Spirituality 1: should spiritual and religious beliefs be part of patient care?

Although spirituality is a difficult concept to define, supporting patients’ individual spiritual needs may help them to cope with their illnesses and contributing to the local community. Religion may influence the development of such relationships or there may be no religious association. Religious practices include prayer, attending religious services and being an active member of the religious community.

In the Royal College of Nursing’s survey (Funning, 2010) only a few nurses (6%) believed that spirituality only involved going to a place of worship. Spirituality was seen to be a fundamental aspect of nursing and the majority of respondents believed that spiritual care also applied to atheists and agnostics. The most important spiritual needs were identified as:

- Respect for privacy, dignity and religious and cultural beliefs;
- Taking time to give patients support and reassurance, especially at times of need;
- Showing kindness, concern and cheerfulness when giving care;
- Allowing patients to discuss anxieties or fears.

DEFINING SPIRITUALITY

There is no single definition of spirituality and this is illustrated by the two dictionary definitions given in Box 1. Koenig (2007) highlighted two difficulties encountered when defining spirituality:

- Atheists may have great meaning, purpose and high personal values in their lives and ways to meet these needs should be considered.

PRACTICE POINTS

- Differentiating between spiritual and religious needs is complex; patients may be non-religious but still spiritual.
- Spiritual and religious beliefs are individual and vary between people.
- The predominant concept of spiritual needs is a sense of meaning and purpose in life and seeing the patient as a person.
- Nurses need to explore ways of assessing patients’ spiritual needs.
- Strategies to meet these needs should be considered.

A recent survey of 4,000 nurses identified that meeting patients’ spiritual needs is extremely important and improves overall quality of nursing care. However, only 5% of respondents felt they achieved this goal (Funning, 2010).

Although nurses appear to be aware of spiritual needs, a lack of clear definitions and practical guidance means they are often uncertain about how these can be addressed as part of clinical care. This is supported by Balboni et al (2007) who, in a study of 230 patients with advanced cancer from diverse ethnic backgrounds, found that 72% felt their spiritual needs were not or were only minimally supported by healthcare systems.

The term “spirituality” is often associated with religion and, while they overlap and can interlink, the two are not synonymous. A person may be deeply spiritual but have no affiliation with any particular religion. Spirituality is about meaning in life and relationships to others (including a god or gods) and can be expressed in many ways including music, art, nature, community or family. Spiritual practices include meditation and yoga, or undertaking voluntary work and contributing to the local community. Religion may influence the development of such relationships or there may be no religious association. Religious practices include prayer, attending religious services and being an active member of the religious community.

BOX 1. DICTIONARY DEFINITIONS OF SPIRITUALITY

- The English Encarta dictionary (Microsoft, 2002) defines spiritual as:
  - “Of soul – relating to the soul or spirit, usually in contrast to material things;”
  - “Of religion – relating to religious or sacred things rather than worldly things;”
  - “Temperamentally or intellectually akin – connected by affinity of the mind, spirit or temperament.”
- Mosby’s (2005) Dictionary of Complementary and Alternative Medicine defines spirituality as: “An individual’s quest for understanding the true meaning of life and the desire to integrate with the transcendent or sacred. May or may not arise from or lead to community formation or ritual observance.”

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Despite spirituality being an important aspect of patient care, few nurses feel they meet patients’ needs in this area. This first in a two part series examines definitions of spirituality and the difference between this concept and religion. It also discusses spirituality at certain points in the patient pathway, such as at the end of life, and finding meaning in illness.
experience connectivity with others, yet deny being spiritual or religious;

- Defining spirituality as psychological wellbeing, associates it directly with mental health, making interpretation of the relationship between spirituality and health, especially mental health, impossible.

Koenig suggested that the term spirituality should refer to the sacred when it is used in research.

Sessanna et al (2007) argued that, in order to recognise spiritual wellbeing or spiritual distress, it was necessary to clearly define spirituality, otherwise holistic healing processes would be misunderstood. In a concept analysis of the definition of spirituality in nursing and health related literature, these authors found the following four themes:

- Spirituality as being the same as religion;
- Spirituality as meaning and purpose in life as well as connection with others;
- Spirituality as non-religious belief and value systems;
- Spirituality as transcendent or metaphysical.

It is apparent from these themes that spiritual needs can be completely non-religious or incorporated with religious beliefs.

To completely exclude religious aspects or separate them from spiritual needs could be detrimental to some patients simply because their spiritual needs are religious in nature. Equally, including religious perspectives for atheists would be inconsiderate. Hence spiritual needs consist of more than those associated with religious worship and are highly individual for each patient.

The predominant theme of spirituality is meaning and purpose in life. For many patients this could mean their family, significant people in their lives, friendships, life achievements, their career, anything they consider sacred or anything of which they are proud.

When addressing spiritual needs, it is essential to take a genuine interest in the patient as a person, show concern and kindness, have empathy with them, take the time to listen and respect their point of view. Some patients may find it difficult to express spiritual concerns and use questions such as:

- If I die, how will my family cope?
- What happens when I die?
- Is there an afterlife?

