Chapter 5

Spirituality

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Finding spiritual meaning {in a chronic illness} is welcoming my lungs into the wholeness of my individual. My lungs are not "the other," but all is part of the whole. Spiritual meaning is about accepting and loving myself as a whole individual. It's honoring the self and body. Life is a journey.

—Mary, living with pulmonary hypertension

Introduction

An individual living with chronic illness experiences many complex emotional feelings that may include frustration, depression, or anger (Lorig et al., 2012). These feelings can lead an individual to feel overwhelmed with the self-management tasks and skills he or she needs to learn to effectively manage the condition. Spirituality is one source of comfort and support that can help an individual cope with the stress and anxiety of chronic illness (Lorig et al., 2012). People can use spirituality to find meaning in chronic illness, which in turn may help them interpret their illness in a positive manner (Lorig et al., 2012).

Consideration of spirituality as a supportive intervention in chronic illness leads to many questions. What are the spiritual care needs of individuals with chronic illness? What is known about nurses and spiritual nursing care? How can nurses meet the spiritual needs of their patients with chronic illness? This chapter addresses these questions and identifies the role of spiritualty in the management of chronic illness. Nursing and healthcare organizations mandate integration of spiritual needs in care plans. The *Code of Ethics for Nurses with Interpretive Statements* by the American Nurses Association (2001), for example, includes statements concerning spiritual care needs. For instance, Provision 1.2 of the *Code of Ethics* requires that an individual's "value system and religious beliefs should be considered in planning health care with and for each individual" (p. 7). The Joint Commission (2013) states that an individual has the right not to be discriminated against due to religion or culture.

National surveys indicate that spiritual beliefs are important to Americans. A national Gallup poll conducted in May 2011 of 1,108 adults aged 18 and older found that 92% of Americans believed in God (Gallup, 2014). In November 1944, by comparison, the same Gallup poll reported that 96% of Americans believed in God; in August 1967, it found that 98% of respondents believed in God. These surveys suggest that more than 90% of Americans continue to believe in God.

Spiritual beliefs are of particular importance to older Americans, who are most likely to be affected by chronic illness. When the Pew Research Center's (2012) Religion & Public Life Project examined the number of people

identifying with a religion, it found that while 32% of people aged 18–29 did not claim any affiliation with a religion, 90% of people aged 65 and older were affiliated with a religion. Among the 46 million unaffiliated adults, 68% believed in God, and 37% stated that they were "spiritual" but not "religious."

Spirituality can be an important source of support in chronic illness. A study of the use of complementary and alternative medicine (CAM) in U.S. adults, using data from the 2002 National Health Interview Survey (NHIS), found that 43% of adults used prayer for health purposes (Barnes, Powell-Griner, McFann, & Nahin, 2004). The five most commonly used CAM therapies were prayer for one's health (43.0%), intercessory prayer (24.4%), natural products (18.9%), deep breathing exercises (11.6%), and participation in a prayer group (9.6%). Conditions treated with CAM included chronic pain, anxiety, and depression. Women, black adults, and Asian adults were most likely to use CAM therapy that included prayer for health reasons. Rates of using mind–body therapies that included prayer for health ranged from 56.3% to 66% in people aged 60–85 and older. Excluding prayer, usage rates of mind–body therapies in older adults ranged from 6.4% in the 85 years and older age group to 14.4% in the 60-69 age group, suggesting a high use of prayer in the oldest age group with the highest rate of chronic illness (i.e., older adults).

Information on the use of prayer as a health intervention is important for healthcare professionals. Put simply, healthcare professionals need to have more knowledge regarding the importance of spirituality to their patients. Unfortunately, the 2007 NHIS survey did not include prayer as a CAM therapy (Barnes, Bloom, & Nahin, 2008). To read more about those spiritual practices that were considered unconventional healing practices, please refer to Kaptchuk and Eisenberg (2001).

Bell and colleagues (2006) analyzed CAM use based on the 2002 NHIS data among people with and without self-reported diabetes—one of the leading chronic conditions in the United States. Their sample included 2,479 people with diabetes and 28,526 people without diabetes. Overall, CAM use rates were significantly higher among people with diabetes (72.8%; $p < 0.0001$) than among persons without diabetes (61.2%). Prayer—that is, self-prayer, other prayer, or prayer groups—was more frequently used as a health intervention by people with diabetes than by people without diabetes.

Holistic nursing care includes care of an individual's body, mind, and spirit. While a cure is usually not possible for persons living with a chronic illness, opportunities for healing, growth, and wholeness are available (Mariano, 2009). Spirituality involves multiple ways of knowing, including cognitive, experiential, intuitive, aesthetic, and an inner sense or knowing (Burkhardt & Nagai-Jacobson, 2009). Spiritual practices can help individuals find purpose and meaning, as well as connection with others and the transcendent, within their illness experience (Burkhardt & Nagai-Jacobson, 2009).

Spirituality and Health

Research suggests a strong link between spirituality and health. However, spirituality can have both positive and negative effects on health. Schnall et al. (2010) examined relationships between religiosity and cardiovascular outcomes in a sample of 92,395 women aged 50–79 years who were enrolled in the Women's Health Initiative Observational Study. Their results indicated that religious affiliation, frequency of religious service attendance, and drawing strength and comfort from religion were linked to decreased all-cause mortality. The risk reduction ranged from 10% to 20%. The results also indicated that religiosity did not protect against coronary heart disease (CHD) events. The authors suggested that the decrease in all-cause mortality was not related to a decrease in CHD events, and that other unknown variables could be involved. The mechanism by which spirituality affects health is unclear.

A study of religion/spirituality in people with chronic pain revealed some interesting relationships between religiosity/spirituality and pain. Rippentrop, Altmaier, Chen, Found, and Keffala (2005) examined religiosity/spirituality in a sample of 122 individuals (54 males, 68 females) with chronic musculoskeletal pain; the individuals had an average age of 52.7 years. The results indicated that private religious practices such as prayer and meditation were related to poorer physical health. Rippentrop et al. (2005) suggested that people with the worst physical health might rely more on spiritual practices for comfort. Lack of forgiveness was related to more pain problems. Daily spiritual experiences, forgiveness, and support from a faith community were associated with better mental health, but religiosity/spirituality was not directly related to pain levels. This study again demonstrates that spirituality can affect health, but the mechanism of action is not well understood.

Several other explanations have been proposed for the beneficial relationship between spirituality and health. McCullough, Hoyt, Larson, Koenig, and Thoresen (2000) conducted a meta-analysis of 42 research studies involving 125,826 participants; their review focused on the relationship between religious involvement and all-cause mortality. The meta-analysis found religious involvement to be associated with lower all-cause mortality (odds ratio: 1.29). Powell, Shahabi, and Thoresen (2003) reviewed studies involving spirituality and religion on health outcomes. They reported evidence that suggested religion or spirituality was protective against cardiovascular disease, probably due to the relationship between spirituality and a healthy lifestyle. Religious attendance also protected against mortality; however, a healthy lifestyle did not entirely account for the beneficial effect. Perhaps religion and spirituality promote development of social supports, resulting in better health (Hill & Pargament, 2003). Attachment to God may also result in lower levels of physiological stress and loneliness. Finally, use of spirituality as a coping tool may promote better health (Hill & Pargament, 2003).

In addition to positive effects, religious and spiritual beliefs can have detrimental effects on people's lives and health. Psychotic disorders can contain delusions or fixed beliefs that involve religious themes (American Psychiatric Association, 2013). In 2002, Andrea Yates drowned her five children due to religious convictions about Satan, herself, and her children (CNN.com/US, 2007). Yates was subsequently diagnosed with severe depression with schizophrenic symptoms. Cases have been reported of people who performed eye enucleations after reading Matthew 5:29–30; these Bible verses instruct an individual to pluck out an eye if it provokes sin (Koenig, King, & Carson, 2012). The New Testament's Book of Revelation was part of the philosophical background and motives for Charles Manson and his "Family," who murdered actress Sharon Tate and six other people in California in 1969 (Bugliosi, 1975).

More knowledge is needed about the type of faith healing that occurs at religious shrines such as that located in Lourdes, France (Koenig et al., 2012). In *The Nun's Story* (Hulme, 1956), Sister William remarked to Sister Luke that the real cure of Lourdes was the peace and happiness of faith that came from the pilgrimage.

