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Nurses' Spiritual Care Practices: Becoming Less Religious?

By Cheryl Delgado

Abstract: *Research indicates that nurses do not consistently provide spiritual care, feel ill equipped to do so, and there is a lack of information as to the type of spiritual care practices nurses use. This exploratory descriptive study surveyed nurses (N = 123) about their spiritual care practices and perceptions of effectiveness, followed by qualitative interviews with volunteers (n = 5) from the surveyed group. The nurses favored spiritual interventions that are not overtly religious, but conveyed concern and support, such as listening and providing comforting touch.*

Keywords: *nursing, nursing interventions, religion, spiritual care, spirituality*

Spiritual care is recognized as an important facet of holistic care, mandated by nursing organizations worldwide (American Association of Colleges of Nursing, 2014; American Nurses Association, 2001; International Council of Nurses, 2012). A decade ago, there were reports that spiritual care was neglected, that nurses felt unprepared to provide such care, and that some nurses questioned the legitimacy of spiritual care as a nursing function (i.e., Meyerhoff, van Hofwegen, Harwood, Drury, & Emblen, 2002; Narayanasamy, 2004). A current literature search on spiritual care in nursing reveals increased interest and research on spiritual care.

We know from research that spirituality is individually and variously defined among nurses and other healthcare practitioners, yet is distinct from religiosity (Delgado, 2007; Sulmasy, 2009). This difference in definitions is reflected by the establishment of distinct nursing diagnoses recognized by the North American Nursing Diagnosis Association (NANDA) related to spirituality and religiosity (Burkhart & Solari-Twadell, 2001; NANDA, 2015). Spiritual care practices refer to a broad range of interventions that reflect a holistic perspective, and can include actions that address a patient's existential concerns, as well as the patient's attention to the fulfillment of religious obligations. Emblen (1992) stated religion as used in the nursing literature "refers to faith, beliefs and practices that nurture a relationship with a superior...power" (p. 43).

Information on specific religious practice often is encountered in nursing when cultural concerns, cultural sensitivity, or cultural competency is discussed.

It also has been established that spiritual beliefs and values influence patients' perceptions of illness and affect how patients make treatment decisions and cope with the challenges of illness (Delaney- & Barrere, 2008; Hilbers, Haynes, & Kivikko, 2010), and self-rate quality of life (Smith et al., 2011). Some studies have documented positive physiologic outcomes with significant associations to spiritual or religious coping and support (Ironson, Stuetzle, & Fletcher, 2006; Mystakidou et al., 2008; Trevino et al., 2010). One implication of this is that the beliefs of the healthcare provider may affect the discussion of treatment options with patients (Anderson, 1999) and ultimately their healthcare choices.

The Joint Commission (TJC) has established that an assessment of spiritual needs is necessary for hospitalized patients but does not state what the content of that assessment must include, although general guidelines are given (TJC, 2008). Based on an international literature review, Van Leeuwen and Cusveller (2004) developed domains for nursing competencies in spiritual care that are general rather than specific (communication, self-awareness, and caring). More specific primary interventions for spiritual care have been grouped into basic categories by several authors, and Nursing Intervention Classifications (NIC) have been developed in association with NANDA diagnoses (Bulechek, Butcher, Dochterman, & Wagner, 2012; Delgado, 2007; Tanyi, McKenzie, & Chapek, 2009). These categories include assessment of spiritual needs, therapeutic communication, assisting in spiritual activities, and providing physical care. However, we know less about specific spiritual care practices and their use by nurses in practice. Specific spiritual care practices have received little attention, with the exception of prayer, which is seen as problematic in some circumstances (French & Narayanasamy, 2011).

Exploring Spiritual Care Practices

This study attempted to identify the spiritual care practices that nurses actively use in practice and how effective nurses perceive these practices to be. It also asked nurses if they felt prepared to provide spiritual care and how comfortable they were in providing care for persons who shared their beliefs and with persons who believed differently. For this investigation, spirituality was not defined by the researcher, and suggestions for spiritual care practices included religious activities that applied to one or more of the major religions, as well as activities that could be applied more generally to persons with no clearly identifiable spiritual base. It is understood that nurses care for persons of many different or of no faith, and that the care they provide is a measure, in part, of their own spiritual journey. Thus, the perceptions examined in this study were those of the nurse, not the recipient of care. Permission from the appropriate Institutional Review Board was obtained prior to the onset of the study. The study used quantitative (survey) and qualitative (interview) methods to collect data in two phases. Data were collected in the winter months between 2012 and 2013.