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<th>BOX 2. CASE STUDY 1</th>
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Katy Robinson (not her real name) is 18 years old and was admitted to the plastic surgery department following an injury to her leg. She was terrified and could not move as her leg was swollen. She had never been in hospital before and was now facing the possibility of losing part of her leg or not being able to walk again.

Ms Robinson was feeling vulnerable: “I remember one of the older nurses sitting with me and trying to talk to me when I first came in but I was still in shock. I have no idea what she said to me. I was terrified of never walking again, never being able to work and not being able to find a boyfriend – why was this happening to me? “She must have realised I was in need of help because the next day another younger nurse suddenly appeared at my bedside. She was lovely, she asked if I was OK and was there anything I wanted to talk to her about? She was really nice to me and spoke to me in a very reassuring way. She really did help me, I can’t explain how. She was a big help to me at the time and I used to like having chats with her. Although she was rushed off her feet, she made the effort to come and see me. “It was about making me feel cared for; I think it gave me a more positive outlook on things. I don’t think I’d have coped without her kindness.”

Comment The first nurse immediately recognised that Ms Robinson had anxieties that she was unable to express. This was handed over to the next shift and another nurse paid attention and showed genuine concern for her. This nurse established a rapport with Ms Robinson and showed she cared, encouraging her to open up and discuss her worries. By talking to the nurse, Ms Robinson felt reassured and better able to cope with her situation.

<table>
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<th>TABLE 1. FEATURES OF SPIRITUALITY AND RELIGION</th>
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<td><strong>Spirituality</strong></td>
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<tr>
<td>- Relating to spirit or soul</td>
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<td>- Referring to those things that are sacred, rather than material</td>
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<td>- Quest to understand the true meaning of life</td>
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<td>- Desire to integrate with that which is transcendent or sacred</td>
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<tr>
<td>- Relating to interconnectedness with others</td>
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<td>- May or may not arise from or lead to community formation</td>
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**How will my children manage without a mother/father?**

**Who will look after my business while I am in hospital?**

**Who will care for my elderly parents?**

Gentle enquiry into what is wrong may provide patients with an opportunity to discuss any worries. Non-verbal actions can also indicate whether they have anxieties or concerns. An example of how spiritual needs may be expressed and addressed is illustrated in case study 1 (Box 2).

Religion is much easier to define and most sources agree that it is “belief in worship of or obedience to a supernatural power considered to be divine or to have control over human destiny” (Collins English Dictionary and Thesaurus, 1995).

Table 1 highlights some of the differences between religion and spirituality, although the lists show that the terms are also interconnected. The most obvious difference between spirituality and religion is the religious belief in the divine and worship of and obedience to an all seeing, all powerful, all controlling god or set of gods.

**WHY ARE SPIRITUALITY AND RELIGION IMPORTANT?**

In a culturally diverse and multifaith society, spirituality is highly subjective and means different things to different people. It gives meaning to life, provides hope, gives a reason to live and can influence health (Wilding, 2007).

There is mounting evidence to show that spirituality and religion play a critical role in how patients cope with illness. In a meta-analysis of more than 1,200 published studies on religion, spirituality and health, substantial evidence was found to support the idea that spiritual and religious beliefs are used to cope with illness and result in positive outcomes (Koenig et al, 2001).
Religious beliefs have also been shown to be a positive influence on mental health outcomes such as suicidal behaviour, wellbeing and substance misuse (Moreira-Almeida et al, 2006). There are many reasons for this including the impact of religious and spiritual views on lifestyle; for example, religious people may be less likely to drink alcohol, take drugs or engage in promiscuous sexual practices. Social support from religious and spiritual groups may also have a beneficial effect on lifestyle and health.

While religion has a predominantly positive effect on health, it also has negative associations. Weaver and Koenig (2006) identified negative effects such as delays in seeking medical treatment, feelings of excessive guilt, abuse by religious advocates and religious factors often being part of psychosis. Feeling judged, criticised or ostracised by a religious community can also have a negative impact on health.

**SPIRITUALITY AT THE END OF LIFE**

A search of health-related literature shows that most articles on spirituality are in the context of end of life care. Balboni et al (2007) showed that meeting spiritual needs was associated with improved quality of life and suggested that spiritual care could enhance patient wellbeing at the end of life. Spiritual and religious views can contribute to the decision making process at the end of life and links have been found between religious and spiritual beliefs and the wish for aggressive, high risk end of life measures such as ventilation and cardiopulmonary resuscitation in patients with advanced illness (Phelps et al, 2009; Balboni et al, 2007; True et al, 2005). For example, a patient with advanced cancer might agree to invasive ventilation or cardiopulmonary resuscitation in the event of a cardiac arrest because they believe that God has not given up. Phelps et al (2009) argued clinicians should consider patients’ spiritual or religious beliefs when a prognosis of death and treatment plan is discussed, as the process of accepting there is no value in treatment and preparing for death may challenge spiritual beliefs.

