physical complaints, superficial listening and putting one’s own background to the fore (Prins, 1996)
- Recognising one’s own feelings, spirituality and shortcomings. Recognising and coping with emotions in patients, such as sadness, and fear of dying, suffering and death. Being able to give a spiritual self-diagnosis. Acknowledging the impact of the spiritual diagnosis of the patient on oneself. Spiritual introspection. Paying attention to one’s own spirituality. Knowing one’s own interest in and experience of the subject. Knowing and caring for oneself. Having an orientation on hope, confidence and belonging. Reflecting on one’s own spirituality and the chances, limitations and awareness of the spiritual dimension in one’s own life. Recognising one’s own quest for the meaning of life. Having experienced crises. Being prepared to ‘give’ oneself. Reviewing one’s own beliefs. Awareness of the relation of one’s own spirituality to the care provided. Being able to formulate one’s own experiences of and views on illness. Being able to reflect on the meaning of spirituality. Having access to one’s own opinions and emotions. Coping with anxiety and tension. Accepting defeats and failures. Coping with tension between professional responsibility and daily reality. Deepening one’s professional role and identity (Prins, 1996; Ross, 1996; McSherry & Draper, 1997; O’Brien, 1999; Greenstreet, 1999; Westrik & Van Leeuwen, 1999; Narayanasamy, 1999; Cone, 1997; Steemers, 2001; Van den Berg, 2001; Weiher, 2001; Driebergen, 2001; Jochemsen et al., 2002)
- Refraining from denigrating and stereotyping people, religious denominations, worldviews and spiritualities. Being prepared to admit wrong interpretations (Campinha-Bacote, 1995; Narayanasamy, 1999; Rijksen & Van Heijst, 1999; Driebergen, 2001)
• Being involved, open, compassionate, hospitable, interested in spirituality, authentic, sensitive, sincere, reliable, perceptive, honest, flexible and present. Showing empathy, trustworthiness, unselfish attention, calmness, surrender, and love for the loveless, ungrateful, noncompliant, aggressive and unreasonable. Commitment to cry with, laugh with, accept, care unconditionally, provide warmth and appreciate (Taylor et al., 1995; Stevens Barnum, 1996; Ross, 1996; Leetun, 1997; O’Brien, 1999; Narayanasamy, 1999)

Professional responsibility, knowledge, vision, methodology

• Engaging helpfully in coping with psychiatric illness, and recognizing the importance of mystic and religious experiences in mental health care (Pieper & Van Uden, 2002; Borsjes, 2001)

• Developing vision for spiritual care, patient-oriented care, matters of meaning and perspective, and giving them a more prominent place in nursing care. Working from a holistic perspective that expresses the multidimensional and integrated functioning of patients, and encompasses physical, social, mental and spiritual aspects. Appreciating the importance of spiritual care, cultural values, individual variation and uniqueness. Recognizing that spiritual care is not to be equated with procedures and standards, or opinions on norms and values in relation to illness and health. Directing attention to patient experiences (Ross, 1996; Prins, 1996; McSherry & Draper, 1997; Leistra et al. 1999; O’Brien, 1999; Borsjes et al., 2001)

• Having knowledge of the bases of religions, existential questions, outlooks on life, worldviews, expressions of ultimate questions, practical information on religions. Knowing about cultural aspects of mental health, expressions, dysfunctions, dimensions and needs of spirituality. Appreciating that spirituality is more than religion. Knowledge of developmental stages in faith, the contribution of other disciplines, Christian theological, existential influences, the distinction between religious/non-religious, and the biological basis of spirituality (Campinha-Bacote, 1995; Prins, 1996; Ross, 1996; McSherry & Draper, 1997; Eliens & Frederiks, 2002; Rijksen & Van Heijst, 1999; Narayanasamy, 1999; Greenstreet, 1999)