Knowledge regarding attitudes of healthcare professionals toward the effects of spirituality on health is also important for the provision of spiritual health care. Many nurses believe in the beneficial effects of spirituality for individuals. Grant (2004) surveyed 299 nurses at a southwestern U.S. university teaching hospital. The results indicated that 100% of the nurses believed that spirituality could provide individuals with inner peace, as well as strength to cope (98%), physical relaxation (97%), self-awareness (96%), and a greater sense of connection to others (94%). The study also found that nurses

who regarded themselves as spiritual generally thought that spirituality could help individuals.

A nurse's own spiritual background can affect spiritual care. In a qualitative study of spiritual care offered by nurse practitioners (NPs) in primary healthcare settings, Carron and Cumbie (2011) found that participants often spoke about the relationship between the spirituality of the NP and using spirituality in practice. Statements by participants included the following:

> *If you have a firm religious belief or you feel comfortable with your own spirituality, then it is going to be easier for you to bring that up to a patient, a friend, whoever. But if you're not even comfortable with your own concept of a higher power … I think that would be more difficult to relate with anyone else. (p. 557)*

Spirituality and religion are coping strategies that can help patients and families manage the stress of illness (Glanz & Schwartz, 2008). As noted in the previous chapter, chronic illness can result in many losses, including loss of health, independence, vigor, ability to work, social relationships, and unmet goals and challenges (Koenig et al., 2012). In their seminal work *Stress, Appraisal, and Coping*, Lazarus and Folkman (1984) stated that psychological stress was "a particular relationship between the individual and the environment that is appraised by the individual as taxing or exceeding his or her resources and endangering his or her well-being" (p. 19). Thus, some individuals might find a particular incident stressful, while other individuals might view the same incident as nonstressful. The difference lies in the person's appraisal or significance of what is happening to him or her (Lazarus & Folkman, 1984). Existential beliefs, such as in God or the order of the universe, can help people find meaning and maintain hope in stressful events (Glanz & Schwartz, 2008; Lazarus & Folkman, 1984).

Use of spirituality can lead to either adaptive or maladaptive coping. Lazarus and Folkman (1984) noted that beliefs such as in God can sustain people and help them cope with very challenging situations—a response known as adaptive coping. Conversely, spiritual maladaptive coping can occur when an individual thinks that a stressful situation or illness is punishment from a punitive God (Lazarus & Folkman, 1984).

A study by Thuné-Boyle, Stygall, Keshtgar, Davidson, and Newman (2012) exemplifies the research suggesting maladaptive religious/spiritual coping in women with a new diagnosis of breast cancer. In this study, a sample of 155 women in the United Kingdom, with a mean age of 55.7 years, 44.8% married, and 72.1% believing in the existence of God, completed several spiritual measures including a religious coping tool. The authors found that negative religious coping, such as feeling punished or abandoned by God, was significantly associated with anxiety and depression, which could in turn affect the woman's adjustment to her diagnosis. Thuné-Boyle et al. suggested that a spiritual assessment could help identify areas of spiritual distress that might represent barriers to illness adjustment.

Positive religious coping, however, was demonstrated in a study of individuals with advanced cancer in the United States. Tarakeshwar et al. (2006) examined religious coping in a sample of 170 individuals with advanced cancer, defined by distant metastasis and failure of first-line chemotherapy. The mean age of the sample was 57.46 years with 77.6% of the sample having health insurance. Religion was important or somewhat important to 85.9% of the study participants. Assessment of several spiritual measures indicated that use of positive religious coping was related to better quality of life. However, positive religious coping was also associated with more physical symptoms. The authors noted that while religious coping can influence quality of life, individuals with better quality of life might also use more religious resources to cope with their illness.

Also, people with more physical symptoms might use religious coping for support and strength. The study further suggested that use of negative religious coping was associated with decreased quality of life. Finally, the authors suggested that a spiritual assessment with a few questions could help ascertain the importance of religion to individuals, the influence of religion on coping and understanding of their illness, and whether the individual's religious needs were met.

In summary, spirituality influences health through mechanisms that are positive and life-giving, but also in very negative ways. It is essential for healthcare professionals to assess the coping skills and effects of spiritual views of patients, caregivers, and families living with chronic illness.

Historical Perspectives of Spirituality in Chronic Illness

Nursing and spirituality have a long history of interrelationship. Florence Nightingale, for example, clearly viewed nursing from a spiritual perspective. At age 16, she experienced a call from God to His service, although the nature of the service was not specified (Macrae, 2001). In a small work entitled "Una and the Lion," Nightingale wrote that nursing was concerned with caring for the "living body—the temple of God's spirit" (Nightingale, 1868/2010, p. 6). In *Notes on Nursing* (1860/1969), she stated that the purpose of nursing was "to put the patient in the best position for nature (i.e., God) to act upon him" (p. 133).

Spirituality has been integrated into health care since the earliest known times. Shamanism is practiced by all indigenous groups worldwide and involves working with the forces of nature and spirits who can bring illness or death (Barnum, 2003). In medieval times, health care was often provided within monasteries (Barnum, 2011). In the United States, many early schools of nursing were affiliated with a religious institution (O'Brien, 2014).

During the latter part of the 20th century, nursing practice began to incorporate more scientific knowledge as the basis of patient care (O'Brien, 2014). Specifically, nursing adopted the biopsychosocial model of health care and eliminated the emphasis on spirituality and spiritual nursing practices (Barnum, 2011). More recently, shifts regarding spirituality in health care have again occurred, with spirituality drawing renewed attention (Barnum, 2011; O'Brien, 2014). In 1961, the inaugural edition of the *Journal of Religion and Health* appeared. The editor, George Christian Anderson (1961), stated that understanding and a multidisciplinary approach to health care was needed; no single group possessed the whole truth. Anderson recognized that a person's philosophy of life contributed to total health; consequently, the interaction among social, psychological, organic, and spiritual factors needed further examination and understanding.

In the 1990s, more research studies examining the relationships among spirituality, religion, and health were published. This trend has continued to grow with the establishment of spiritual institutions such as the Center for Spirituality, Theology, and Health at Duke University (http://www.spiritualityandhealth.duke.edu/). The Center, founded in 1998, promotes dialogue among researchers, clinicians, theologians, and others interested in the connection between spirituality and health.

Many national health organizations that deal with chronic illness have made information about spirituality and health available on their websites. For example, information on the role of spirituality as a support resource can be found on the following websites: National Center for Complementary and Alternative Medicine (NCCAM; http://nccam.nih.gov.), Centers for Disease Control and Prevention (CDC; http://www.cdc.gov), American Heart Association (http://www.heart.org), and American Cancer Society (http://www.cancer.org).

Definitions

To provide effective spiritual care to people with chronic illness, it is important to distinguish between terms used in the literature such as *spiritual* or *spirituality* and *religion* or *religiosity*. These terms can be difficult to define due to the wide variety of religious and spiritual practices, as well as the evolving meaning of the terms over time.

The term *religion* is derived from the Latin word *religare*, meaning "to tie back or restrain" (*Merriam-Webster Online Dictionary*, 2014). Religion can be practiced in a community or alone, but it generally includes shared beliefs and practices (Burkhardt & Nagai-Jacobson, 2009). Religion usually concerns the relationship between an individual and the transcendent, whether this is God, Allah, Buddha, Dao, a higher power, or ultimate truth or reality. The term "religion" can also be accompanied by negative connotations, including issues related to rigidity, hypocrisy, and church–state separation (Koenig et al., 2012).

Spirituality is more difficult to define due to the lack of accepted characteristics and its evolving nature (Koenig et al., 2012). The word *spirit* is derived from the Latin word *spiritus*, meaning "breath" (*Merriam-Webster Online Dictionary*, 2014). Many people express their spirituality within the structure of their religious denomination (Burkhardt & Nagai-Jacobson, 2009). Chittister (2001) identified a clear distinction between religion and spirituality: "religion is about ritual, about morals, about systems of thought … spirituality is about coming to consciousness of the sacred … It is in that consciousness that an individual comes to wholeness" (p. 16). Burkhardt and Nagai-Jacobson (2009) wrote, "Spirituality is the essence of who we are and how."

