



# Spiritual Care: The Nurse's Role

*And remember every nurse should be one who is to be depended upon . . . she must have a respect for her own calling, because God's precious gift of life is often literally placed in her hands.*

Florence Nightingale, 1859

I look at nursing's role definitely as a calling to serve the sick. Because I think any nurse has to give 100% of herself or himself into the profession and to truly be a professional, they have to look at it beyond being an ordinary type of job; to include spiritual as well as physical and psychosocial care. I think it is truly a caring profession; nurses need to give of themselves sometimes when they are not feeling up to giving of themselves. I think I recognized from the time I became a nurse that in order to find it a satisfying and fulfilling career, you have to look at nursing and see it as much more than just an ordinary job.

Annemarie, School Health Nurse

**I**n years past, spiritual care was generally not considered a dimension of nursing therapeutics. With the advent of the holistic health movement, however, together with the notion of holistic nursing, assessment of an ill person's spiritual needs, and in some cases the practice of spiritual care, became recognized as legitimate activities within the domain of nursing. In light of the current interest in the nurse's role in patients' spiritual care, the present chapter explores the practice of spiritual care as nursing intervention; the attention given to patients' spiritual needs and concerns within the grand theories of nursing; some basic tenets of key Eastern and Western religious traditions; and the nurse's use of spiritual and religious resources such as prayer, Scripture, and sacred music. Referral to a formally designated pastoral caregiver is an acceptable option for the nurse not personally comfortable with the practice of spiritual care.

## THE NURSE'S ROLE IN SPIRITUAL CARE

Clinical and research professionals sometimes question whether indeed the nurse has a relevant role in providing spiritual care to patients in his or her charge. The topic can be addressed briefly in terms of nursing assessment of spiritual needs. The point bears repeating, however, that identification of the nurse's role in providing spiritual care is in no way meant to devalue the role of the hospital chaplain or the pastor ministering to the ill in the community. Rather, the nurse and pastoral care provider can work together to assess the spiritual needs of the ill person and support a comprehensive plan of spiritual care. Although not all nurses may feel comfortable providing spiritual care in all situations, the nurse should always be sensitive to the spiritual needs of his or her patients. With the advent of the holistic healthcare concept, it is suggested that the "nursing profession must expand its awareness and competence in the spiritual dimension" (Nelson, 1984, p. 26).

Contemporary nursing textbooks, particularly those addressing fundamentals of nursing and medical–surgical nursing, reveal that the nurse's role in both assessment of patients' spiritual needs and the provision of spiritual care is a significant component of overall nursing. Several fundamental texts contain chapters with titles such as "Spirituality," "Spiritual Health," and "Spirituality and Religion" (Kozier, Erb, Blais, & Wilkinson, 1995; Potter & Perry, 1997; Taylor, Lillis, & LeMone, 1997). These chapters include such topics as spiritual health, spiritual problems, assessment of patients' spiritual needs, religious practices, spirituality and family needs, spirituality and the nursing process, and nursing diagnosis of spiritual distress. Many current medical–surgical nursing texts also contain discussions of the nurse's role in spiritual care of the patient. Topics included are spirituality and nursing practice, spiritual care, assessment of patients' spiritual needs, nursing diagnoses, religious beliefs and practices, death-related spiritual beliefs, and spiritual beliefs in coping with acute and chronic illness (Black & Matassarini-Jacobs, 1997; Ignatavicius, Workman, & Mishler, 1995; Phipps, Cassmeyer, Sands, & Lehman, 1995; Smeltzer & Bare, 1996). In discussing the psychosocial dimensions of medical–surgical nursing, Edmision (1997) stated unequivocally that "meeting the spiritual needs of clients has become a recognized part of nursing care" (p. 68).

In the periodical nursing literature also, spiritual care is identified as a recognized element of holistic practice (Bruner, 1985; Labun, 1988; Sims, 1987) and is viewed as central to quality care (Clark, Cross, Dean, & Lowry, 1991; Simsen, 1988). A number of spiritual care models (Ceronisky, 1993; Karns, 1991) and creative approaches to spiritual care (Prail, 1995) have been advanced. Julia Lane (1987) suggested that the spiritual care of patients be addressed in three parts: first, by identifying the characteristics of spiritual care in relation to the essential nature of the human person; second, by identifying spiritual care interventions; and finally, by viewing nursing as a vocation (p. 332). Emblen and Halstead (1993) identified

five spiritual care interventions appropriate to nursing: “listening to the patient express key concerns; praying with the patient; reading favorite portions of religious readings; spending time with the patient; and making a referral to a chaplain” (pp. 181–182). Dennis (1991), in a study of 10 nurses who reported providing spiritual support from a nonreligious perspective, also found the concepts of listening and spending time with patients to be important components of spiritual care. Recent research has demonstrated that there is a need for educational strategies to prepare nurses for spiritual caregiving (Greenstreet, 1999); spiritual care infiltrates all aspects of nursing care (Carroll, 2001); there are cultural aspects involved in spiritual care (Sellers, 2001); and nurses themselves derive much satisfaction from providing spiritual care to their patients (Nolan, 2000; Narayanasamy & Owens, 2001; Treloar, 2001; Stephenson & Wilson, 2004; and Kumar, 2004). From a review of the literature, three key competencies of spiritual care were identified, including “awareness of the use of self; spiritual dimensions of the nursing process; and assurance and quality of expertise” (van Leeuwen & Cusveller, 2004, p. 234).

Explorations into the nature and role of spiritual care in nursing were conducted by Ellis and Narayanasamy (2009) and Pierce (2009). Tanyi, McKenzie, and Chapek (2009) investigated the incorporation of spiritual care into practice by nurse practitioners and other healthcare professionals. Spiritual care was defined by Hummell, Galek, Murphy, Tannenbaum, and Flannelly (2008). Nurses' understanding of spiritual care was explored by Kemp (2009); Chung, Wong, and Chan (2007); Swift, Calcutawalla, and Elliott (2007); and Moore (2007).

How can the nurse not grounded in a religious tradition or spiritual philosophy practice spiritual care? Should such a nurse attempt to intervene relative to the spiritual needs of an ill person? Ultimately the response must lie with the individual nurse.

As noted earlier, all nurses are responsible for being aware of and sensitive to their patients' spiritual needs as a dimension of holistic health care. It is suggested that nurses may even “be called upon to pray with or for patients as a part of holistic care” (Narayanasamy & Narayanasamy, 2008, p. 394), and in a discussion of “ethical principles of spirituality,” Cheryl Lantz observed that nurses are “ethically obligated to provide spiritual care to clients” (2007, p. 36). It has also been noted, however, that the lack of a clear definition of spirituality may hinder nurses from providing adequate spiritual care (Denholm, 2008, pp. 451–452).

The minimizing or neglect of this aspect of patient care may have serious implications for the overall illness adaptation. The nurse must consider spiritual needs as part of a comprehensive nursing assessment. What may vary, however, is the degree to which individual nurses carry out therapeutic intervention in response to spiritual needs. Many nurses do feel both comfortable and confident in engaging in such spiritual care activities as praying with patients, sharing the reading of

Scripture passages, and listening to and counseling a patient about spiritual concerns. These activities may be appropriately carried out by a nurse if acceptable to the patient and family. For the nurse who does not feel adequately prepared to be involved in the practice of spiritual care, the appropriate course of action is referral to another nurse comfortable with providing spiritual intervention or to a formally trained pastoral caregiver.