• Acquiring methodology: observation, probing, intervention, knowledge of assessment tools and nursing process (Eliens & Frederiks, 2002; Rijksen & Van Heijst, 1999; Narayanasamy, 1999; Greenstreet, 1999; O’Brien, 1999; Steemers, 2001)

• Professional responsibility for spiritual care of problems in this area may have urgent consequences for patients’ well-being. UKCC: being competent in identifying patients’ spiritual needs, designing a care plan and contributing to providing and evaluating care using a problem-solving approach. NBS: being able to assess spiritual care, plan, intervene and evaluate on behalf of individual patients, friends and family. AACN: being able to understand the importance of human spirituality in order to recognise the relationship between religion, culture, behaviour, health and recovery, and be able to plan and provide adequate care (Ross, 1996; Westrik, 1999)
Using the accumulated data in the cumulative analytical framework, RvL re-formulated the competencies found in the literature in the form of a ‘competency profile’ (see Table 3). This profile presents the answers to the research questions in a structured way. The sources from which the competencies were derived, are detailed in the right-hand column relating to each competency in the table. This provides an indication of how these articles contributed to the formation of the competencies in the profile. We suggest, furthermore, that the accumulated data in the analytic framework lead to three ‘domains’, or elements, relating to: the person of the nurse (attitude and personal qualities, professional responsibility, knowledge and vision); the nursing process (observation, assessment, diagnosis, coaching, information and advice, continuity and co-ordination of care, and multidisciplinary co-operation); and the institutional context of the care provided (fostering institutional conditions).

Selecting only those that were mentioned in multiple sources, six main competencies emerged in the three domains described above. We have labelled these domains:

- Awareness and use of self: this domain consists of competencies concerned with the way that nurses relate to patients
- Spiritual dimensions of nursing: this domain contains competencies required to handle different phases of the nursing process
- Assurance of quality and expertise: this domain pertains to competencies in handling contextual conditions for providing spiritual care within the organization

Furthermore, the six resulting competencies were described according to guidelines suggested by Pool-Tromp et al. (2001), including:

- A description of the competency (as labelled above);
- Vignettes indicating situations in which such behaviour is appropriate;
- Key focus for behaviour;
- Desired results.

An outside expert (from the Pool-Tromp et al. 2001 group) was consulted about the appropriateness of our use of the competency description model, and this resulted in a final reformulation. The result is shown in Table 3.
### Table 3  Proposed description of nursing competencies for spiritual care

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<th>Domain</th>
<th>Vignettes*</th>
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| A. Awareness and use of self | Nurse: At first, I did not realise that patient’s story had touched me. I made a few notes in her care plan: she had no relatives, never got married, lived in her parent’s house for a long, long time. She was afraid about what was to come. In my first talk with her she said ‘I hope God is not going to test me all that much, because I don’t know if I will be strong enough, but I want to trust Him’. Those words touched me: ‘I want to trust Him’. In the grocery store I thought ‘How can you trust in something like that? How can anybody have a confidence that strong?’ It kept chasing me. It made me restless and even annoyed. (Steemers 2001, p. 96)  
An older man stayed here who had been through quite a lot. He had cancer and there was no hope. He was very religious. A few years ago he had lost his wife and he had never been able to accept this loss. He then faced a situation in which life didn’t mean that much to him anymore. He wanted to request euthanasia but this conflicted with his faith. ‘I cannot make a request for euthanasia, what will They Up There think? If I do that, I will be in another part of heaven and I may never see my wife again.’ In short, a conscientious conflict. I could not help that man with this conflict. I asked if he would like to see a pastor and talk about it. He said ‘Yes’. And it was very good. He appreciated that. Not that it solved all his problems, but he found some rest and he was able to go home. (Prins 1996, p. 111)  
The man was in a lot of pain. I offered to call the doctor for pain medication. But he wanted to bear the pain. To me that was a very strange answer. I had always | A 1 Nurses handle their own values, convictions and feelings in their professional relationships with patients of different beliefs and religions  
Key focus for behaviour:  
• to show respect for patients’ beliefs; not to be prejudiced against people, churches or religions; not to label spirituality as pathological; not to force one’s own beliefs on patients;  
• to reflect on the interaction between one’s own spirituality (values and convictions) and response to the care one provides: e.g. feelings of frustration, distress, fear of illness, suffering and death, and the effects of personal experiences;  
• to recognise and admit personal limitations in providing spiritual care and to communicate these to the patient and the team;  
• to refer to another provider of spiritual care (another nurse or spiritual counselor or pastor) in a timely and appropriate way.  
Desired results:  
To provide appropriate spiritual care to meet the needs of patients | Campinha (1995), Prins (1996), Ross (1996), McSheery & Draper (1997)  
learned that pain is neither good nor necessary and that it was to be combated with all means available. We got to talk about it. ‘Pain has a meaning that is not unimportant’, he said. ‘When you go through your pain without sedating yourself, you build up a positive karma. Pain does not only have a cause, but a reason as well.’ (Steemers 2001, p. 186)