Chittister (2001) states:

> *The truly spiritual individual … knows that spirituality is concerned with how to live a full life, not an empty one. Real spirituality is life illumined by a compelling search for wholeness. It is contemplation in the eye of chaos. It is life lived to the full … spirituality … is the individual search for the divine within us all. (pp. 13–14, 61)*

Spirituality is defined by *Merriam-Webster Online Dictionary* (2014) as being concerned with spirit, sacred matters, religious values, or the supernatural. O'Brien (2014) conceptualized spirituality as having two dimensions: (1) a spiritual connection with God or the transcendent and (2) a religious component consisting of an individual's faith practices, which might or might not be based in an organized religious tradition. Religion and spirituality both share a belief in the transcendent, but spirituality often involves a path of discovery, questioning, belief, devotion, and surrender that goes beyond organized religion (Koenig et al., 2012). In contrast, secularists, agnostics, and atheists do not acknowledge a connection with the transcendent (Koenig et al., 2012).

Spiritual well-being is another commonly encountered term in spirituality research and practice. This term is not found in *Merriam-Webster's* online dictionary (2014). Rather, spiritual well-being is defined by common threads in the literature that include connection to God or a higher power (religious well-being) and having a purpose and meaning in life (existential well-being) (Ellison, 1983).

The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being Scale (FACIT-Sp), a commonly used spiritual assessment tool, measures spiritual well-being with two subscales that reflect this view (Peterman, Fitchett, Brady, Hernandez, & Cella, 2002). The first subscale is labeled "meaning and peace" and measures meaning, peace, and purpose in life. The second subscale, labeled "faith," measures the relationship between spiritual/religious beliefs and illness. In a similar manner, the *Nursing Interventions Classification* (NIC) describes spiritual well-being as a "process of developing/unfolding of mystery through harmonious interconnectedness that springs from inner strengths" (Dochterman & Bulechek, 2004, p. 881).

The terms *spirituality* and *healing* are related. The words *heal*, *whole*, and *holy* stem from the same Old English word *hal*, meaning "whole" (Burkhardt & Nagai-Jacobson, 2009; *Merriam-Webster Online Dictionary*, 2014). Burkhardt and Nagai-Jacobson (2009) wrote:

> *{B}y its nature, healing is a spiritual process that attends to the wholeness of a person. The work of healing requires recognition of the spiritual dimension of each person, including the healer, and awareness that spirituality permeates every encounter. (p. 623)*

In summary, healthcare professionals need to understand the common links between religion and spirituality. It is an oversimplification of the differences between terms to label "religion" as based on the practices and beliefs of a particular organization and "spirituality" as more individual. A fundamental link between religion and spirituality is that both involve the sacred as expressed through God, the transcendent, or one's interpretation of the ultimate. The search for the sacred in life is the journey and destination of many people (Hill & Pargament, 2003).

Spiritual Context in Nursing Theories

Many nursing theories have a spiritual context. Interventions and programs to influence health behavior, such as lifestyle changes, are most effective when they are based on a theory of health behavior (Glanz, Rimer, & Viswanath, 2008). Theories help explain human behavior that may be facilitating or blocking chronic illness management. A *theory* can be defined as a "a set of interrelated concepts, definitions, and propositions that present a *systematic* view of events or situations by specifying relations among variables, in order to *explain* or *predict* the events or situations" (Glanz et al., 2008, p. 26). Nursing theories address areas of interest and are "patterns that guide the thinking about, being, and doing of nursing" (Smith & Parker, 2010, p. 8).

While it is not the goal of this chapter to review the spiritual context of every nursing theory, a few examples are presented here to emphasize the relevance of spiritualty to nursing theory and nursing care. Although Florence Nightingale is not considered a nursing theorist according to modern standards, her vision of nursing continues to influence modern nursing (Dunphy, 2010). Spirituality played a major role in Nightingale's individual development and her views on health and nursing (Dossey, 2000). Specifically, she equated service to God with care of humanity (Calabria & Macrae, 1994). According to Nightingale, scientific truths were God's laws, and by discovering these laws of truth in areas such as sanitation, health could be promoted (Calabria & Macrae, 1994; Dunphy, 2010).

Watson's theory of human caring (2008) was based on the concept of caring science, which Watson proposed was the "essence of nursing and the foundational disciplinary core of the profession" (p. 17). She described caring as including spiritual ways of knowing and being. Many of the 10 core *Caritas Processes* in her theory, for example, integrate caring with honoring belief systems, connection to an individual's spirit, creation of a healing environment, and openness to the spiritual dimension of the human experience of life and death. Watson built on Nightingale's ideas that the body is often able to heal itself if placed in the right environment. A *Caritas* nurse incorporates an individual's spiritual beliefs to promote healing, strength, and wholeness.

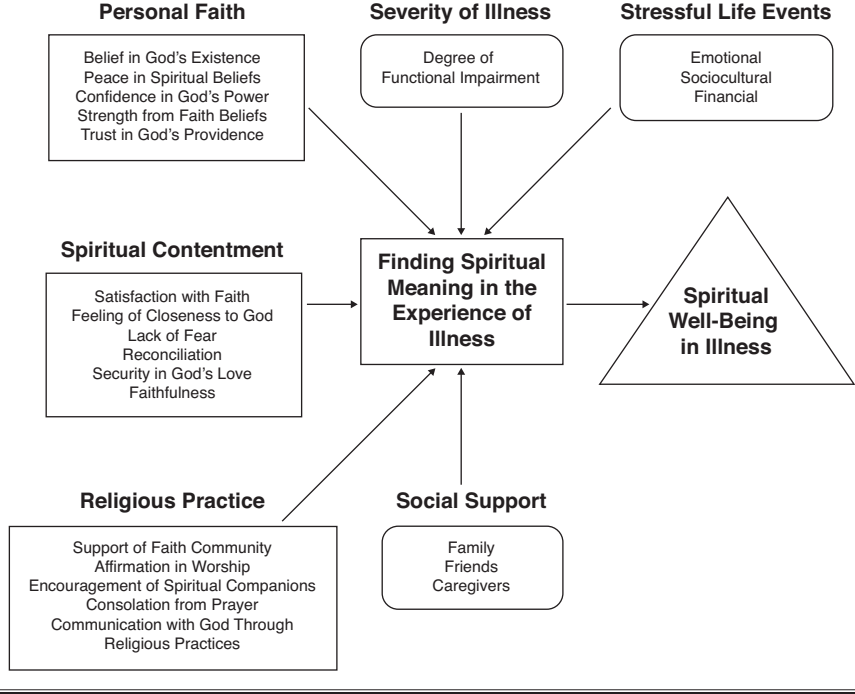
The Roy adaptation model assumed that people find support in each other, the community, and a supreme power (Roy, 2009). According to this model, a supreme power or God is manifested in the diversity of the world. Roy's nursing model focuses on the role of nurses in helping people to adapt to changing circumstances. Roy (2009) believed that knowledge about an individual's spirituality helps one understand that individual's values and beliefs. These beliefs and values, in turn, influence an individual's response to environmental factors.

In particular, spirituality helps to define an individual's concept of self, which could influence health behavior.

In a similar manner, other nursing theories also emphasize the role of an individual's spirituality in shaping attitudes and responses to illness. The Neuman systems model, for example, focuses on the role of an individual's spirituality in shaping an individual's response to environmental stressors with lines of defense and resistance (Aylward, 2010). Leininger's theory of culture care diversity and universality also includes the importance of religious and spiritual factors that can affect the cultural response of people to illness (Leininger & McFarland, 2010). Rogers's theory of the science of unitary human beings, however, does not include a specific spiritual component. Rogers believed that people were unified human energy fields that could not be subdivided into systems such as a spiritual system (Butcher & Malinski, 2010). In contrast, Cowling (2004), in his description of unitary appreciative inquiry that built on Rogers's science of unitary human beings, included the value of physical, mental, and spiritual data to explain the "wholeness of human existence" (p. 279) and create the "inherent pattern of unity that is human life and the fullness of human experience" (p. 279).

O'Brien (2014) developed a conceptual model for a middle-range theory of spiritual well-being in illness (**Figure 5-1**). O'Brien believed that

Figure 5-1 A conceptual model of spiritual well-being in illness.