Related to the nurse's role as anonymous minister, the majority of spiritual care provided as a component of nursing activity is unrecognized and unacknowledged. Spiritual care is rarely documented on patients' charts (Brotten, 1997, p. 29). Nevertheless, current nursing research and clinical evaluations continue to identify the value placed on the nurse's role in providing spiritual care, by both patients and families.

A number of more recent articles confirm the importance of the role of spirituality in contemporary nursing practice. Nursing leader Phillip Kemp points out that spiritual care is so central to nursing practice that it is incorporated in "the way in which [a nurse] behave[s], talk[s], care[s], guide[s] or treat[s] people" (2009, p. 334). Spiritual care, it is asserted, "is widely recognized in nursing theory," and "involves a complexity of social processes, of which developing caring relationships is core" (Carr, 2008, p. 686). Nevertheless, it is also recognized that spiritual care is not always understood and sometimes "dwells on the periphery of the profession" (Carr, 2010, p. 1379). Nursing leader Anna-Marie Stevens suggests that there can be "a role for spirituality in palliative care leadership" (2011, p. 315), and nurse educator Donia Baldacchino reported the introduction of an experience in spiritual care for nursing students in order to expose them to the practice (2010).

Pediatric nurse practitioner Mary Sweat observes that part of spiritual care may be simply providing a "quiet place" for the patient and suggests four premises to support the idea; these ask the nurse to "respect privacy," "create an environment that promotes respect," "respect individual preferences," and "respect yourself" (2012, p. 180). Wright and Neuberger (2012) offer "a seven point manifesto" for integrating spirituality into nursing care. The positions include:

1. Spiritual care is not a luxury . . . but goes to the heart of care.
2. Educational programs that nurses undertake must provide an in-depth understanding of what people mean by spirituality.
3. Imaginative educational programs for nurses relating to spiritual care [should be offered].
4. The workplaces of nurses should ideally provide all patients with access to spiritual support.
5. Spirituality has a direct effect on health and well-being.

6. Spiritual care . . . is essential for the ongoing training of all nurses.
7. Spiritual care is also a part of enhancing the healing environment (p. 21).

## **SPIRITUAL CARE AND RELIGIOUS TRADITION**

In order to engage in the assessment of spiritual needs and the provision of spiritual care for patients whose personal spirituality is intimately interwoven with religious beliefs and practices, the nurse should have some basic knowledge about the traditions of the major world religions. Obviously, the nurse may not herself subscribe to the religious tenets and practices of a particular patient; however, a broad understanding of the patient's religious culture will assist in identifying spiritual problems and in making referrals to an appropriate pastoral caregiver. The spiritual care of the atheist, who denies the existence of God, and the agnostic, who questions the existence of God, may consist of listening to and providing emotional support for the patient.

It is neither the intent nor within the scope of this text to present a comprehensive review of world religions. The following discussion is intended only as an overview of key tenets of the religious groups described. This delineation of selected spiritual and religious beliefs and practices may, however, provide the nurse with a starting point in interaction with patients of different faiths. The best strategy in conducting a spiritual assessment is to attempt to learn from the patient or a family member which religious beliefs and practices are most important, especially those pertinent to health and illness issues.

Two major categories of religious tradition are generally considered to be Western spiritual philosophy and Eastern spirituality. The three key Western religions are Judaism, Christianity, and Islam; all are founded on a monotheistic theology. Major Eastern traditions include Buddhism, Hinduism, and Confucianism, the tenets of which differ, especially in regard to the worship of God or of a multiplicity of gods.

Native American religions, of which there are many, generally look to the earth and the spirits of nature for comfort, sustenance, and support. Most Native American religions share a common view of the cycle of life and death and use ritual ceremonies to mark life transitions (Taylor, Lillis, & LeMone, 1997).

### **Western Religious Traditions**

Within the Western religions of Judaism, Christianity, and Islam, the one supreme being is named Yahweh, God, or Allah.

Judaism is described as one of the oldest religions “still practiced in western civilization” and “the foundation on which both Christianity and Islam were built” (Taylor, Lillis, & LeMone, 1997, p. 885). The major religious Jewish groups are

Orthodox, Conservative, and Reform; a more recently identified fourth Jewish tradition, which emerged out of a conservative mindset, is Reconstructionist Judaism (Pawlikowski, 1990, p. 543). The groups differ significantly in regard to religious beliefs and practices. Orthodox Jews follow the traditional religious practices, including careful observance of the Talmudic laws; the Conservative and Reform movements interpret the laws more broadly (Charnes & Moore, 1992). All Jewish traditions emphasize the practice of good deeds or mitzvahs each day (Nutmiewicz, 1993, p. 561). Although daily religious rituals are central to the faith of most Jewish persons, health is so valued that “almost all religious injunctions may be lifted to save a life or to relieve suffering” (Charnes & Moore, 1992, p. 66). Jewish people tend to believe that the occurrence of illness is not an accident but rather a time given one to reflect on life and the future (Beck & Goldberg, 1996, p. 16). The keeping of a kosher dietary regimen, if not injurious to health, is very important to many Jewish patients’ coping with an illness experience (Fine, 1995), as is the keeping of Shabbat or Sabbath, which is observed from sunset on Friday evening to sunset on Saturday. “It is suggested that home visits should not be scheduled on the Sabbath [*Shabbos*, from sundown Friday to sundown Saturday] for this is a day set apart for God, to honor him and use for prayer, studying scripture and special family time” (Salladay & Bitting, 2012, p. 15). Death, for the Jewish believer, is viewed as part of life; it is important to document the precise hour when death occurs in order to establish the time of mourning, shiva, and the annual “honoring of the dead, Yahrzeit” (Beck & Goldberg, 1996, p. 18).

Christianity, the largest of the world religions, consists of three main divisions: Roman Catholicism, Eastern Orthodox religions, and the Protestant faiths.

Roman Catholicism identifies that group of Christians who remain in communion with Rome, and who profess allegiance to the doctrines, traditions, philosophies, and practices supported by the pope, as religious leader of the Church. Roman Catholics are trinitarian in theology and place great importance on the seven sacraments: Baptism, Reconciliation (Confession), Holy Eucharist, Confirmation, Matrimony, Holy Orders, and Anointing of the Sick (formerly called “Extreme Unction”); participation in the holy sacrifice of the Mass is the central element of worship.

The Eastern Orthodox tradition, which represents a group of churches whose international leaders are located in Eastern Europe, differs from the Roman Church on both theological issues and aspects of ritual and worship. These churches respect the primacy of the patriarch of Constantinople and include reverence for the Holy Trinity as a central spiritual tenet of the faith. Veneration of holy icons is an important devotion leading ultimately to worship of God the Father, God the Son, and God the Holy Spirit. Currently the term Eastern Orthodox Church refers to four ancient patriarchates (Constantinople, Alexandria, Antioch, and Jerusalem), as well

as a number of other churches such as those of Russia and Romania, Cyprus, Greece, Egypt, and Syria (Farrugia, 1990, p. 306).

The term Protestant generally refers to the churches that originated during the 16th-century Reformation (Gros, 1990). Some characteristics of original Protestantism are “the acceptance of the Bible as the only source of revealed truth, the doctrine of justification by faith alone, and the universal priesthood of all believers” (Livingstone, 1990). Protestant Christians generally regard Baptism and Holy Communion as important sacraments, although denominations may differ on associated rituals. Some of the major Protestant denominations are Adventist, Baptist, Church of the Brethren, Church of the Nazarene, Episcopal (Anglican), Friends (Quakers), Lutheran, Mennonite, Methodist, and Presbyterian.