It may be appropriate to involve chaplains or other professionals such as psychologists or counsellors to investigate beliefs coping mechanisms at the early stages of disease. These professionals may also help liaise with families when patients cannot voice their opinions, such as in intensive care.

**SPIRITUALITY IN OTHER SITUATIONS**

The role of spiritual and religious beliefs is not restricted to end of life care; they are important and beneficial in a variety of clinical contexts including:

- Treatment of depression (Wittink et al, 2009; Bekelman et al, 2007);
- Arthritis (McAuley et al, 2008);
- Chronic pain and fatigue (Baetz and Bowen, 2008);
- Mental health (Wilding, 2007);
- Medical patients including those with advanced cancer or chronic obstructive pulmonary disease (Steinhauser et al, 2006);
- Hypertension (Gilliam and Ingram, 2006);
- Heart failure (Griffin et al, 2007).

Spiritual needs apply to people of all ages, not just older people and those approaching death. They have an important role in suicide prevention in adolescents (Goldston et al, 2008) and adolescents with chronic illness (Cotton et al, 2009).

Yanez et al (2009) argued that supporting both spiritual and religious aspects of care is important as they empower patients to find meaning and peace resulting in improved outcomes. Women who had recently completed treatment for breast cancer who had meaning in life were less likely to have depression and showed increased vitality than those who had a religious faith but had low meaning in life.

In patients with advanced medical illness, Steinhauser et al (2006) emphasised the importance of being at peace when making crucial medical decisions and of emotional and spiritual wellbeing.

Krupski et al (2006) examined faith and higher meaning/peace in relation to quality of life and found that faith was unrelated to outcomes, whereas having a higher meaning in life correlated to having a higher quality of life. This suggests that finding meaning in illness is more advantageous than religious faith.

**FINDING MEANING IN ILLNESS**

Exploring the meaning of illness can give patients a different perspective on their life. Sometimes illness can give people time to think and in serious illness they may re-evaluate their life and give renewed value to those around them. The pain and difficult emotions experienced during illness may highlight the need to have the support of others (Moore, 2010). Patients may use their illness as an opportunity to live life differently or lead a less stressful life.

They may find the process of facing their mortality enhances their appreciation for what they have and motivates them to make new plans for their future. Nurses can provide psychological support and help patients explore the meaning of their illness and transform a frightening situation into something with a positive outcome, giving patients something new to focus on. This is illustrated in case study 2 (Box 3).

**CONCLUSION**

Differentiating between spiritual and religious needs is not easy. Some patients may be non-religious but still spiritual while others may have spiritual needs that are religious in nature.

It is clear that spiritual and religious beliefs are individual and vary greatly between people. The predominant concept of spiritual needs is a sense of meaning and purpose in life and addressing them successfully means seeing the patient as a person and not just a medical condition.

The benefit of meeting patients’ spiritual needs is apparent from the growing body of

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**BOX 3. CASE STUDY 2 – CONVERSATION BETWEEN A PATIENT AND A NURSE**

**Patient:** “I’ve been feeling so vulnerable and down the past few days – why me? Why have I been put through all of this? What’s the purpose of this tumour? Is there a big message in all this for me?”

**Nurse:** “Mmm… that’s a possibility. What do you think the meaning of this is?”

**Patient:** “It’s made me realise what great friends I have; they’ve all been here to support me… Also the tumour was adhered to the stomach… I comfort eat a lot.”

**Nurse:** “When do you comfort eat? What’s going on in your life when you comfort eat?”

**Patient:** “I do it when I’m stressed.”

**Patient:** “I was going to do the tumour was adhered to the stomach… I have; they’ve all been here to support me… Also the tumour was adhered to the stomach… I comfort eat a lot.”

**Nurse:** “So does that mean anything to you?”

**Patient:** “Yes, that’s it. Of course! My body is trying to tell me to slow down and restrict the stress in my life. Why couldn’t I see that sooner? You know, I had so much time to think while I’ve been in hospital. I need to start making time for me when I go home and the first thing I’m going to do is go on a nice holiday in the sun.”

**Comment**

The nurse allowed the patient to find the meaning to illness herself. The nurse not only actively listened but also asked questions that encouraged the patient to search for a deeper meaning, thus empowering her to come to a positive conclusion.
evidence in health-related literature. Feelings of wellbeing appear to be associated with positive outcomes. Nurses are ideally placed to contribute to positive health outcomes through their interactions with patients, and often do this well without realising it.

It is important to explore ways of assessing patients’ spiritual needs and define whose role it is to make such assessments. Implementing strategies to meet patients’ spiritual needs, including involving other members of the healthcare system such as psychologists, counsellors and hospital chaplains, must also be considered.

Part 2 of this series, to be published in next week’s issue, gives an overview of assessment and ways of addressing spiritual needs in practice.

REFERENCES