Their oldest son died that afternoon. He was a Hindu. After the last care for the deceased boy, his parents sat next to him for a while. When I entered the room and ask if there was anything else I could do for them, they asked me to take their deceased son from the room. I was very surprised. I did not expect it at all. I also couldn’t understand it. They could read the surprise on my face. His mother looked at me and said ‘We want him to leave us rather than the other way around. If we went away we would leave him alone, and we do not want to do that.’ (Steemers 2001, p. 178)

I grew up in a Pentecostal family. Every day we read from a bible study guide. Prayed before and after meals and before going to sleep. I still pray. Now I’ve been admitted to hospital. I’ve had no contact with anyone about matters of faith. I had when was admitted for the first time. I would appreciate to have the opportunity to talk to someone about my faith. Religion is simply never spoken about, but I would like to. A nurse with the same faith would be nice, but she doesn’t have to.’ (Borsjes et al. 2001)

On the table next to her bed she kept a silver tobacco box. According to the inscription the little box contained pipe tobacco. The box puzzled me. I couldn’t imagine this lady smoking a pipe. I thought she probably kept something else in the box. She saw me looking and smiled. She told me ‘I have been

B.3 The nurse collects information about the patient’s spirituality and identifies the patient’s need

Key focus for behaviour:
• To listen actively for aspects of patients’ customary spirituality and spiritual aspects of the episode of illness, handicap, etc.;
• To accept the other person, to be committed and compassionate, encouraging, empathetic, authentic, sensitive, sincere, unselfish and accessible, and to use touch;
• To use relevant conversation skills (e.g. support the patient after receiving bad news, explore aspects of transcultural communication).

Desired results:
To make patients feel understood in their spiritual needs and to give them the opportunity to express thoughts and feelings about their spirituality

a widow for ten years now. My husband died quite suddenly. He used to smoke this tobacco fervently. He even used this little box the very day he died. I have always kept it carefully. I still miss him every day and when I have too much sorrow, I open the tobacco box. Then I can smell the fragrances of the past, the fragrance of homeliness, togetherness and happiness. This little box has become very dear to me. Often it will suffice just to pick it up. It brings my husband back for a moment. And then I’m able again to go through another day. (Steemers 2001, p. 94-95)

We always ask very carefully, because not everybody wants nurses to know these things about them. So we first ask them: ‘Would you like us to mention your religion? Perhaps there will be times when we have to take that into account. Maybe you have certain dietary wishes, or want to worship on Sundays, or talk to a pastor?’ (Prins 1996)

A hospital chaplain: Right now, I’m running this way and that. Ideally, the nurse should offer the services of the hospital chaplaincy according to a diagnosis, from which you can work with the patient. At the moment, the information only comes my way when things are already starting to give trouble. That problem once used to be a slight difficulty, it is only that it was never noticed among the multitude of other difficulties.’ (Prins 1996, p. 99)