Christianity is based on the worship of God and promotion of the Kingdom of God through the living out of the Gospel message of Jesus of Nazareth. For the Christian patient, the nurse will need to be sensitive to a multiplicity of religious beliefs and rituals associated with such health-related events as birth, childbearing, organ donation, and death. For example, infant Baptism is required by Roman Catholics and Episcopalians, and Last Rites or the Sacrament of the Sick is optional for some Protestant groups, but traditional for Eastern Orthodox Christians (Krekeler & Yancey, 1993). In a study of Christian patients’ attitudes toward spiritual care, Conco (1995) found that three key themes emerged from interview data. Christian patients described the spiritual care they received as “enabling transcendence for higher meaning and purpose,” which helped the patients find meaning in their illness and suffering; “enabling hope,” which included the belief that the patients could find a better future; and “establishing connectedness,” a theme that spoke to the support provided by the caregiver in terms of such activities as touching, listening, and being present to the patient (pp. 271–272).

Other Western churches of which the practicing nurse should be aware include Christian Science, Church of Jesus Christ of Latter Day Saints (Mormons), Jehovah’s Witnesses, and Unitarian Universalist Association of Churches (Taylor, Lillis, & LeMone, 1997, p. 886).

Islam is frequently viewed as having been founded by the prophet Muhammed in the 7th century, with the revelation of the Holy Qur’an. Muslims themselves, however, do not regard Islam as a new religion; “they believe that Allah is the same God who revealed His will to Abraham, Moses, Jesus and Muhammed” (Esposito, 1990). A key tenet of Islam is Tauhid, which means faith in the total Lordship of Allah as ruler of heaven and earth; allied with this concept is the understanding that one’s life must be centered on this belief (Abdil-Haqq Muhammad, 1995). Important religious practices for Muslims include the ritual prayer, prayed five times each day (preceded by ritual washing) while facing Mecca (the east); honoring Ramadan, the month of fasting from sunup to sundown, which occurs in the ninth lunar month

of the Islamic calendar; and the experience of a hajj, a pilgrimage to Mecca, once in one's lifetime, if possible. Spiritual care for a hospitalized Muslim patient should be focused on providing the time (about 15 minutes) and the setting (a quiet, private place) for the five-times-daily ritual prayer (Kemp, 1996, p. 88). Most hospitals have access to the services of a Muslim spiritual leader, an imam, if requested by the patient (Rassool, 2000).

A Muslim registered nurse, Selia, spoke about some of the needs of Muslim patients who have entered into the healthcare system:

A Muslim patient, what they need during their sickness is similar to what a Christian patient needs: they need a faith in God; they need someone to listen to them; someone to talk about God with them; to know the support coming from God. We have some people in Islam, Muslim women, like who you might say is a "nun," and they are very prayerful and we might ask them to visit and to pray for someone who is sick. We also have in Islam, an imam, who is the spiritual leader of the mosque; he can be called to visit and pray with patients.

Selia also spoke of the importance of faith in helping her own sister accept a diagnosis of cancer. "The staff nurse helped her see that the cancer was not a punishment from God. The nurse sat with her and prayed with her in Arabic and after this she was able to accept her chemotherapy. The 'spiritual' was the most important thing in helping my sister accept her cancer and her treatment." Selia noted that if a patient was not physically able to pray facing Mecca during an illness or treatment, "They can pray while they are lying in bed; they can pray in their minds, even if they are not able to talk. Nurses should encourage Muslim patients to pray to accept their disease because it will help them to cope." She added, "One does not mourn if a family member dies from an illness; they accept this as the will of Allah and one does not contradict this."

Selia continued, "Although a Muslim patient who is very ill is not required to pray five times each day, Muslim hospitals usually prepare prayer rooms; one for women and one for men, who are able to move about. During Ramadan, a patient is not required to fast. The Qur'an says that the sick person, after he gets well, can fast then. She explained, however, that some patients "insist on fasting because they think it is like a prayer; it is something from God."

Finally, Selia spoke of the importance in Islam of visiting the ill:

The Prophet Mohammed, in the Holy Qur'an, it is written in his own words, that each Muslim should visit patients who are sick and support them and pray with them. It is a must for each Muslim to pray; to ask Allah to help that patient and to help all patients all over the world, whatever their religion.

## Eastern Religious Traditions

The major Eastern traditions—Buddhism, Hinduism, and Confucianism—incorporate beliefs about God that differ significantly from those of religions of the Western tradition.

Buddhism derives its beliefs and practices from the life and teachings of the Buddha, the “enlightened one,” who lived in India some 2500 years ago (Borelli, 1990). Myriad Buddhist traditions are associated with the cultures of particular geographical communities, such as Tibetan Buddhism or Chinese Buddhism. Wherever Buddhists are found, there are usually monasteries of monks, and sometimes nuns, who preserve the Buddhist teachings and liturgies. Buddhists believe that suffering can be ended by following the eightfold path: “right understanding, right intention, right speech, right action, right livelihood, right effort, right mindfulness and right contemplation” (Borelli, 1990, p. 146). Buddhists do not revere any particular sacraments.

Hinduism does not embrace one particular body of beliefs and practices; the name Hindu is derived from the geographical region of the Indus river valley and the subcontinent, Hindustan, where many of those who practice Hinduism reside (Cenkner, 1990). Key concepts in Hinduism relate to reincarnation or rebirth and the idea of karma, or “the law by which one’s personal deeds determine one’s present and future status in this life and in future lives” (Cenkner, 1990, p. 467). Hindus who have lived well do not fear death; it is seen as the preparation for reincarnation into another life.

Confucianism is an Eastern tradition derived primarily from the personal philosophy of the ancient Chinese scholar Confucius. Inherent in Confucian thought is belief in the importance of maintaining harmony and balance in the body. Two potentially conflicting forces are thought to occur in the world, the “yin” and the “yang”; it is critical that these dimensions of function be kept in balance in order to achieve and maintain a good and productive life.

## NURSING THEORY AND SPIRITUAL CARE

In the ideal world of nursing, clinical practice would be based on and directed by well-validated nursing theory; this includes the practice of spiritual care. Nursing theory, however, is still relatively new, having been developed primarily over the past three decades. And in a number of the grand theories of nursing, the spiritual needs of the ill person are given only minimal attention. As more grand nursing theory, as well as theory of the middle range, is generated, scholars anticipate that spirituality will be an important concept of interest. One example is the work of Judith Allen Shelly and Arline Miller, *Called to Care: A Christian Theology of Nursing* (1999).

Speaking from the practitioner's perspective, hospital charge nurse Andrew Oldnall (1995) decried the fact that many nurse theorists have either omitted discussion of the concept of spirituality from their models or have "referred to it only implicitly" (p. 417). There has, however, been a recent reawakening to the importance of the spiritual nature of the human person among contemporary nurse theorists. Barbara Barnum (1995) posited three reasons for what she describes as a "spiritual resurgence" in nursing; these include "a major shift in the normative world view," "a spiritual focus in the growing self-help movement," and "a renewed drive on the part of traditional religious groups and individuals within nursing" (p. 24). Barnum's suggestion that the "self-help movement" has been a catalyst for nursing's current interest in spirituality may be related to the holistic healthcare concept, a central premise of the holistic approach being patient autonomy and participation in therapeutic planning.