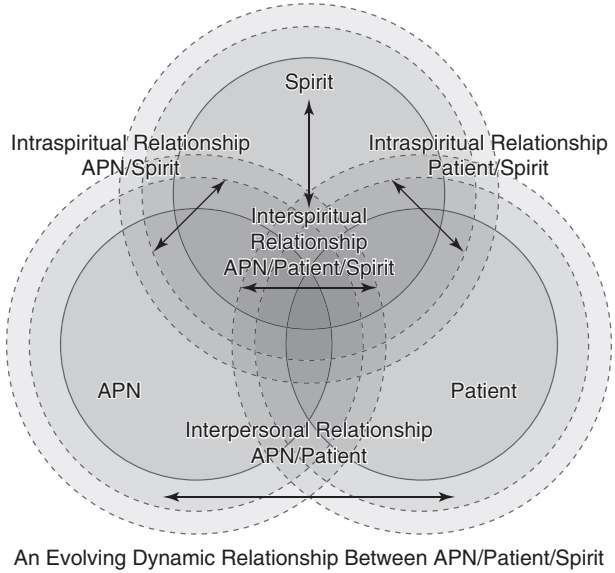
Source: O'Brien, M. E. (2014). *Spirituality in nursing: Standing on holy ground* (5th ed.). Burlington, MA: Jones & Bartlett Learning.

people have a spiritual nature, in addition to their physical and psychosocial nature, that is capable of transcending or accepting illness or disability. O'Brien's theory emphasizes the ability to find spiritual meaning in the experience of illness, which in turn could lead to spiritual well-being. According to this theory, several factors affect an individual's ability to find spiritual meaning in illness, including individual faith, spiritual contentment, and religious practices. Mediating factors in the relationships may include severity of illness, social support, and stressful life events.

The quality of an individual's faith may influence an individual's ability to find spiritual meaning and well-being in illness (O'Brien, 2014). For example, some people might consider illness to be a punishment from God for a past transgression. Other people might be fearful of God's judgment or anger rather than trusting in God's love for them. Nurses have the opportunity to intervene and support an individual with spiritual distress through referrals, encouragement of spiritual practices used in the past, and guidance and advocacy for the ill individual (O'Brien, 2014).

Carron and Cumbie (2011) developed a conceptual model for the implementation of spiritual care by nurse practitioners/advanced practice nurses (NPs/APNs) in adult primary care settings (**Figure 5-2**). Their model emphasizes the nurse–patient relationship. As the NP and patient develop a relationship, the NP conducts a spiritual assessment of the patient's spiritual supports. Based on this patient assessment and the NP/APN's own spiritual knowledge and

Figure 5-2 Nursing model for the implementation of spiritual care by APNs.



Source: Carron, R., & Cumbie, S. A. (2011). Development of a conceptual nursing model for the implementation of spiritual care in adult primary healthcare setting by nurse practitioners. *Journal of the American Academy of Nurse Practitioners, 23*(10), 552–560. doi: 10.1111/j.1745-7599.2011.00633.x.

background, the practitioner develops and integrates spiritual interventions into the relationship with the patient to help the patient manage life challenges. The three interconnecting circles in Carron and Cumbie's model (see Figure 5-2) represent the NP/APN, patient, and spirit. The circles are dotted to reflect an evolving dynamic between these three entities.

Nursing theory influences all levels of care in chronic illness management, including nursing care, education, administration, and knowledge development, as well as providing structure for nursing practice, research, and scholarship (Smith & Parker, 2010). Nursing theories support the concept that an individual is a holistic combination of body, mind, and sprit. Nurses caring for people with chronic illness need to be familiar with the various nursing theories and their use in providing optimal nursing care for people living with chronic illness.

Issues

A discussion of spirituality and health includes many complex issues. Some of these issues, such as the positive and negative aspects of spirituality for health, have been discussed in earlier sections of this chapter. Other significant issues in spirituality and health include measurement and outcomes.

A primary concern in spirituality research is measurement. What is being measured, and are these appropriate items to be measuring? For example, it is relatively easy to measure the number and frequency of people who attend a faith-based service on a regular or intermittent basis. It is not quite so easy to measure the effects of prayer for an individual, commonly known as intercessory prayer. Which outcomes should be measured? Pain relief? Spiritual well-being? Complication rate after surgery?

Benson et al. (2006) measured the effects of certainty and uncertainty of receiving intercessory prayer with three groups of patients undergoing cardiac bypass (CABG) surgery. The first group (Group 1) of randomly assigned patients received intercessory prayer after being told they might or might not receive intercessory prayer. The second group (Group 2) did not receive intercessory prayer after being told they might or might not receive intercessory prayer. The third group of patients (Group 3) received intercessory prayer after being told they would receive intercessory prayer. Primary outcomes of the study included postoperative complications within 30 days of the CABG procedure; secondary outcomes were major events and 30-day mortality. The results indicated postoperative complications occurred in 52% of Group 1, 51% of Group 2, and 59% of Group 3. Major events and 30-day mortality were similar across the three groups. Intercessory prayer was provided for 14 days beginning the night before each participant's surgery. The intercessory prayers included the phrase for a successful surgery, with a quick recovery and no complications. Benson and colleagues (2006) concluded that intercessory prayer did not affect the chances of experiencing a complication-free recovery, and the certainty of receiving intercessory prayer resulted in a higher incidence of complications. Benson et al. (2006) also noted that the increase in complications in Group 3 could have been due to chance.

The Benson et al. (2006) study illustrates the difficulty associated with measurement in spiritual studies. Carron, Hart, and Naumann (2006) questioned the role of prayer as a primary medical treatment as in the Benson study. Carron et al. proposed that the purpose of prayer was to support the inner spiritual life of an individual; thus, prayer could serve as an adjunct coping resource in a challenging life situation such as CABG surgery. For example, Dunn and Horgas (2000) reported that 96% of a sample of 50 community-dwelling elders used prayer as a coping resource for stress. In the Benson et al. (2006) study, it appeared to be difficult to control the prayer intervention, as almost all participants in all three groups believed that friends, relatives, and their religious communities would be praying for them. Benson et al. also noted

that the participants could have also been praying for themselves, and non-study prayer could not be controlled.

A Cochrane review examined the role of intercessory prayer (Roberts, Ahmed, Hall, & Davison, 2009). Ten intercessory prayer studies with 7,646 patients were analyzed for outcomes including death, clinical state, rehospitalization, quality of life, and satisfaction with treatment. The authors concluded that, based on the evidence, a recommendation could not be made either for or against the use of intercessory prayer, because the majority of studies did not support a positive effect from intercessory prayer. This review again illustrates the complexity of conducting spiritual studies, particularly in regard to measured outcomes.

Another issue in spirituality measurement is the challenge of measuring spiritual care provided by nurses. What is nursing spiritual care, and what should be measured? Hubbell, Woodward, Barksdale-Brown, and Parker (2006) examined the spiritual care practices of a sample of 65 nurse practitioners in North Carolina. To assess use of spiritual care by NPs in their practice, the NPs completed a modified Nurse Practitioner Spiritual Perspective Survey (NPSCPS) questionnaire based on the Oncology Nurse Spiritual Care Perspective Scale (Taylor, Highfield, & Amenta, 1994). The results indicated that 73% of the participants only rarely or occasionally provided spiritual care to their patients. The most commonly reported spiritual activities were referral to clergy (54%), encouraging a patient to pray (46%), and talking about a spiritual topic with a patient (39%). Notably, NPs defined spiritual care as listening, talking, holding hands, using music, and caring—a range that may not have been fully captured by the NPSCPS.

Other issues with spiritual care include the definition of spiritual care. Carron and Cumbie (2011) found that older patients equated spiritual care with a kind and caring attitude on the part of the nurse. However, a nurse practitioner who was interviewed for the study believed that a kind and caring attitude was part of nursing and that spiritual care depended on your definition. Spiritual care is not standardized, and while nurses believe in the value of spiritual care, they are uncertain when and how to implement spiritual interventions (Grant, 2004). Nursing needs to develop a consensus on the meaning of spiritual care and the manner in which it is to be implemented (Grant, 2004).

Spiritual Assessment

A spiritual assessment can provide clues regarding the influence of a person's spiritual views on his or her health. Healthcare professionals often establish long-term relationships with individuals and families living with chronic illness. A spiritual assessment can be helpful in developing spiritual care interventions.

Prior to conducting a spiritual assessment, Anandarajah and Hight (2001) described several prerequisite factors that could enhance a spiritual assessment—namely, spiritual self-understanding and self-care, relationship, and timing. First, a healthcare professional needs to acknowledge his or her own spiritual background to understand another individual's values and beliefs. Healthcare professionals also need to take the time to care for themselves so that they will have the energy to give to others. Spiritual self-care measures may include time with family and friends, contemplation, community service, or religious/spiritual practices.