A condition for adequate referral is that the nurse in her co-ordinating role does not only direct the request to a hospital chaplain, but that she also talks to the patient prior to that. (Prins 1996, p. 102)

A nurse: When people see their disease as a punishment from God for something wrong they did in the past,

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<td><strong>A.4</strong> The nurse discusses with patients and team members how spiritual care is provided, planned, and reported.</td>
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<td>To help co-ordinate which health professionals could best provide the spiritual care needed for the patient;</td>
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- To determine and report (in writing) the patient’s spiritual needs.
- Desired results:
  - To make an assessment of the patient’s spiritual situation so that possible caring interventions meet the patient’s spiritual needs.

- To help co-ordinate which health professionals could best provide the spiritual care needed for the patient;
- To make use of nurses with the same conviction as the patient in providing spiritual care (when possible and desirable);
when illness is interpreted in religious terms, I always get a pastor involved. Meaning, when people’s spiritual background starts playing a role. That touches on religious themes, which are not my turf. (Prins 1996, p. 104)

As we speak, I am doing a bible group led by the hospital’s pastor. I never dared to speak about religious experiences, as they are often easily labelled as pathological and also because I was uncertain about them being ‘healthy’. I have experienced talking about them as a liberation of sorts. (Borsjes 2001, p. 48)

I never dared to tell this to anyone. When our baby died, my husband said there was no point in talking about it. ‘You won’t get it back by talking about it, you’ll only rip our wounds open’, he said. I have remained silent since that day. But that didn’t make my grief go away. On the contrary, it seemed to hold me in its jaws. I could not accept her death, I could not give it a place in my life. She was my little girl, the meaning of my life. Now that I have told my story the pain surges up again, but I also feel some relief. It is getting lighter inside me. It was not right to keep the lid on it all that time. If I release it, maybe I will be released. (Steemers 2001, p. 49-50)

Mr. G. has leukaemia. He has been admitted to the hospital and his situation is deteriorating rapidly. One day he asks if he could go to church on Sunday. He was raised a Catholic but has not gone to church regularly for many years. ‘I sense the need more and more every day to talk in silence. Sometimes to God; he once said. He kept a children’s bible in his room. Sometimes he asked a nurse to read a passage to him. He was too tired to read for himself. The church visit was also exhausting for him, but he said it meant a lot

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<th>B.5 The nurse provides spiritual care and evaluates it with the patient and team members.</th>
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<td><strong>Key focus for behaviour:</strong></td>
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<td>• To refer the patient to a pastor or another spiritual leader (when desirable) and see to it that contact is established;</td>
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<td>• To consult a pastor (if needed) in case the nurse has questions about spiritual care for the patient.</td>
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<td><strong>Desired results:</strong></td>
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<td>• To provide a multidisciplinary effort to meet the spiritual needs of patients.</td>
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I had already been caring for him for months. From his medical records I knew a little bit about his life, but he kept very much to himself. On my nightshift, I found him crying. I'd never seen any emotion from him and was very surprised. I was taken aback when I saw him weeping. I walked up to his bed, put my hand on his shoulder and asked 'Is there anything I can do for you?'. He shook his head, unable to speak. I reflected then on what I would like someone to do for me in such a sad situation. While I was standing there, I noticed his glass was empty. ‘Would you like a glass of water?’, I asked. He nodded. I fetched a fresh glass of water for him and put it next to him. I also gave him a few extra tissues and went away quietly. After thirty minutes, he rang. He thanked me for the water and the tissues and started talking. He allowed me to get to know him. I will never forget that man. (Steemers 2001, p. 50)

He was very restless. His hands kept moving around. I asked myself what I could do for him as a nurse. We could not talk anymore. We always maintained a good relationship. From our conversations I remembered he had a rosary. He was a Muslim and that’s why I remembered talking about the little rosary and prayer. I looked in his drawer and there it was. I took it out and put it in his hands. Then he calmed down. I saw his lips form words. He was praying. ‘Praying is being with God’, he once told me. I saw now that it was true. (Steemers 2001, p. 102)