In examining the writings of some of the key nurse theorists of past and present, one finds significant variability in terms of interest in spirituality or the spiritual needs of the ill person. One of the earliest theorists, Virginia Henderson, writing with Harmer in 1955, observed that "sickness may threaten the patient's faith in the ultimate 'goodness' of life. He cannot believe in a God that lets terrible things happen; or he may fear he has lost favor in the sight of God, considering illness a punishment for real or imagined sins" (p. 74). In her later work, Henderson (1966) identified as one of 14 "Components of Basic Nursing Care" provision for "Worship according to one's faith" (p. 17); she did not, however, explore this precept in any detail. Faye Abdellah (Abdellah & Levine, 1979), in "Criterion Measures of Patient Care," also included a patient care component related to personal faith "to facilitate progress toward achievement of personal spiritual goals"; Abdellah, like Henderson, viewed attention to the patient's spiritual needs as a key component of nursing care.

Joyce Travelbee, in her theory of illness as a "self-actualizing experience," was more explicit in her concern with both the patient's and the nurse's spirituality, observing, "It is believed the spiritual values a person holds will determine, to a great extent, his perception of illness. The spiritual values of the nurse or her philosophical beliefs about illness and suffering will determine the degree to which he or she will be able to help ill persons find meaning, or no meaning, in these situations" (1971, p. 16). Travelbee further asserted that a patient's religious beliefs will greatly influence the experience of, and the ability to cope with, suffering (p. 64). She admitted, however, that the degree to which a person actually practices his or her religion is a mediating factor in relation to coping with distress and suffering (p. 71).

Nurse theorist Betty Neuman's systems model is a conceptual framework that addresses the spiritual dimension and needs of the ill person. In Neuman's model, the patient system is assessed holistically from five perspectives: physiologic, psychological, developmental, sociocultural, and spiritual (Sohier, 1997, p. 112).

For Neuman, the spiritual dimension of a person supports and permeates all other systems (Fawcett, 1989, p. 172). In her earlier work, Betty Neuman placed less emphasis on the spiritual; the spiritual aspects of her theory were first significantly displayed in her 1989 understanding of the patient system (Meleis, 1991, p. 294). In the third edition of the theorist's book *The Neuman Systems Model*, Neuman's "spiritual variable" is described as the pivot on which the framework centers and as having important implications for patients from a variety of world cultures (Curran, 1995, p. 581).

Callista Roy's adaptation model, which focuses on the adaptive needs of the ill person and family, includes a self-concept adaptive mode that emphasizes the psychological and spiritual characteristics of an individual. This model addresses the "self-consistency, self-ideal and moral-ethical-spiritual self" of a patient (Phillips, 1997, p. 177). Religion or religious practice is considered one of the significant cultural influences on a patient's adaptation. Although Roy identified the concept of religion as primarily associated with the major organized traditions of Eastern and Western society, she noted that this cultural category may also include "spiritual beliefs, practices and philosophies that are not necessarily attached to institutional forms of religion" (Sato, 1984, p. 69). Callista Roy views religion as an important variable in the adaptive process, as she perceives religiosity or religious practice as potentially influencing all dimensions of a person's life view and functional capacity, especially in terms of attitudes and behaviors related to health and illness.

Two other nursing theories that indirectly address the concept of the patient's spiritual nature in terms of phenomenological and humanistic approaches are the models of Parse (1981) and Paterson and Zderad (1976). Parse accepted the transcendent nature of humanity. "Nursing is unfolding in simultaneous mutual interchange with the world transcending with greater diversity and complexity" (p. 172). Paterson and Zderad viewed the human person as "an incarnate being, always becoming, in relation with men and things in a world of time and space" (p. 19).

And finally, nurse theorist Jean Watson (1985) explained the nature of personhood by placing significant emphasis on the existence of the "human soul [spirit or higher sense of self] that is greater than the physical, mental and emotional existence of a person at any given point in time" (p. 45). Sarter (1992) asserted that Jean Watson is the only nurse theorist who explicitly describes the concept of the soul (p. 152).

In examining the writings of the select group of nursing theorists mentioned, one finds key words related to patients' spiritual needs, including faith, worship, spiritual goals, spiritual values, transcendence, human soul, higher authority, and organized religion. Identifying the patient's understanding of these concepts is important for a nurse undertaking the practice of spiritual care.

## NURSING INTERVENTION: THE PRACTICE OF SPIRITUAL CARE

Admittedly, a nurse may not know precisely which nursing therapeutics to employ when faced with a patient experiencing spiritual need. Simple guidelines presented in an earlier publication may provide some basic ground rules for spiritual care:

The nurse must attempt to respect and understand a patient's religious beliefs and practices, even if very different from his or her own. The nurse must take time to allow the patient to express religious, ethical, or philosophical views, as well as any fears and anxieties related to the patient's spiritual belief system. The nurse must be spiritually supportive, assisting the patient whenever it is within the realm of his or her understanding or expertise, and recognize the need to seek outside spiritual or ministerial counseling, either personally or for the patient, when the situation warrants.

(O'Brien, 1982, p. 108.)

Nurses should keep two important principles of spiritual intervention in mind when ministering to those who are ill. First, because each person has a unique spirituality, the provision of spiritual care cannot be derived from a procedure book of orders; and second, to intervene in the spiritual needs of others, the nurse must first understand his or her own spirituality or relationship to God (Fish & Shelly, 1979, p. 68).

In his best-selling book, *Care of the Soul*, Thomas Moore (1992) observed that spiritual caring forces one to transcend the self and to “recover a sense of the sacredness of each individual life” (p. 19). Moore asserted that spiritual care of the soul incorporates the mystery of suffering and does not deny life's problems (pp. 19–20). Ultimately, Moore contended that spiritual care “requires craft (techne), skill, attention and art” (p. 285).

A number of factors, both positive and negative, have been identified that can affect the practice of spiritual care by nursing staff. In a study of 110 nurses, nursing professor Moon Fai Chan learned that “the greater the nurse's [positive] spiritual care perceptions, the more frequently spiritual care is included in that nurse's practice” (2009, p. 2128). Chan's tool measuring “perceptions” of spiritual care included such topics as the importance of spiritual care to the sick, the strength that can be drawn from spiritual care, and the relevance of spiritual care as an “important dimension of nursing” (p. 2132). Family practice physicians and nurse practitioners were studied to determine how spiritual care was carried out “in spite of documented barriers” (Tanyi, McKenzie, & Chapek, 2009, p. 690). Five key themes emerged from this phenomenological research: “(1) discerning instances for overt spiritual assessment; (2) displaying a genuine and caring attitude; (3) encouraging the use

of existing spiritual practices; (4) documenting spiritual care for continuity of care; (5) managing perceived barriers to spiritual care” (p. 690).

## **NURSING INTERVENTION IN SPIRITUAL DISTRESS**

A patient’s experience of spiritual suffering, or spiritual distress, may pose unique challenges for nursing intervention (Kahn & Steeves, 1994). Spiritual distress may be experienced by any ill person questioning the reason for his or her suffering (Harrison, 1993). Defining characteristics of spiritual distress include questioning one’s relationship with God, attempting to identify religious idols, guilt feelings, and a variety of somatic symptoms (Heliker, 1992, p. 16); questioning the meaning and purpose of life; expressing anger toward God; refusing to participate in usual religious practices; regarding illness as God’s punishment; and seeking spiritual assistance, other than usual spiritual or religious support (Tucker, Canobbio, Paquette, & Wells, 1996, p. 52).