In Phase One, Registered Nurses who were baccalaureate or RN-to-BSN graduates of a Midwestern university school of nursing were recruited by direct e-mail from a list of graduates and currently-enrolled graduate students who had an active license to practice nursing. Additional Registered Nurse participants for Phase One were recruited from members of the Ohio League for Nursing by a general announcement in the League's on-line newsletter that directed them to the on-line survey. This recruitment method has an inherent assumption that respondents are Registered Nurses and active in the profession. There were no exclusions based on age, gender, education, or practice area. Nurses who were both alumni and members of the League were asked to complete a survey only once.

The nature and purpose of the study was fully explained in the open recruitment letter that contained a link to access the on-line survey. This letter contained information needed for an informed consent, and submission of the survey was considered to be understanding and agreement to participate. A total of 123 Registered Nurses participated in the study's quantitative component.

Participants for Phase Two interviews were recruited from the participants in Phase One. The final question on the survey asked for volunteers to participate in an interview to discuss further the topic of spiritual care practices. A telephone number and e-mail address were provided to contact the researcher. In the second phase, volunteer participants met with the Principal Investigator in one-on-one interviews that were audio-recorded. Prior to the start of the interviews, an informed consent was read by participants (or read to participants who were telephone interviewed), and participants indicated understanding and willingness to volunteer by signing the consent form or verbally assenting. In two cases, at the request of the participant, interviews were completed by telephone. The one-on-one interviews lasted 45 to 80 minutes, and all were done with the Principal Investigator. Only five nurses volunteered for the qualitative interviews, but they represented a variety of practice settings. Transcripts of the interviews were analyzed, and this qualitative data enriched and added to the interpretation of quantitative findings.

Spiritual Practices Survey

The quantitative Spiritual Practices Survey for Phase One was comprised of 22 questions; some questions would accept multiple responses. Research indicates that differences exist in spirituality, religious orientation, and psychological adjustment related to age, ethnicity, and children in the family structure (Brown et al., 2010; Cowlinson, Niele, Teshuva, Browning, & Kendig, 2013; Miner, 2009; Mystakidou et al., 2008). Therefore, demographic data including age, gender, race/ethnicity, marital and employment status, job title, family income, number of children, education, and religious affiliation were requested. Additional questions asked about degree of activity in religious affiliations, and if the participant considered him- or herself a spiritual person.

Questions directed at nursing practice asked if the nurse had cared for persons: of the same faith; of a belief tradition different from their own; then asked the nurses' comfort level in doing so. A list of 14 specific spiritual care interventions (Table 3) was developed based on spiritual care competencies (van Leeuwen & Cusveller, 2004), NIC (Bulechek et al., 2012), and Nursing Outcome Classifications (Moorhead, Johnson, Maas, & Swanson, 2012), and categories of spiritual care identified in the literature (Delgado, 2007). Participants were requested to indicate all intervention they had used with patients from both their own and different belief systems and then to indicate what specific interventions they thought most effective. Space was provided to list "Other" spiritual care interventions; however, no participants listed any interventions beyond the 14 provided in the survey.

To gather information on professional preparation for providing spiritual care, participants were asked if spiritual care had been a part of their nursing education and if they believed spiritual care to be a legitimate concern for nurses. Participants also were asked if the spiritual care they provided to patients was initiated by the patient, the nurse, or a third person. The complete Spiritual Practices Survey is available on-line as supplemental digital content at <http://links.lww.com/NCF-JCN/A42>.

In Phase Two, a script of open-ended questions was followed for the interviews:

1. Please share your experiences of providing spiritual care for patients.
2. Do you believe that spiritual care is important?
3. Do you believe that other nurses and patients feel that spiritual care is important?
4. How do your personal beliefs inform the spiritual care you provide?