The second prerequisite for spiritual assessment is establishment of a strong relationship with the individual (Anandarajah & Hight, 2001). A patient might feel more open to spiritual discussion if that individual already has a trusting relationship with the healthcare professional.

The last prerequisite for spiritual assessment is appropriate timing of the spiritual discussion (Anandarajah & Hight, 2001). Spiritual discussions could be appropriate especially when discussing a new diagnosis of a chronic illness, ongoing chronic illness or chronic pain, advance directives, or terminal care planning.

Table 5-1 THE HOPE QUESTIONS FOR A FORMAL SPIRITUAL ASSESSMENT IN A MEDICAL INTERVIEW

H: Sources of **h**ope, meaning, comfort, strength, peace, love, and connection

O: **O**rganized religion

P: **P**ersonal spirituality and **p**ractices

E: **E**ffects on medical care and **e**nd-of-life issues

Source: Anandarajah, G. & Hight, E. (2001). Spirituality and medical practice: Using the HOPE questions as a practical tool for spiritual assessment. *American Family Physician, 63*(1), 81–89.

Table 5-2 B-E-L-I-E-F MNEMONIC

B: Belief system (involvement in spiritual or religious group)

E: Ethics or values (important values or ethics)

L: Lifestyle (spiritual rituals, dietary restrictions)

I: Involvement in a spiritual community (participation in spiritual community activities)

E: Education (spiritual instruction, involvement in religious schools)

F: Future events (immunization, birth control, abortion, blood transfusions, death)

Reprinted from Journal of Pediatric Health Care, 14(5), McEvoy, M. An added dimension to the pediatric health maintenance visit: The spiritual history, Pages 216-220, Copyright 2000, with permission from Elsevier.

A spiritual assessment can be either formal or informal. An informal spiritual assessment involves listening to the patient for spiritual clues regarding his or her spiritual care needs (Anandarajah & Hight, 2001). These spiritual clues could include conversation focused on topics such as a search for meaning, fear of the unknown, hope and hopelessness, or isolation (Anandarajah & Hight, 2001).

The HOPE spiritual assessment was developed for healthcare professionals in a routine clinic environment (Anandarajah & Hight, 2001). This assessment focuses on open-ended questions built around the mnemonic of HOPE (**Table 5-1**).

McEvoy (2000) developed the B-E-L-I-E-F mnemonic to aid in spiritual assessment in a pediatric setting. However, this mnemonic is also applicable in adult settings (**Table 5-2**).

Several types of follow up to a spiritual assessment are possible (Anandarajah & Hight, 2001). Sometimes, only the presence of the healthcare professional is needed. Other suggested actions include incorporating spirituality into a patient's preventive care (e.g., prayer or walks in nature), using spirituality as an adjunct therapy (e.g., saying the rosary during a treatment), or modifying treatment based on a patient's spiritual preferences, particularly in regard to end-of life issues (Anandarajah & Hight, 2001).

In the spiritual care research of Carron and Cumbie (2011), a study participant offered an example of a simple spiritual assessment, based on the relationship between the nurse and individual. An intervention was derived from the following assessment:

> *If you let that individual really know you're concerned about that condition, whether it's a cold or it's a lifetime thing or whether it is terminal, that individual is going to feel it {Relationship}. When that individual feels it, it's awfully easy then; that individual becomes open to you. You view the opening … you can't just come across bluntly, but you can maybe, at some time or the other, ask them if they believe in God or if, you don't want to say "God," you might say "a higher being" to open the door {Assessment, knowledge of own spiritual base}. A lot of times that's all it takes and then they will usually come back with, "Yes, I believe." But then also, you can go further and say, "There is hope; no matter in what you're dealing with, there's hope" {Intervention based on relationship and assessment}. (p. 557)*

Table 5-3 General Spirituality Measures

- The Spiritual Perspective Scale (Reed, 1986)
- Spirituality Assessment Scale (Howden, 1992)
- The Spirituality Scale (Delaney, 2005)
- The Ironson-Woods Spirituality/Religiousness Index (short form) (Ironson et al., 2002)

Table 5-4 Spiritual Well-Being Measures

- The Functional Assessment of Chronic Illness Therapy—Spiritual Well-Being Scale (FACIT-Sp) (Peterman et al., 2002)
- The Spiritual Well-Being Scale (SWBS) (Ellison, 1983)
- JAREL Spiritual Well-Being Scale (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1989)
- The Spirituality Index of Well-Being (SIWB) (Daaleman & Frey, 2004)

Table 5-5 Spiritual Coping Measures

- A Semi-Structured Clinical Interview for Assessment of Spirituality and Religious Coping for Use in Psychiatric Research: Interview Based (Mohr, Gillieron, Borras, Brandt, & Huguelet, 2007)
- The Spiritual Strategies Scale (Nelson-Becker, 2005)

Table 5-6 Spiritual Needs Measures

- Spiritual Needs Inventory (Hermann, 2006)
- The Spiritual Interests Related to Illness Tool (Spirit) (Taylor, 2006)

As these examples demonstrate, a spiritual assessment can be performed in a clinical setting. Begin with one question from the HOPE or B-E-L-I-E-F tool, for example, and then expand or branch out with your own ideas to find the center of strength and connection for an individual and/or family.

Spirituality Measures and Tools

Several tools are available to measure levels of spirituality in people. These spiritual measurement tools are especially useful in spiritual research, but can also be used in a clinical setting. Monod et al. (2011) conducted a systematic review of spirituality instruments and measures. Their literature search found 35 spiritual instruments that assessed spirituality in adults. Instruments that focused exclusively on religiosity were excluded. The instruments were classified as general spirituality (N = 22), spiritual well-being (N = 5), spiritual coping (N = 4), and spiritual needs (N = 4). Examples of the spiritual measures identified by Monod et al. (2011) are included in **Tables 5-3, 5-4, 5-5, and 5-6**. These measurement scales were validated in many populations, including patients with breast cancer, arthritis pain, alcoholism, substance abuse, acute or chronic disease, psychiatric problems, cancer, and HIV/AIDS; felony offenders; and geriatric outpatients (Monod et al., 2011). Consequently, many of the tools are applicable to chronic illness. The reader is encouraged to read more about the specific tools of interest, for which literature can be located by name or author. Spirituality tools can be used to further assess the relationships between spirituality or spiritual well-being and outcomes such as quality of life (Monod et al., 2011).

The Spiritual Well-Being Scale (SWBS) and the Functional Assessment of Chronic

Illness Therapy—Spiritual Well-Being Scale (FACIT-Sp) are among the most commonly identified spiritual measurement tools used in research (Monod et al., 2011). The SWBS, which was developed in 1982 by Paloutzian and Ellison, is one of the oldest spiritual measurement tools. This self-report scale measures spiritual well-being with two subscales: (1) religious well-being or relationship to God and (2) existential well-being, which is a measure of finding purpose and satisfaction with life. The SWBS has been criticized for its emphasis on a more evangelical Protestant perspective of spiritual well-being due to questions focusing on an individual's relationship with God (Peterman et al., 2002).

Peterman et al. (2002) developed the FACIT-Sp in response to a need for a measure of spiritual well-being in chronic or life-threatening illness that broadly interprets spirituality. These authors noted that their scale was designed for people who considered themselves spiritual, but not religious. The tool consists of two subscales: (1) faith and (2) meaning/peace. There are no references in the scale to God or the use of a specific religious practice such as prayer. Instead, the FACIT-Sp focuses on spiritual well-being as a search for meaning, peace, and purpose in life, as well as the relationship between illness and an individual's spiritual beliefs. The FACIT-Sp includes statements about the value of faith or spiritual beliefs, purposefulness of life, having a sense of peace, and knowing that everything will happen for the best within the illness experience.

All of these spirituality instruments and measures have limitations. Monod et al. (2011) identified limited data on the psychometric properties of most of the reviewed instruments. Also, test–retest reliability data were limited for the instruments. In addition, Monod et al. (2011) noted that while some scales measure spiritual well-being, there is a lack of scales that measure spiritual distress; as these authors noted, the absence of spiritual well-being is not necessarily equivalent to spiritual distress. In conclusion, the range of spiritual instruments indicates the interest in measures of spirituality and health.

Nursing Spiritual Interventions

Spiritual care interventions in chronic illness are based on knowledge gained through theory, historical perspectives, assessment, and measurement. O'Brien (2014) proposed a theology of caring to ground spiritual nursing care and interventions. According to this author, the essential components of spiritual care are *being*, *listening*, and *touch*. These actions between a nurse and individual can reflect the spiritual dimension of the nurse–patient relationship. The nurse could be present with an individual, actively listening, and then responding to thoughts of the individual with either physical or verbal touch through a word of support or comfort (O'Brien, 2014).