The nurse does not need religious training to meet the needs of a patient in spiritual distress (DiMeo, 1991, p. 22); nurses continually engage in the process of assessing, planning, intervening, and evaluating (the nursing process) related to physical and emotional nursing diagnoses. In assessing spiritual need, the nurse must determine whether he or she may provide the spiritual care, such as listening and counseling, or whether referral should be made to a chaplain or formally trained minister of the patient’s denomination (Duff, 1994).

Counseling a person in spiritual distress can constitute a growth experience for the nurse while also providing support for the patient (Burnard, 1988). This was validated in the observations of Gail, a 16-year veteran of nursing interviewed by the author:

Spiritual care, listening, advising is so important, because people are hurting so much. They suffer a lot and the main thing is to listen and let them tell you their pain. I can’t tell them there’s a cure and they know that; they lean on God, because there is no other answer. Sometimes chaplains come up and do a “quickie”: “I’ll keep you in my prayers.” But sometimes the patient just needs somebody to sit and listen to her, and be with her. . . . I have seen and listened to much more spiritual distress in patients than I would ever have imagined, and I think it has made me grow spiritually. It’s helped me to think about Christ’s forsakenness. Suffering in itself can be a prayer.

Spiritual care interventions were identified in response to a nursing diagnosis of spiritual distress in a 41-year-old AIDS patient who demonstrated symptoms of fear of death and questioning belief in God. These nursing therapeutics included assisting the client to explore the spiritual meaning of coping with the

HIV experience, providing support for the expression of feelings, and allowing the patient to proceed through the grief process related to physical and psychosocial losses (O'Brien & Pheifer, 1993, p. 314).

The success of spiritual interventions such as prayer in patients with spiritual distress, related to a number of disease/illness conditions, has been documented in the literature. Some examples are: "seeking comfort through prayer" among coronary artery bypass graft patients (Hawley & Irurita, 1998); prayer as a health strategy in managing HIV-related symptoms (Coleman, Nokes, Corless, Kirksey, Nicholas, & Tsai, 2006); and the benefits of prayer for cancer survivors (Levine, Aviv, Yoon, Ewing, & Au, 2009; Ross, Hall, Fairley, Taylor, & Howard, 2008). The importance of spirituality in coping with the distress of early Alzheimer's disease was documented by Beuscher and Grando (2009).

Findings from an online survey of 4054 nurses in the United Kingdom revealed that "nurses recognize that attending to the spiritual needs of patients enhances the overall quality of nursing care" (McSherry & Jamieson, 2011, p. 1757). In addition, two nursing authors contend that spiritual care includes considering the "soul" of the patient being served: Stephen Wright (2011) asserts that spiritual care is "an essential feature of high-quality patient care" (p. 18) in "The Heart and Soul of Nursing," as does Fenske (2011), an advanced practice nurse who used "multiple theoretical frameworks to make meaning of her severely developmentally disabled son's untimely death" (p. 229) in "Soul Mate: Exploring the Concept of Soul."

## **The Problem of Suffering**

Perhaps the most difficult challenge a practicing nurse may face in attempting to carry out the theological mandate of caring is addressing a patient's suffering. Washholtz, Pearce, and Koenig (2007) explored the relationship between spirituality and the suffering of chronic pain in order to understand why "some people rely on their faith to cope with pain" (p. 311). These authors concluded that "spiritual and religious coping may affect a number of physiological, psychological, neurological and zemotional domains that influence pain perception and tolerance" (p. 316). Nurse theorist Katie Eriksson has asserted that "the mission of caring is the alleviation of human suffering and the serving of life and health" (2007, p. 8). And a team of palliative care providers report that addressing the "spiritual issues in suffering . . . is recognized as a very important component of palliative care" (Hinshaw, Carnahan, Breck, Mosoiu, & Mosoiu, 2011, p. 7).

In some cases, the nurse's therapeutic toolbox will contain instruments to alleviate the suffering, at least for a time. In other situations, the pain, whether physical, emotional, or spiritual, seems to take on a life of its own; no techniques or supplies in the nurse's armamentarium prove effective. At such an impasse the nurse, like

the chaplain, must wrestle with the imponderable “why.” And for the caregiver with a strong religious foundation, be it of the Judeo-Christian tradition or some other belief system, the “why” of suffering may take on a powerful spiritual élan. Why does an all-powerful God allow an infant to be born with multiple congenital anomalies? Why does a loving and compassionate God not intervene to alleviate a teenage cancer patient’s intractable pain? Why does a merciful God not use his strength to heal a terminally ill mother whose death will leave orphaned children?

The nurse may also be called on to respond to patients’ and family members’ inability to understand or accept the reason for an injury or illness. Joyce Travelbee (1971) focused specifically on this point when she defined the purpose of nursing as being “to assist an individual, family or community to prevent or cope with the experiences of illness and suffering, and, if necessary, to find meaning in their experiences” (p. 16). Often, however, it is difficult to articulate a profound existential meaning in an illness experience; thus, the nurse must indeed draw on Moore’s thesis of accepting suffering as mystery and of not attempting to offer a patient or family false hope or an unreal prognosis.

Several years ago, the author spent a summer as a chaplain intern at a research medical center whose treatment was directed primarily to those with life-threatening illness. Most of the patients were coping with the potential for a relatively imminent death or at least a shortened life; many were burdened with pain and suffering, both physical and spiritual. For the patients, the families, the staff, and the chaplains, the “why” question always seemed to be lurking in the background. Sometimes it was spoken aloud; at other times it could be read in the eyes of the patients and those who loved and cared for them. The following excerpt from the author’s chaplaincy journal describes a mother’s distress over the suffering of her son:

This morning Catherine, the mother of a teenage son, Michael, who was facing mutilating surgery in hope of slowing the progress of advanced rhabdomyosarcoma, came to me in great spiritual pain; she said: “I need you to answer a question: Why? Why my beautiful, generous, loving son? Why not me; I’ve lived a full life? Why is the God I pray to letting this happen to him? I don’t understand.” I tried to respond to Catherine’s question with some thoughts about the mystery of God’s ways; mostly I just listened. Catherine spoke for over an hour, pouring out all of the pain in her heart, all of the love for her son, stopping only once to remind me gently, “You still haven’t answered my question: Why?”

At the end of our meeting Catherine said, “Thank you for spending this time with me; it’s helped more than I can ever tell you.” She did not raise the “why” question again; I breathed a sigh of relief.

When this experience was shared with other medical center chaplains, one observed, "I'm sure that mother knew in her heart there was no answer to the question, 'why?'; she just needed someone to be with her while she asked it."

Most patients and families who suffer, especially those with spiritual foundations, understand that in the realm of the Holy Mystery, the why question has no answers that we, as humans, can comprehend. Rather, what they ask of us as caregivers is, like Catherine, that we be there with them while they ask the questions, that we accept with them the mystery of human suffering, and that we offer no false illusions. This is the essence, the heart of spiritual caregiving.