Additional questions to clarify and encourage disclosure, along with verbal and nonverbal communication techniques such as facilitation, were used during the interviews. The audiotapes were transcribed, and confirmation of the accuracy of the transcriptions was made by reviewing the transcript while listening to the audiotape and making corrections as necessary.

Quantitative data were originally obtained in the form of a Microsoft Excel spreadsheet without any participant personal identifiers from the on-line survey managers. These data were transferred to a database in the SPSS PASW 18 statistical program for analysis. Data were primarily nominal, with some ordinal level data. Descriptive frequency and percentage statistics were used for analysis in Phase One.

Phase Two analysis consisted of content examination of the transcripts obtained by interviews. Common threads or themes were uncovered and compared to the quantitative findings. Quotes from the interviews were used to aid in the interpretation of quantitative data and to illustrate and support the themes identified. From this process, three major categories evolved.

Table 1. Participant Religiosity and Spirituality

Response Choice:	Active in Own Faith	Consider Themselves Spiritual
Very active	29.3%	48.8%
Somewhat active	17.1%	31.7%
Average in activity	11.4%	13.0%
Not very active	22.8%	4.9%
Not at all	19.5%	1.6%

Table 2. Experience of Caring for a Person of a Different Faith

Cared for person of another faith		Comfort in caring for a person of another faith	
Often	60.2%	Very comfortable	57.3%
Occasionally	33.9%	Somewhat comfortable	30.8%
Rarely	3.4%	Neither comfortable nor uncomfortable	8.5%
Never	2.5%	Not very comfortable	3.4%
		Very uncomfortable	0%

Survey Findings

Most respondents were female (94.3%) and middle-aged (mean 48.5, range 26-78years). Caucasians comprised 8-1.9% of the sample, African Americans 9.7%, and Asian-Pacific Islanders, Native Americans, and those who self-identified as "mixed" heritage were also represented. More than half of the respondents were married (67.7%) and had children (mean 1.7, range 0--5). The mean annual family income for the sample was \$98,000, ranging from \$0 to \$500,000. Most were employed full time (77.4%) and working in patient care areas (69.1%), 21.1% were educators, and three (2.4%) identified themselves as ministry workers or volunteers. All respondents held baccalaureate or higher degrees (BSN 50.0%, MSN 39.3%, and PhD 9.0%).

Participants reported themselves to be 42.3% Catholic (Roman and Orthodox), 45.5% Protestant, and 4.1% Jewish; 2.4% were agnostic or atheist. No participant identified with an Islamic, Buddhist, or Hindu faith. The responses to a question of how active they were in their religious faith showed a somewhat bimodal distribution, with less than half saying they were "somewhat" or "very" active in their faith (46.4%), although the majority of participants (89.5%) considered themselves to be "somewhat" or "very" spiritual (Table 1). A great majority (94.1%) had provided care for a person of a faith different from their own, and most (88.1%) were comfortable in doing that (Table 2).

Spiritual care was initiated most often by the nurse (59.8%), requested by the patient slightly more than one-third of the time (35.0%), and by third persons such as family least often (5.1%). The nurses felt strongly that spiritual care is a legitimate part of the profession (92.4%), with less than 6% (5.9010) unsure. A small number of nurses (11.5%) reported that spiritual care had not been included in their professional education. Most reported that spiritual care had been mentioned but not taught (38.3%), some reported that spiritual care had been mentioned but not emphasized (34.2%), and slightly more than one-tenth (11.7%) said it had been thoroughly covered.

Spiritual care practices and the nurse's self-reported perceived effectiveness of the practice are summarized in Table 3. Nurses most often reported listening to patients to provide support or comfort (91.5%) and used physical contact such as hand holding, hugging, and nonsexual touch for comfort and support (84%). Assessing spiritual needs (80.2%) and communicating those needs to other healthcare providers were activities done frequently, especially for patients of another faith (72.6%). Contacting a spiritual advisor was identified as the fourth most frequent practice, followed by assisting the patient to maintain dietary restrictions, more often done for a patient of a different faith (54.7%). Allowing time, privacy, and providing material for spiritual practices (72.7%) were perceived as effective and done more often than engaging in "meditation and prayer" with patients. More nurses prayed for (54.7%) rather than with (46.2%) patients, but the percentage of nurses who perceived "meditation and prayer" as effective (34.2%) was lower than the actual number of nurses who engaged in this activity (46.2). Although listening to a patient's concerns was considered effective (78.6%), more nurses listened than believed in the effectiveness of this practice, and listened more to patients of a different faith (85.5%) than to patients who shared their belief system (80.9%).