Knowledge is needed regarding spiritual care interventions by nurses and nurse practitioners. Grant (2004) examined the spiritual practices of 299 nurses in a southwestern U.S. state teaching university hospital. The five spiritual therapies most commonly used by nurses were holding a patient's hand (92%), listening (92%), laughter (84%), prayer (71%), and being present with a patient (62%). Spiritual counseling ranked 11th on the list (29%), and scripture reading was 12th (26%). The spiritual interventions used least often were biofeedback (8%), acupuncture (7%), chanting (4%), fasting (4%), and repatterning (2%). The study also indicated situations in which nurses thought spiritual interventions could be beneficial. The five most frequently cited situations were a patient explicitly requesting spiritual support (98%), a patient who is about to die (96%), grieving (93%), a patient or family who receives bad news (93%), and crying (86%). Other situations where spiritual interventions could be useful, according to the nurses, included a patient who often prays or seems close to God (81%), a patient who is a member of a church (71%),

a patient who is alienated from friends and family (67%), a patient who is angry at God (65%), and a patient who is experiencing physical pain (46%). Based on his study, Grant (2004) reported that nurses believed spirituality could be beneficial, but the results also suggested nurses were unsure which spiritual therapies to use and when to use them. Grant (2004) suggested more research was needed in spiritual nursing care.

Quinn Griffin and colleagues (2008) examined spiritual practices among 84 individuals with and without heart failure. The authors designed a religious and spiritual interventions checklist for the study. The heart failure group consisted of 30 men and 14 women, and the non-heart failure group consisted of 7 men and 33 women. The participants were older than age 65, with the majority between 65 and 75 years of age. The results indicated that participating in family activities, helping others, and recalling positive thoughts were the religious and spiritual interventions used the most both by the total sample and by each subgroup. Praying alone and going to a house of worship or quiet place were also used by a majority of the participants in both groups. This study further adds to the body of knowledge regarding spiritual practices of older adults, many of whom live with chronic illnesses.

Carron and Cumbie (2011) identified spiritual nursing care perceptions of older adults (aged 65 or older) (N = 5) in their study of spirituality in primary care. The older adults stated that spiritual care by nurses included a kind and caring attitude on the part of nurses. One adult participant stated: "If you're kind and considerate and helping an individual, what more spiritual could you be?" (p. 555). Another adult participant supported this view with his remarks:

> *It's the sense of caring and sense of being welcome; what that does is cause a patient to feel better about the environment, feel better about himself, and help with the potential practices that are going to take place. Now all of that … will find {its way} into the spirit and improve spiritual well-being, I believe. And I believe that a smile costs nothing. (pp. 555–556)*

All of these studies confirm Grant's (2004) assertion that research needs to clarify which spiritual care interventions are appropriate and when they should be used in practice. In addition, the development of tools to measure nurses' spiritual and/or religious care interventions and intentions are needed. In other words, are nurses measuring what needs to be measured?

The time needed to implement spiritual interventions in practice by clinicians is also a critical factor in their development and use. A 2011 randomized controlled trial (RCT) examined the effectiveness of a home-based video and workbook encouraging spiritual coping in helping a sample of older adults manage chronic illness (McCauley, Haaz, Tarpley, Koenig, & Bartlett, 2011). A sample of 100 adults, of whom 62% were female, with an average of three chronic illnesses, was randomized into two groups. The most common chronic illnesses were hypertension (74%), arthritis (54.5%), diabetes (41.4%), and heart disease (27.3%). The spiritual intervention video consisted of stories of spiritual coping told by adults from various spiritual backgrounds. The workbook supplemented the video themes of (1) trusting in the care of a higher being, (2) cleaning "house" of destructive habits, (3) giving thanks for life's blessings, (4) helping others or finding life's purpose, and (5) asking for help or social and spiritual support. The control group received an educational intervention focused on standard care educational themes, including weight, diet, smoking, blood pressure, and activity. The results indicated that energy levels increased significantly in the spiritual intervention group and decreased in the educational intervention group. The researchers concluded that their spiritual intervention was not offensive, required no additional clinical time, and produced increased energy in the patients. The authors noted that

fatigue can be an indicator of depression. They also recommended incorporating a spiritual history into the patient assessment and further suggested that patients explore how to incorporate their beliefs into their healthcare management.

Nursing interventions can also involve care of the inner spirit of the individual being cared for, as well as the healer or nurse. Nurses need to be aware that each individual manifests his or her own spirituality in unique ways (Burkhardt & Nagai-Jacobson, 2009). Interventions tending to the spirit can include touch, such as holding hands; supporting significant individual relationships through family, friends, spiritual groups, pictures, artwork, or pet visits; and supporting spiritual rituals such as prayer, meditation, mindfulness, presence, and awareness (Burkhardt & Nagai-Jacobson, 2009).

Spiritual interventions do not have to be difficult, be time consuming, or involve a particular religious domain. As an example, Treolar (2000) described the use of a spiritual intervention in an individual encounter with a patient suffering from metastatic lung cancer. Treolar noticed a Bible in the room and asked the woman if she had a religious faith that was important to her. Faith was important to the woman, but the hospital chaplain had not been to see her. Treolar offered to pray with the woman, and she accepted. Treolar wrote, "I began to pray for comfort and strength for her and her family, for wisdom for her and the health care staff, and for future decisions about treatment" (p. 283). According to Treolar, the intervention took 5 minutes during an IV infusion. This author concluded that "spiritual care can be integrated into everyday interactions with patients, providing that one is sensitive to spiritual cues" (p. 284).

Spirituality and Research

Research suggests that an individual's spirituality influences health outcomes in the face of many chronic illnesses. Spirituality has been evaluated from multiple perspectives in the literature. This section addresses the role of spirituality research and provides examples of spirituality as a health outcome in well-being and several chronic illnesses.

Well-Being

Well-being relates to life satisfaction, happiness, hopefulness, and morale, as well as finding purpose and meaning in life (Koenig et al., 2012). Self-rated health is a strong predictor of well-being, according to recent research. Religion and spirituality can influence well-being through direct effects such as beliefs and activities or indirectly through psychosocial effects. In a review of 224 quantitative studies, Koenig et al. (2012) reported that 78% found a positive relationship between religion and well-being.

For example, the positive effects of spirituality and well-being were demonstrated in a forgiveness study. Krause and Ellison (2003) examined forgiveness and psychological well-being in a nationwide sample of 1,316 people (51% white and 49% black) with an average age of 74.5 years. The results indicated that forgiveness of others was associated with increased psychological well-being compared to being less willing to forgive others. Receiving forgiveness from God was also important in well-being, but not as important as forgiving others. However, the authors suggested that receiving forgiveness from God could enable the participants to forgive others. Forgiveness was also associated with fewer depressive symptoms and greater life satisfaction. The authors suggested that forgiveness was important in maintaining social relationships. These results are similar to those in Grant's (2004) study, which found that 93% of nurses believed that spirituality could help with the forgiveness of others.

Human Immunodeficiency Virus/Acquired Immunodeficiency Syndrome

Research suggests spirituality is supportive to people living with human immunodeficiency virus (HIV)/acquired immunodeficiency syndrome (AIDS). An illness such as HIV/AIDS can lead individuals and their families/significant others to question the meaning and purpose of life as well as their relationship to God or others (Cotton et al.,

2006). One study examined the role of spirituality in 450 individuals—86% male, 55% minorities, mean age 43.3 years—with a mean length of HIV diagnosis of 8.4 years. Factors associated with increased spirituality and religion included religious affiliation, African American ethnicity, lower alcohol use, higher self-esteem, greater optimism, higher life satisfaction, and lower overall functioning. On the meaning/peace and faith subscales of the FACIT-Sp (Expanded Version), 94% of the participants found some sense of purpose in their life, 88% found some comfort in their faith, and 75% reported a stronger faith as a result of their illness. Clinical parameters such as viral counts were not generally associated with spirituality. The participants also used positive coping strategies such as seeking a connection to God more often than negative coping strategies such as feeling abandoned by God.