Suffering as a concept has been defined as "any experience that impinges on an individual's or a community's sense of well being" (Sparks, 1993, p. 950). Sparks added that suffering may be "physical, psychological, interpersonal or spiritual," though he commented that generally it is a combination of all four (p. 950). Suffering is usually understood as a state rather than an incident. It is described not "by sharp pains and moments of terror but by an almost unbearable duration and inescapability" (Maes, 1990, p. 29). Suffering defines an ongoing and consistent state of distress, not merely a brief encounter with painful stimuli. Many of those who are chronically ill well understand the notion of an ongoing state of distress; they may experience, at any one time, a combination of physical, emotional, and spiritual suffering related to an illness condition.

A dimension of suffering frequently encountered in the healthcare setting and explored in the theological literature relates to the question of "why"; what or who is responsible for the suffering? Suffering, religious faith, and illness have long been associated concepts (Hufford, 1987). The "why" query is highlighted in the classic biblical story of Job. "They [Job's friends] sat down upon the ground with him seven days and seven nights, but none of them spoke a word to him, for they saw how great was his suffering" (Job, 2:13). Job was, seemingly, a good man, and yet he suffered great physical trials, which both he and his friends questioned. In his anger and frustration Job cried out to God, "Why?" According to the Scripture, God never answered Job's question but simply asked him to have faith, which ultimately Job accepted. Theologians agree that the story of Job, often quoted in relation to suffering, leaves the "why" question unanswered and supports the need for absolute faith in God (Baird, 1994; Bergant, 1990; Kidner, 1983).

Robert, a young man who had been living with cancer for more than 5 years, described a kind of "Job-like" anger at God. Like Job, Robert ultimately was able to trust in his long-standing faith relationship with his creator:

When I found out I had cancer I was depressed and really mad at God. But then, because I was so scared, I started to pray. And, you know, I learned about praying and about how you really can talk to God. God has always been with me and he'll be with this too. I just have to trust his love.

Robert's conclusion is supported by theologian Kathleen O'Conner's commentary on the "Job Story." O'Conner (1990) observed that the book of Job is not really about suffering but about one's relationship to God while experiencing suffering (p. 104). She asserted, like Robert, that the lesson to be learned is to pray, to ask God for answers, and then to accept and trust.

In discussing religious interpretations of sickness-related suffering, Emeth and Greenhut (1991) decried explanations claiming that illness is a form of God's punishment or that God gives illness and suffering to those He loves (p. 63). While obviously God allows suffering and may use a suffering experience to draw an ill person to Him, most contemporary theologians would argue that a loving God could not purposely choose to hurt or cause pain. This thinking was reflected by Eriksson (1994) who warned against attempting to find "premature" or "quick-fix" explanations for suffering, asserting that to do so might block an individual from discovering his or her own phenomenological understanding of the meaning of a suffering experience (p. 7). As Eriksson observed, "Suffering in itself has no meaning, but people could, having lived through it, realize that it was in fact meaningful to do so" (p. 7).

In a pastor's response to the suffering experience, especially as related to illness, Rabbi Harold Kushner, author of the best-selling book *When Bad Things Happen to Good People*, asserted, "The God I believe in does not send us the problem; He gives us the strength to cope with the problem" (1981, p. 127). Rabbi Kushner's position is reflected in the comments of Paul, a middleaged cancer patient:

God doesn't design diseases; He is a God of love. Why does God allow His people to suffer from sickness? I don't know! But I do know He holds us up. We are His. We belong to Him and He will sustain us. We may walk the way of suffering but we will not be alone.

For the individual who denies or is uncertain about the existence of God, the condition of human suffering is more difficult to manage. Nurses need to be aware of the secular humanist philosophy of such a person. In the case of a patient who professes to be either an atheist or an agnostic, the listening, loving presence of a caring nurse may provide spiritual support and comfort in an experience of suffering.

The most difficult suffering for a nurse to work with is that which is unrelieved. Hospice physician Ira Byock (1994), in discussing persistent suffering, admitted that he sometimes asks himself the question, "how complete is my commitment?" (p. 8). Sister Rosemary Donley (1991) believes that part of the nurse's mission is to "be with people who suffer, to give meaning to the reality of suffering"; it is in these activities, Donley asserted, that the "spiritual dimension" of nursing lies (p. 180).

## SPIRITUAL AND RELIGIOUS RESOURCES

In order to provide spiritual care to patients from a variety of religious traditions, the nurse must have some familiarity with the available resources, particularly pastoral care, prayer, Scripture, religious rituals, devotional articles, and sacred music. The importance of nurses' understanding the meaning of spiritual and religious resources for patients from a variety of ethnic and religious groups was identified through hospital-based interviews and panel discussions (Davidson, Boyer, Casey, Matzel, & Walden, 2008).

### Pastoral Care

Pastoral care describes the interventions carried out by religious ministers in response to the spiritual or religious needs of others. The activities of the pastoral caregiver, "including sacramental and social ministries, can be as informal as conversational encounters and as formal as highly structured ritual events" (Studzinski, 1993, p. 722). Howard Clinebell (1991), identified five specific pastoral care functions: "healing, sustaining, guiding, reconciling, and nurturing" (p. 43). Such spiritual care interventions may promote significant healing on the part of ill persons.

Shelly and Fish (1988) noted the importance of the clergy as a resource in spiritual care of the ill; they asserted that spiritual care given by clergy and nurses should be complementary (p. 138). For such complementarity to exist, three conditions are suggested: mutuality of goals in the caregiving, a delineation of role responsibilities, and communication (p. 138). The activities of the minister or pastoral caregiver offer an important religious comfort dimension by providing the patient with familiar symbols and experiences (Atkinson & Fortunato, 1996, p. 99). A pastoral advisor understands the patient's religious belief system and can plan care to be congruent with the individual's religious heritage (Krekeler & Yancey, 1993, p. 1010).

In making a pastoral care referral, the nurse may contact a priest, minister, rabbi, imam, or other spiritual advisor of the patient's acquaintance and tradition, or refer the patient to a healthcare facility's department of pastoral care. To facilitate a pastoral care visit, the nurse may prepare a place close to the patient for the spiritual minister to sit, provide privacy to the degree possible in the setting, and cover the bedside table with a white cover if a sacrament such as Anointing of the Sick is to be administered (Taylor, Lillis, & LeMone, 1997, p. 896).

A renal failure patient, Catherine, spoke about the importance of pastoral ministry in helping her cope with the acute onset of her disease:

When I first went on dialysis and was in the hospital, I was sick as a dog. I had pneumonia plus the kidney failure and I thought I might die. But the response that I got from my minister and the church was just fantastic. The minister prayed for me, and I had everybody wanting to know how's my

dialysis going, and I got a list of 35 people from the church, especially the deacons, who were willing to drive me anywhere I need to go.

## Prayer

The word prayer is generally understood as a request or a petition to obtain some good outcome. There are a number of other kinds of prayer, such as prayers of thanksgiving, as well as specific methods of prayer, including vocal prayer, contemplation, and centering prayer.

Spiritual writer Carlo Carretto (1978) observed that “we can never define what prayer is . . . prayer is communicating with the mystery” (p. 75). Prayer is envisioned as the spiritual action one takes to bring an individual “into connection with God” (Johnson, 1992, p. 148). Prayer, whether formal or informal, may be central to healing the sick (Normille, 1992, p. 74). Healing prayer has been described as bringing oneself and a situation of disease before God, “with at least one other person to listen, discern, speak and respond, so that healing in relation to or with God can take place” (Bacon, 1995, p. 15).