Table 3. Nurses' Spiritual Care Practices: Utilization and Perceived Efficacy

Spiritual Care Practice*	% Who used this for patient of different faith	% Who used this for patient of same faith	% Who perceived practice as effective
Listened to a patient to provide support or comfort	91.5	85.5	88.0
Listened to the patient's concerns	85.8	80.9	78.6
Assessed the patient's spiritual needs or asked about their spiritual concerns	80.2	70.9	73.5
Provided physical contact for support or comfort (holding hand, hugging, hand on shoulder)	84.0	70.9	67.5
Contacted a spiritual advisor on behalf of the patient	68.9	61.8	61.5
Communicated with other caregivers regarding the patient's spiritual assessment or needs	72.6	54.5	54.7
Allowed time or privacy for spiritual practice or rite	58.5	48.2	53.0
Allowed time for meditation or prayer in the patient's schedule	49.1	40.9	51.3
Assisted patient to maintain dietary restrictions	54.7	30.9	40.2
Medicated or prayed for a patient without their knowledge	54.7	53.6	35.9
Medicated or prayed with the patient	46.2	42.7	34.2
Contacted a family member or friend of the patient regarding the patient's spiritual assessment or needs	30.2	33.6	30.8
Provided spiritual texts for reading	18.9	18.2	19.7
Provided physical materials for spiritual practice or rite	14.2	12.7	17.1

*Spiritual care practices are listed in order of perceived effectiveness.

Interview Findings

Analysis of interview transcripts revealed three shared areas that were important to the interviewees: (1) personal spirituality and experiences that shaped practice, (2) respectfully connecting with patients, and (3) ambivalent attitudes of other providers regarding spiritual care. Nurses who were interviewed and a large majority of the survey respondents felt that spiritual care was a legitimate nursing responsibility. In the interviews, this was often connected to a holistic point of view that spiritual care was "caring for the whole person," and "part of me... (I) cannot be a nurse without being spiritual, and I cannot be spiritual without nursing." One nurse who worked directly with patients stated, "Caring is spiritual...My spirituality has no limits from my faith base; spirituality transcends."

Reinforcing the survey finding that physical contact was a popular nursing intervention, the interviewed nurses reported "being there," "going to people," and "reaching out respectfully" as most commonly-used practices. Physical contact was perceived to create a connection that communicated comfort and safety. One nurse stated, "I am not a hugger, but I hug patients sometimes," and another said, "For that moment [the hug], they are surrounded and nothing can hurt them."

Stressful situations often overwhelm patients and families, and nurses relied on their knowledge of various cultures, but were cautious about stereotyping patients. "I try to avoid making any kind of assumptions about their [patients'] spirituality or even if they have any spirituality." Nurses learned spiritual care practices from experience, and it was common to ask a nurse with experience in caring for patients from a particular faith to care for all such patients. "Because I worked for a Jewish hospital at one time, everyone felt I did it [cared for Jewish patients] better." Life experience also was considered a factor in providing spiritual care. "Experience makes you more adept at seeing certain things."

This illustrates the ambivalent atmosphere in healthcare noted by the interviewees. When asked if they felt that other nurses felt the same about spiritual care as they did, they responded "yes and no." There were two stories where the nurses reported "getting in trouble," one for "praying with a patient" at the patient's request, and another for honoring a Native American family's request not to have a stillborn infant photographed according to the hospital policy; as the parents believed that photographs would steal the soul. The interviewed nurses felt their colleagues were caring but afraid to offend. One stated, "Spirituality is right there with sexuality. Nurses compartmentalize and don't talk about it."