A patient’s daughter: I don’t cry for my mother’s death, but because of everything that happened: that she never thanked me; that I never had the feeling that it was alright that I existed. I rather cry for the mother that

- To apply relaxation techniques;
- To coach family and friends with regard to spirituality e.g. giving information about facilities in the institution such as services of chaplains, supporting communication with the patient, monitoring their own feelings and emotions);
- To check if there has been enough attention to the patient’s story, if the patient’s need has been formulated adequately and if the care provided has been attuned sufficiently to the patient’s need.

**Desired results:**
To provide patients with professional spiritual care that meets their spiritual needs.
she was not, who I longed her to be. (Van den Berg 2001, p. 7)

In the public's eye the hospital is famous because of good publications and good research. We're the best academic hospital. In addition, good patient treatment statistics are very important to the staff. But if all that gets in the way of what treatment means to a patient, you are just on the wrong track. The hospital may get good grades for hotel services or whatever, but what happens in the dialogue between doctor and patient or nurse and patient is much more difficult to sell to the outside. That is the internal 'score'. Emphasis on that score depends on the person in charge. But if we do not increase our awareness of the personal care for people, we can no longer call ourselves a top-notch hospital. (Prins 1996, p. 107-108)

We have group meetings every two months. We take it in turn to present an experience we have had. At first we thought it would be very difficult. After all, it is not merely about a patient but also about your own experience with spirituality. Along the way we have learned that it can be very interesting and fun to discuss patients' experiences, how you interact with them, what you say and how. Our biggest mistake is that we want to be counsellors and advisors too quickly. It is a wonderful lesson that we give each other every time. We also learn that we all face the same questions and have the same doubts. (Steemers 2001, p. 106)

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<th><strong>C. Assurance of quality and expertise</strong></th>
<th><strong>C. 6 The nurse contributes to quality assurance and improving expertise in spiritual care in the organisation.</strong></th>
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- To address work problems in unit meetings and to coach colleagues with regard to spiritual care;
- To make policy recommendations about spiritual care supervisors and administrators;
- To implement projects for improvement of spiritual care.

Desired results:
To integrate spiritual care into the overall care process in the institution. |


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*Vignettes have been translated from the Dutch.*
Discussion

On the basis of this literature review, we have been able to formulate competencies that nurses need for providing spiritual care. Firstly, the following nursing interventions and activities regarding spiritual care are described in the nursing literature:

• The nurse is able to collect information about the patient’s spirituality and to identify the patient’s need
• The nurse is able to discuss with patients and team members how spiritual care is provided, planned, and reported.
• The nurse is able to provide spiritual care and to evaluate spiritual care with the patient and team members

Secondly, these requirements concerning the nurse’s professional attitude regarding spiritual care are described in the nursing literature:

• The nurse is able to handle their own values, convictions and feelings in her professional relationships with patients of different beliefs and religions
• The nurse is able to address the subject of spirituality with patients from different cultures in an caring manner

Thirdly, the organizational conditions for the provision of spiritual care are described as follows:

• The nurse is able to contribute to quality assurance and the expertise improvement regarding spiritual care in the organisation

Using the interventions and conditions from the literature review, the components of competencies understood in the abovementioned manner, yield the nursing competency profile for spiritual care as shown in the table.

Study limitations

On a theoretical level, it is still an open question how spiritual care fits into the realm of professional nursing responsibility. Although the first section of our paper provides an initial perspective, overlaps and differences between the expertise of nurses and pastors/chaplains are still unclear. As this issue is pertinent to interdisciplinary co-operation and referral, it deserves further investigation.
We are aware of the limited scope of the literature review itself and the small number of researchers making the selections. While saturation was reached after summarising 29 documents, it is hard to tell whether a much more comprehensive study might have different outcomes. However, our claim that our findings sufficiently represent much of the existing body of literature is supported by the fact that our competency profile resembles elements of well-grounded studies such as those conducted by Nayaranasamy (1999, 2001), Greenstreet (1999) and Cone (1997).