Although prayer may be engaged in individually by a patient, and often is, it is important to remember that illness, especially acute illness, may create a “barrier to personal prayer” (Shelly & Fish, 1995, pp. 9–10). In such instances a nurse’s prayer for and with the patient can be an important spiritual care intervention. Shelly and Fish remind the nurse that his or her prayer should reflect what the patient would pray for if capable of doing so; they advised, “The most helpful prayer is usually a short, simple statement to God of the patient’s hopes, fears and needs, and a recognition of God’s ability to meet the patient in his [or her] situation” (p. 11). Prayer as a nursing intervention was described by a practicing nurse as “possible in any setting, as long as we ask people’s permission” (Mason, 1995, p. 7). Mason believes that prayer can be an important source of peace and comfort for an ill person (p. 7).

In a 1995 editorial in the *Journal of Christian Nursing*, editor Judith Shelly posed the rhetorical question, “Is prayer unprofessional?” In answering, decidedly in the negative, Shelly cited an address by Florence Nightingale to students at the Nightingale School of Nursing. Nightingale commented, in part, “Did you ever think how Christ was a nurse; and stood by the bedside, and with His own hands, nursed and did for the suffering?” (p. 3). In supporting prayer as an appropriate dimension of holistic nursing, Lewis (1996) also drew on the wisdom of Florence Nightingale as mentor and guide. “Nightingale recognized that the use of prayer attuned the inward man to the universal laws of God . . . and . . . contended that prayer could be applied to daily life for health, wholeness and healing” (p. 309). The importance of the healing power of prayer in holistic nursing was supported by Narayanasamy and Narayanasamy (2008), DiJoseph and Cavendish (2005), and Ameling (2000).

Two chronically ill persons experiencing bouts of acute exacerbation of their conditions described the comfort personal prayer afforded them. Agnes, a maintenance hemodialysis patient who was hospitalized at the time, reported, "I believe in a hereafter, and in a God someplace, and that makes you feel like, OK, I can go on. If I feel bad, I can lay in bed and talk to Him, when I don't want to talk to anybody else about my feelings. That's it. That's what religion is all about." Nicholas, an AIDS patient suffering from acute symptoms of cytomegalovirus, admitted, "Sometimes when I'm having a bad day, you know, Why is this happening to me? I say to God, 'could you give me a little hand here?' And usually what happens is I get overwhelmed with gratitude, and I get a sense that God's saying, 'You can handle it, Nicholas; I'm right here.' Sometimes His words actually come to me. I mean, I don't hear a booming voice, but I hear real words in my heart."

A family member of an AIDS patient who had recently died in the ICU after a bout with pneumocystis carinii pneumonia, described the importance of a nurse's prayer in the unit:

I was particularly touched when [she] prayed for Jonathan in the hospital. I didn't say it at the time but when she prayed aloud it was like I was burning inside. And I prayed too. She really had a way with words and I hoped to emulate that.

As advised by Shelly and Fish, the nurse praying aloud for a patient should try to pray as the patient would. An example is a prayer said by the author while in chaplaincy training. Michael, a 36-year-old hospitalized patient suffering from an anaplastic astrocytoma, had described himself as a born-again Christian. Michael loved to talk to and about Jesus in a very direct and simple manner; however, it was difficult for him to articulate a prayer, so he asked that it be done for him. The prayer, recorded in a clinical pastoral education report, is as follows:

Lord Jesus, put your arms around Michael as he prepares for his chemo treatment. Let him know that he is not walking on this path alone, that you are right there by his side; you are holding him up and supporting him with your strength. Let him know that you are holding his hand. Remind Michael that his name is written on the palm of your hand. [Michael frequently responded, "Amen" or "Thank you, Jesus."] Michael knows you, Jesus, and knows that you are His Lord. Help him to feel your love and care during this illness. Bless the doctors and the nurses who are giving Michael his treatments, that their hands may be Your Hands as they care for him on this journey. God, our Father, you know what Michael needs in these days, and you know the prayers that are in his heart. Bless his prayer, protect him, guide him and comfort him, we ask this in the name of your son, our Lord Jesus. Amen.

Michael responded to the prayer by saying, “Thank you, your coming here and ministering means a lot to me.”

## Scripture

Scripture, or the “word of God,” is written material that represents venerated and guiding principles for many religious traditions. For the Jewish community, the Hebrew Scripture as contained in the Torah represents God’s word and laws for his people. For a Christian, both Old (or “First”) and New Testaments contained in the Bible are revered. The Old Testament, shared with the Jewish religion, contains “the story of God’s work in the world from creation to the period of the second temple (built in 515 B.C.E.);” the second, or “New Testament . . . begins with the story of Jesus, and contains documents and letters and visions of the early Christian community in the 1st century CE” (Nowell, 1993, p. 857). Merriam-Webster’s New Collegiate Dictionary (1976) defines the term scripture, not only as “the books of the Old and New Testaments,” but also, broadly, as “the sacred writings of a religion” (p. 775). Thus, other scriptural materials, comforting for patients of the appropriate denominations, might include the Holy Qur’an (for Muslims) or the Book of Mormon (for members of the Church of Jesus Christ of Latter Day Saints).

Shelly and Fish (1988) cautioned that a “principle of appropriate timing” should govern the nurse’s use of Scripture (p. 121). If a patient is angry or depressed, or experiencing severe discomfort, such as that accompanying acute pain, the seemingly glib quoting, even of an apparently comforting Scripture passage, may seem like “rubbing salt into the wounds” of the sufferer. If, however, it seems that a patient might benefit from a Scripture passage, the nurse can always ask permission in a noncontrolling manner, leaving the patient free to refuse without discomfort. Related to nurses’ sensitivity to timing in the use of Scripture, a study of the spiritual caring behaviors of 303 nurses (Hall & Lanig, 1993) revealed that of three types of interventions (conversing, praying, and reading Scripture), nurses were least likely to read Scripture to their patients (p. 736). Ultimately, Piles (1990) suggested that prior to a nurse initiating the sharing of Scripture with patients, he or she should have acquired some sense of when the use of Scripture is an “appropriate intervention” (p. 39).

When a nurse feels comfortable sharing a passage of Scripture with a patient or family member, the reading can represent an important and valid dimension of spiritual care. Following are some suggested Scripture passages and their underlying messages:

For comfort in times of fear and anxiety—Psalm 23; Philippians 4:4–7; 1 Peter 5:7; Romans 8:38–39

For fear of approaching death—Psalm 23; John 14:17

For one in need of healing—Isaiah 53:4–6

For one seeking God's care and protection—Isaiah 43:2; Isaiah 40:28–31; Psalm 25; Psalm 121; Psalm 139:11–19; Deuteronomy 8:2–3; Jeremiah 29:11; Matthew 10:26–33; Luke 12:22–31

For one seeking God's mercy and forgiveness—Isaiah 1:18; Isaiah 53:5–6; Hebrews 4:14–16; 1 John 1:9

For one who is fatigued by illness or life stress—Isaiah 40:31

## Religious Rituals

*“One must observe the proper rites” . . . “What is a rite?” asked the little prince. “These are actions too often neglected,” said the fox.*

Antoine de Saint-Exupéry, *The Little Prince*

The concept of rite or ritual may be understood theologically as “a social, symbolic process which has the potential for communicating, creating, criticizing and even transforming meaning” (Kelleher, 1990, p. 906). Religious rituals are sets of behaviors that reflect and honor spiritual or religious beliefs on the part of the participant. There can be a profoundly healing value in participation in religious ritual, especially for the acutely ill person (Texter & Mariscotti, 1994). Thus, the use of or support for religious rituals meaningful to a patient should be an integral part of spiritual care intervention provided by a nurse. Some important religious rituals in relation to health and healing have been identified by Young and Koopsen (2011) as including such activities as prayer, meditation, visualization, guided imagery, dance, and storytelling.