Scarinci, Quinn Griffin, Grogoriu, and Fitzpatrick (2009) examined spiritual well-being and spiritual practices in a sample of 83 HIV-infected women (62.7% African American, 75.9% single, and 86.7% Christian). The average time since HIV diagnosis was 10.88 years. The most commonly used spiritual practices included praying alone (51.81%), helping others (37.35%), and exercise (36.14%). The women also had a high level of spiritual well-being that was related to spiritual practices. The authors suggested their results continued to support the positive link between spirituality and health.

Heart Failure

Spirituality can help in the management of chronic heart failure. Heart failure affects 5.1 million individuals in the United States (CDC, 2013). Bekelman et al. (2007) examined the relationships between spiritual well-being and depression in 60 people aged 60 and older with New York Heart Association Class II–IV heart failure. The mean age of the study participants was 75 years, and 22% of the sample was female. Spiritual well-being was measured with the FACIT-Sp (Peterman et al., 2002) and depression with the Geriatric Depression Scale—Short Form (GDS-SF) (Yesavage & Sheikh, 1986). The meaning/peace subscale of the FACIT- Sp was significantly associated with lower depression scores ($r_2 = -.57$, $p < .001$). The faith subscale of the FACIT-Sp was also significantly associated with lower depression scores ($r_2 = -.38$, $p < .01$). The results suggested that increased levels of spiritual well-being could help mitigate the depression that often accompanies chronic heart failure as well as improve quality of life. Bekelman et al. (2007) also suggested having a sense of meaning and peace in one's life could help the individual transcend the limitations and challenges associated with chronic illness.

Depression

Many studies have explored the link between depression and spirituality. Koenig et al. (2012) examined 124 studies of depression and spirituality. They reported that 65% of these studies noted inverse relationships between religion and depression. Examples of research focusing on depression and spirituality in chronic illness are described in this section.

Payman and Ryburn (2010) found that intrinsic religiosity significantly predicted depression scores at 24 months follow-up in 94 patients (71% women, mean age 76 years) diagnosed with geriatric major depression. "Intrinsic religiosity" referred to motivation from religious beliefs. The authors proposed that persons with a high level of intrinsic religiosity might hide depression because their spiritual beliefs would encourage them to appear to be happy. Conversely, people with religious beliefs might be more truthful in responses, so the results might, in fact, be accurate. Regardless of the mechanism involved, the authors recommended that use of religion be considered to support older adults as they encountered the losses associated with aging.

The second research study is an example where an investigation into spirituality and depression showed mixed results. Baetz, Bowen, Jones, and

Koru-Sengul (2006) analyzed data from the 2002 Canadian Community Health Survey of approximately 37,000 community-dwelling Canadians aged 15 and older to examine relationships between spirituality and psychiatric disorders; their goal was to determine if spirituality had a protective effect. Participants in the survey were asked if spiritual values were important in their lives, and if spiritual values provided a sense of meaning, strength, and understanding in life. Frequency of worship was also assessed. More-frequent worship attendance was associated with less risk for depression and other psychiatric conditions (adjusted odds ratio: 0.87–0.93; 95% confidence interval: 0.82–0.97). In this study, higher spiritual values were associated with greater risk for depression, mania, and social phobia (adjusted odds ratio: 1.06–1.21; 95% confidence interval: 0.99–1.32). The authors suggested that worship attendance might be protective against depressive and other related disorders, while people with depression might attend services less often due to fatigue and the low energy associated with depressive disorders. The authors suggested that the association of high levels of spiritual values with depression and other psychiatric disorders might be the result of depression, mania, or social phobia leading people to seek answers through spiritual values of meaning, strength, and understanding. Spiritual values might also help people grow and learn from their psychiatric illnesses.

Rye et al. (2005) examined the effects of forgiveness in relation to depression in divorced adults. The sample was composed of 149 people, of whom 75% were women, with a mean age of 45 years. The participants had been divorced a mean of 1.08 years. The subjects were divided into three groups, with one group receiving instruction on a secular forgiveness intervention, one group being given a religious intervention, and a third control group having no intervention. The secular and religious interventions both consisted of eight group sessions discussing the themes of processing and coping with negative feelings, learning about forgiveness, and moving toward forgiveness. However, the leader of the religious intervention group encouraged its members to use their religious beliefs as support in working out forgiveness. Non-denominational scriptural texts were used to support forgiveness. The control or comparison group was provided with information about community sources for divorce support. The results on forgiveness, depression, and anger scales indicated that both the secular and religious interventions helped the participants develop forgiveness toward their former spouses. Members of the secular intervention group decreased their depressive symptoms over time compared to the control group, although trait anger was not affected by the intervention. The religious intervention group showed no treatment effects on depression or trait anger compared to the control group. The authors suggested that some of the participants in the secular group could have been using some type of individual religious forgiveness practice, or religion might not be important to some people in forgiveness.

Koenig et al. (2012) suggest that the lack of treatment effects in some studies involving spirituality and depression could be the result of the study design, scoring error, or measurement tools that are not able to adequately measure the topic of interest. In addition, failure to account for confounding factors might affect the outcomes. Finally, these authors suggest that more information is needed on the effects of spirituality and depression, including factors such as the type of depression, the kind of religion or spirituality used in the study, and the characteristics of the individual or situation used in the study.

Type 2 Diabetes Mellitus

The prevalence of type 2 diabetes mellitus (T2DM) is increasing in the United States. The CDC (2011) reported that 25.8 million people—8.3% of the U.S. population—had diabetes in 2010, with T2DM accounting for 90% to 95% of all cases of diabetes. Self-management practices, such as diet, exercise, and blood glucose monitoring, are important to help control the condition and avoid complications of T2DM (CDC, 2011).

Spirituality can be a valuable coping resource for people living with T2DM. Utz et al. (2006) examined self-management practices among 73 African Americans living with type 2 diabetes. The sample consisted of 42 women and 31 men, with a mean age of 59.8 years. Spirituality was a source of support for many of the participants, although some participants stated that spirituality did not have a role in their self-management practices. Spiritual practices that supported diabetes self-management included prayer for support and strength to care for self, prayer for help with coping with the illness, and social support through church activities. The study participants also believed that God gave knowledge to the healthcare professionals who cared for them. Utz et al. (2006) suggested that healthcare professionals be supportive of individuals who use spiritual support for coping with their illness.

Similarly, Polzer and Miles (2007) found that spirituality was an important factor that influenced self-management in a sample of 29 African American men and women with T2DM aged 40–75. Grounded theory was used to analyze participant interviews. The results indicated that participants' relationship with God was expressed through three themes of relationship and responsibility. In the first theme, God was in the background with a supporting role in T2DM self-management; the individuals' spirituality taught them that they should care for themselves out of respect for God's gift of being created in the divine image. The second theme of relationship and responsibility revealed God to be in the forefront and the individual with T2DM in the background. Participants who believed in this type of God relationship saw God as in charge. They believed that if God disapproved of their self-management program, there could be consequences for the individual with T2DM. In the third thematic group, God was seen as healer. Participants in this group believed that God could heal them; as a result, T2DM self-management was not necessary. Polzer and Miles (2007) noted there were only two participants in the third group, so only tentative conclusions could be drawn. These authors suggested that a spiritual assessment could help identify people living with T2DM who could benefit from incorporation of spiritual beliefs and practices into their T2DM plan of care.

Evidence-Based Practice Box

Harvey and Cook (2010) examined the role of spirituality in self-management practices in a sample of 41 African American and non-Hispanic white women. The average age of the women was 72.9 years, and chronic illnesses in the sample of women included heart disease and hypertension (48.8%), arthritis (24.4%), diabetes and complications from diabetes such as dialysis (14.6%), and other chronic illnesses (12.2%). Qualitative interviews were conducted with the women, and the results were analyzed using grounded theory from a symbolic interactionism framework. The women were asked to define spirituality and to describe the role of spirituality in their self-management practices. The results showed that most of the women defined spirituality as a connection to a higher power (i.e., God) and connection with others. The women relied on God for guidance, and they often spoke to God during their day. The women's spirituality gave them a sense of purpose and meaning in life.

Four themes emerged regarding the role of spirituality in self-management practices: (1) God's involvement in illness management (God was in charge of their health and the women trusted God with the outcomes); (2) prayer as mediator (women petitioned God to help with management or to ease symptoms); (3) spirituality as a coping mechanism (connection with God helped the women to cope with stress, pain, and helplessness); and (4) combining conventional and spiritual practices (the women believed God and self-management/medicine worked together to maintain health). The authors reported that the

(continues)

women's spirituality supported their self-management practices on a daily basis. Also, the women noted they had a responsible role to play in their self-management—for example, taking their medicine. The evidence from this study indicated that more research needs to look at cultural and spiritual implications for self-management programs among the elderly living with chronic illness.