Less Religious Spiritual Care

Nurses in this study favored spiritual interventions that are not overtly religious, but conveyed concern and support through things such as providing physical care and comforting touch. Perhaps nurses felt reluctant to approach religion-oriented discussion out of respect for the patient's personal spiritual beliefs. This is a slightly different finding from Grant (2004), who reported that prayer was used more frequently as a nursing spiritual intervention, but it is understandable as a reflection of the "religionlessness" of mainstream Western society described by Salander (2006). Two of the nurses interviewed spoke of their reluctance to discuss religious beliefs with patients because they feared their employer would consider this action proselytization and would discipline them as a result. In the interviews, this emerged from nurses who worked both in publicly-supported medical centers and in those with a clear religious affiliation. Nurses expressed more comfort in responding to conversations that originated with the patient.

Although previous research has reported some nurses feel uncomfortable in providing spiritual care and attributed this to lack of knowledge, among other factors (Chan, 2010), the nurses in this survey were comfortable in providing care and often took the initiative in doing so when they recognized spiritual distress or when they anticipated that phenomenon. Some findings from this study may reflect a shift in the degree and nature of spiritual care practices provided by nurses. This study found that nurses felt confident in providing competent spiritual care, which disagrees with McSherry and Jamieson's (2011) position that nurses are not well prepared, but concurs with the findings of Kociszewski (2004) that spiritual care was imbedded in everyday nursing practice as integral nurse behaviors. The connection

between spiritual care, spiritual care content in nursing education, and spiritual care competence needs further exploration.

An interesting question raised by the findings is why nurses engaged in spiritual care practices in which they expressed less confidence, specifically meditation and prayer. Participants were asked, "Which of the following spiritual care practices do you believe the most effective?" and 14 response options were provided, two of which were, "Meditated or prayed with the patient" and "Meditated or prayed for a patient without their knowledge" (Table 3). Roughly half of the nurses said they did these things with patients of the same or different faith, but only a third thought the practice effective. It is impossible to know how respondents viewed "meditation and prayer," meaning, Did they see meditation and prayer as the same or different? If they saw meditation and prayer as different, it is not clear which practice they were responding to when they chose this option. That the nurses meditated and prayed with patients might be attributable to a desire to be respectful and supportive to patients, but they also engaged in meditation/ prayer for a patient without the patient's knowledge, when they did not express confidence in the efficacy of this action, as well. This finding appears to indicate some ambiguity in which the nurse may choose to pray for the patient without scientific evidence of effectiveness of this care practice as a last resort, or as an action that might do good, but could do no harm. Additional research is needed to determine the actual effectiveness of commonly-used spiritual practices, such as meditation and prayer so that best practices can be identified. It is recommended that prayer and meditation be asked as separate interventions in future research.

The generalizability of study findings is limited to nurses with baccalaureate degrees from a Midwestern college. Study limitations include a sample that may have self-selected for nurses who are more comfortable with spiritual care. The sample also is skewed toward nurses with baccalaureate degrees or higher as a function of the recruitment method that sought participants from the graduates of a university school of nursing and a professional nursing organization. However, because the school of nursing has included an RN completion program for more than 25 Years, a number of the alumni participants may have begun their nursing careers at an Associate Degree or Diploma level. Another factor that may have affected the responses of participants is the ethnic diversity of the community in which the study was based, although this is mediated by the knowledge that many alumni participants are now practicing in other states and in the armed forces abroad.

Conclusion

The findings of the survey and the illustrations from the interviews indicate that nurses feel strongly about providing spiritual care as part of a holistic practice. They learn from their personal spiritual faith system and nursing experience how to provide spiritual care comfortably. This is congruent with the findings of Vance (2001) that nurses consider themselves spiritual persons.

Participant responses indicate sensitivity to patients of a faith different from their own, as indicated by the finding that a greater number of spiritual interventions were enacted for patients of a different faith than for patients of the same faith as the nurse. The nurses in this study were concerned with patients' spiritual and emotional needs and were aware that cultural and religious factors impact care and patient outcomes. This study presents evidence that nurses do initiate and engage in a variety of supportive spiritual care practices and feel competent to do so. However, they may favor spiritual interventions that are not overtly religious.

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