It is clear that the results of the literature review are not the results of a survey of clinical experience. The practical validity of the competency profile remains to be tested, for instance by interviewing nurses and patients in our own country. In addition, the research questions were general in nature; there was little distinction between fields of nursing, categories of health problems, or spiritual backgrounds of patients. Although the general structure of the competency profile may be useful, it might be the case that specific spiritual functioning differs across settings and contexts.

Conclusions

Implications for research

Taking these two limitations together, the following areas for research may be suggested. Firstly, patients’ expressions of spiritual function may appear differently in different health problems. This means that nurses may need different competencies when working in maternal and neo-natal care, care for people with disabilities, care of those with long-term conditions, care of the dying, and so on. Secondly, and related to the first point, various aspects of spirituality may differ across the settings in which nurses work. Their professional responsibilities and, thus, their competencies may vary in settings that range from community care, rural areas, and missionary work to ‘high-tech’, inner-city, acute, intensive care and academic hospital settings. Thirdly, in multicultural societies, nurses may have to deal with patients from different religious and cultural groups in different ways. Competencies appropriate to each of these three areas (problems, settings and culture) have received little attention. Further research is needed in these areas to provide solid bases for nursing competency profiles.
Implications for education

Lastly, how these competencies could be embedded in nurse’s development as professionals and what a competency profile for spiritual care in professional nursing means for nurses’ own personal spirituality are also matters of further investigation. If accepted, therefore, domains and competencies in our profile have implications for nursing education (McSherry & Draper 1997; Ross 1996). We will hint in some directions of possible further development and investigation.

First of all, this competency profile may provide a guideline for designing educational programs. It might serve as a backbone for a nursing curriculum in spiritual care. From the competencies, program objectives, module objectives and content could be developed.

Nursing students must learn to provide spiritual care in a systematic way. Curriculum components, for instance those addressing the nursing process and communication skills, should also address the variety of spiritual expressions in the patient’s behaviour. By way of case studies and role-playing essential aspects of spiritual care can be highlighted. Moreover, nurses will be expected to contribute to the contextual and organisational conditions for spiritual care, for instance by influencing staffing and building policy, as spiritual care takes time, personnel and private surroundings. This means nurses have to learn to perform quality assessments of nursing care and to produce policy recommendations for their effective management.

An essential condition for adequate spiritual care, seems to lie in the nurse’s use and awareness of self. Developing the right attitude in spiritual care needs to be aimed explicitly at handling the nurse’s own spirituality in relation to the patient’s spirituality. For this development relates directly not only to one’s skills of communication with the patient, but also to relating to a patient with different beliefs, to the limitations of sharing one’s own faith with a patient, and to coping with conflicts in one’s own conscience.

One form of education that may support such attitude development is the “reflective education” model. Reflection is to be understood as considering and critically...
reviewing one’s own conduct, emotional responses and thoughts with the purpose of learning from these experiences and putting this learning experiences to future use in a conscious manner. It is a way of structuring one’s own experience in a clinical situation, involving real life problems, in their context, through reflection, by interacting with other learners.

Such a model offers opportunities to encourage reflection, involving explicitly the student’s full personality. To state the point in relation to spiritual care: spiritual care means support of the patient’s spiritual function, but it also requires support of the nurse’s own spirituality. Those two are connected in the patient-nurse relationship. Reflection will have to make that connection transparent for the students. They must become aware of their values and convictions and of the way these are entangled with the care they provide.

Although work remains to be done in different directions, we believe a valid attempt has been made to outline extant information. Especially in the area of education, some important challenges for the development of professional nursing appear. This paper is intended as a contribution to this development.

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References