Source: Harvey, I. S., & Cook, L. (2010). Exploring the role of spirituality in self-management practices among older African-American and non-Hispanic White women with chronic conditions. *Chronic Illness*, 6, 111-124. doi: 10.1177/1742395309350228

CAREGIVERS

No discussion of spirituality outcomes would be complete without mentioning the role of spiritual support for caregivers of people with chronic illness. When concern focuses on only the individual with chronic illness, the needs of the caregiver—usually a family member—can often be overlooked.

Yeh and Bull (2009) examined the role of spiritual well-being and mental health in a convenience sample of 50 family caregivers of older people with heart failure. The caregivers had a mean age of 60.3 years and were 70% female and 30% men. Family caregivers represented 98% of the caregivers. The mean age of the patients with heart failure was 76.47 years, and 79% were women. The tool used for measuring spiritual well-being was the JAREL Spiritual Well-Being Scale (Hungelmann, Kenkel-Rossi, Klassen, & Stollenwerk, 1996). Coping strategies of caregivers were measured with the Carers' Assessments of Managing Index (CAMI) (Nolan, Keady, & Grant, 1995). The mental health of the caregivers was measured with the Symptom Questionnaire (Kellner, 1987).

The results of this study indicated high levels of spiritual well-being among the caregivers on the three subscales of faith/belief, life/self-responsibility, and life satisfaction/self-actualization. The caregivers also had high levels of coping skills on the three subscales of problem solving and coping, alternative perception of events, and dealing with stress symptoms. The mean scores on the Symptom Questionnaire revealed that the caregivers were moderately anxious, although scores for depression, somatic symptoms, and hostility were in the normal range. However, some caregivers scored in the severe range of anxiety (28%), had above-average scores for depression (22%), and evidenced increased somatic symptoms (16%). Spiritual well-being demonstrated a significant inverse relationship with mental health scores ($r = -.055$, $p = 0.000$). The total coping scores also had a significant inverse relationship with the total negative mental health scores ($r = -0.44$, $p = 0.001$).

In conclusion, higher levels of spiritual well-being were associated with better caregiver mental health in the Yeh and Bull (2009) study. The coping strategies of problem solving and reappraisal of events were also associated with better mental health of caregivers. This study suggested that attending to the spiritual needs of caregivers was important in helping them cope with the burden of chronic illness.

Illness Narratives and Chronic Illness

Illness narratives provide another lens through which to view the effects of spirituality on chronic illness. Molzahn et al. (2012) used narrative inquiry from a social constructionist perspective to understand how individuals living with serious illness "story and re-story their lives, and how they story health, healing, living, and dying over time" (p. 2349). The sample consisted of 32 participants (18 men, 14 women) with an age range of 37–83 years. Chronic illnesses in the sample included cancer (10 people), end-stage renal disease (14), and HIV/AIDS (8). Four spiritual themes emerged from the study: (1) reflecting on spirituality, religion, and personal beliefs; (2) crafting beliefs for their own lives; (3) finding meaning; and (4) transcending beyond words. The authors found that the

participants discussed spirituality from a broad perspective that included developing their own belief systems with a "self-defining spirituality" (p. 2354). Molzahn et al. (2012) concluded:

> *Rather than believing that they understand all religious or spiritual perspectives, health professionals may find that careful listening and engaging in thoughtful discussion about important life questions and beliefs will enhance spiritual holistic care. (p. 2354)*

Outcomes

Spirituality can be an important adjunct therapy in caring for persons with chronic illness. Research has demonstrated the positive effects of spirituality on health. However, as with all treatments, spirituality can also have negative effects on health depending on the individual's perspective of spiritual issues. Healthcare professionals need to complete a spiritual assessment prior to suggesting incorporating spiritual practices into a treatment program, to help avoid negative consequences. Use of spiritual practices as a treatment modality could be integrated into care with the cooperation of the individual.

The current state of the science in regard to spirituality demonstrates that more research needs to be conducted, particularly in the areas of assessment, implementation, and outcomes. Healthcare professionals also need to assess their own thoughts and beliefs regarding the use of spiritual practices in conjunction with conventional allopathic medicine.

Chronic illness is increasing in the United States. Older Americans, in particular, are susceptible to one or more chronic, lifelong illnesses. Assessing the spiritual needs of people living with chronic illness will help healthcare professionals use an individual's spiritual beliefs as a powerful, supportive, coping tool (**Table 5-7**). The strength that comes from faith may enable people with chronic illness to find purpose and meaning within the lived experience of their illness.

Table 5-7 Clinical Guidelines Incorporating Spiritual Care

Occupational Therapy Practice Guidelines for Adults with Alzheimer's Disease and Related Disorders

Schaber, P. (2010). *Occupational therapy practice guidelines for adults with Alzheimer's disease and related disorders.* Bethesda, MD: American Occupational Therapy Association. http://www.guideline.gov/content.aspx?id=16321&search=spiritual+care

Clinical Practice Guidelines for Quality Palliative Care

National Consensus Project for Quality Palliative Care. (2009). *Clinical practice guidelines for quality palliative care* (2nd ed.). Pittsburgh, PA: Author. http://www.guideline.gov/content.aspx?id=14423&search=spiritual+care

Assessment and Management of Chronic Pain

Institute for Clinical Systems Improvement (ICSI). (2011). *Assessment and management of chronic pain.* Bloomington, MN: Author. http://www.guideline.gov/content.aspx?id=36064&search=spiritual+care

End-of-Life Care During the last Days and Hours

Registered Nurses' Association of Ontario (RNAO). (2011). *End-of-life care during the last days and hours.* Toronto, ON: Author. http://www.guideline.gov/content.aspx?id=34759&search=spiritual+care

Department of Defense Clinical Practice Guideline for Management of Major Depressive Disorder

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CASE STUDY 5-1

Miranda is a 54-year-old black female who presents for a 3-month check-up for her type 2 diabetes. She was diagnosed 6 months ago in the busy family practice clinic where you work as an RN. Miranda is currently working on lifestyle changes, is taking metformin, and is engaging in daily self-management practices of glucose testing and foot care. She does not smoke. Her latest hemoglobin A_{1c} level is 7.2, which is a decrease from her last 3-month check of 7.6. While you are checking her in and getting her weight and vital signs, Miranda mentions how difficult her diabetes is for her to manage at home. She mentions that she prays for help from God.

Discussion Questions

1. Miranda mentioned that she is having difficulty managing her diabetes. She also introduced the role of spirituality in her diabetes care. How would you respond to the clinical cues she provided?
2. How could spirituality be incorporated into her plan of care?
3. Would you feel comfortable discussing spiritual care interventions with Miranda? Why or why not?

CASE STUDY 5-2

John Simpson is a 76-year-old white male who presents for his annual physical in your cardiology clinic. You work in the clinic as an RN. The last time you saw John was 6 months ago, when he came in for a check-up for his heart failure. He was diagnosed with heart failure 1 year ago and is on multiple oral medications. You know from reading the newspaper that John's wife died 2 months ago. The clinic sent John a sympathy card, which you signed. While talking with John, he mentions how lonely he is since his wife died. He said his wife used to attend church services on a regular basis, but he seldom went with her. He looks at you and asks if he might find support for his loneliness and difficult heart failure regimen at church.

Discussion Questions

1. How would you respond to John?
2. Which spiritual assessment questions would be appropriate to ask John?
3. Houses of worship often have an active social agenda for members, sometimes including nursing activities. How would involvement in church activities help John's loneliness and heart failure?

STUDY QUESTIONS

1. Why has current research in spirituality increased?
2. How would you differentiate between the terms *spirituality* and *religiosity*?
3. What are issues that complicate spirituality research?
4. Which factors should be evaluated in spiritual care research?
5. What is the role of spirituality in the management of an individual with a chronic illness?
6. Is a spiritual assessment an important part of management of a chronic illness management? Why or why not?
7. What are some nursing spiritual interventions to use in chronic illness management?
8. How does spirituality affect healthcare outcomes in chronic illness? Explain.
9. Which questions would you ask patients to elicit stories about the role of spirituality in their lives?
10. Is spirituality incorporated into your work? Explain.

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