A number of religious rituals may be appropriate for an ill person, whether at home or in the hospital setting. For the Muslim patient whose theology is anchored in the five pillars of Islam, formal prayer (salat) is prayed five times daily, facing the east (Mecca). To support the Muslim's daily prayer requirement, a nurse may provide a prayer rug facing the east, situated in a place of privacy, as well as facilities for the ritual washing of hands and face. Advice from an imam may have to be sought regarding fasting if a Muslim falls ill during the holy period of Ramadan. Some other important Muslim rituals are those associated with birth and death. At the birth of an infant the husband stands near his wife's head; when the infant is born, the new father whispers a prayer from the Qur'an in the child's ear. Usually a dying Muslim chooses to lie facing Mecca (the east); he or she may also wish to confess prior sins and to recite the words, “There is no God but Allah, and Muhammed is His prophet.”

The Orthodox Jewish patient is required to pray three times each day. A male patient, if able, may wish to wear a yarmulke (skull cap) and prayer shawl, as well as phylacteries (symbols of the Ten Commandments) when praying (Charnes & Moore, 1992, p. 66). On the 8th day after birth, a Jewish male child must be circumcised.

Circumcision may be done in the hospital, if necessary, or in the home by a mohel or Jewish rabbi trained in the procedure. When a Jewish patient is dying, family and friends consider it a religious duty to visit and pray with the dying person and his or her family. In the case of an Orthodox Jew, the nursing personnel may not need to perform postmortem care, as a group from the patient's synagogue, the "burial society," will come to care for the body.

For the Christian person who is ill, the sacraments, as mentioned earlier, as well as prayers particular to each denomination, may be an important part of the healing process. Some years ago, a Roman Catholic could only receive Anointing, then called Extreme Unction, when death was perceived to be imminent. Current Church teaching allows the Catholic patient to request the anointing in the revised ritual of the Sacrament of the Sick at any point during an illness experience. Receiving Holy Communion at that time, or at any time during one's illness, is an important religious ritual for the Catholic and also for many Protestant patients.

Infant Baptism is also an important Roman Catholic ritual. Ordinarily it is carried out in the parish church several weeks after mother and baby have left the hospital. If, however, an infant is in danger of death, any nurse may perform an emergency Baptism by pouring a small amount of water on the child's head and reciting simultaneously, "I baptize you in the name of the Father and of the Son and of the Holy Spirit." Many other Christians practice infant Baptism; some of these church groups include the Episcopal, Lutheran, Methodist, and Presbyterian denominations. Baptismal rites may vary slightly. For example, in the Methodist tradition, "the one baptizing should put his or her hands in the water and then place the wet hand on the baby's head and repeat the baptismal words. In the Lutheran rite, the water is poured on the head three times, while saying the baptismal words" (Reeb & McFarland, 1995, p. 27).

Rosemarie, an operating room nurse for more than 20 years, described a situation in which she felt that she was providing spiritual care by supporting a patient's religious ritual belief, even though she was of a different faith.

In this situation I was a fairly new nurse, and the patient came in [to the OR suite], and I just had a sense that this patient was going to die. The patient was very ill; he was elderly and had a bowel obstruction. He had come in the middle of the night for emergency surgery. The man was Catholic, and I thought, "well if this man is this bad, then he needs to see a priest." I felt strongly about supporting that and the surgeon got angry with me for not taking the patient in. I literally stepped in front of the gurney, and didn't let the patient get rolled into the OR until the priest came and he was able to give his last confession. That patient died on the table!?. . . It was scary for me. I don't know why I felt so strongly; normally I wouldn't go up against

an authoritative role like the surgeon. I don't know what drove me to do it but it was based on my own religious beliefs . . . . The wife of the patient was so grateful that I insisted on waiting for the priest; the family never got to see him alive again.

## Devotional Articles

Frequently the first clue to an ill patient's religious beliefs and practices is the presence or use of religious or devotional articles. A Jewish person, especially one of the Orthodox tradition, may use a prayer shawl and phylacteries during times of prayer. A Muslim may choose to read passages from the Holy Qur'an, or to pray with prayer beads, which identify the 99 names of Allah. A Christian patient, as well as reading sacred books such as the Bible or the Book of Mormon, will often display devotional items such as relics, medals, crosses, statues, and holy pictures with symbolic meaning for the person. For example, an ill Mexican American of the Christian tradition will frequently carry a medal or picture of Santo Niño de Atocha, a religious personage believed to be instrumental in healing the sick. Other religious symbols an ill person might display include sacred threads tied around the neck of a Hindu, Native American medicine bags, or mustard seeds used by Mediterranean groups to ward off the "evil eye" (Morris & Primomo, 1995, p. 111).

A medical–surgical nurse caring for acutely ill patients validated the notion that the visible presence of patients' devotional articles signaled religious belief and practice. "Usually we get a cue; if you see a Bible or a prayer book, or if they have a cross or a rosary, you think the patient probably has an interest in spiritual matters."

## Sacred Music

Music, especially music reflecting an interest in the transcendent, expresses the depth of feeling of one's spirit. Music is a part of all cultures and religious traditions, especially as a central dimension of religious worship (Hurd, 1993, p. 75). Music is frequently used by individuals to relieve stress, and music therapy may be used as an adjunct to healing (Keegan, 1994, p. 169). In a nursing study exploring the use of music in the postoperative recovery period, researchers learned that experimental group patients reported that the music served to relax them, as well as serving as a distracter from pain and discomfort (Heiser, Chiles, Fudge, & Gray, 1997).

Karen Sutherland observed that "the first recorded use of music as an instrument of healing is in the Bible" and cited the story of the young shepherd David who was "summoned to play his music to heal King Saul's emotional and spiritual distress" (2005, p. 29). "The therapy was so successful," Sutherland adds, "Saul requested that David remain in his service (1 Samuel 16:14–23)" (p. 29). The story of a contemporary David is reported in *The Nurse with an Alabaster Jar: A Biblical*

*Approach to Nursing.* The author was told an anecdote about a hospitalized elderly end-stage emphysema patient who was experiencing severely compromised breathing. While she received prescribed nebulizer treatments periodically throughout the day, her breathing and her anxiety became more and more pronounced toward the end of each afternoon. Thus, “a young respiratory therapist, who had been working with the patient, asked the head nurse if he could try an intervention with music; he was a folk guitarist. The head nurse, desperate for any kind of relief for her patient, agreed. The respiratory therapist brought his guitar to the unit and began to play gently for the patient during the periods when her breathing became extremely labored. Everyone, including the head nurse, was amazed at how this gentle ‘folk guitar therapy’ eased the rapid, labored breathing of the anxious patient” (O’Brien, 2006, p. 104).

Religious music ranges from religious rock, folk, or country-western music, which may appeal to younger patients, to the traditional religious hymns and classical religious pieces such as Handel’s *Messiah*, often preferred by the older generation. Playing a recording of religious music, or even softly singing a hymn with a patient, may be incorporated into spiritual care (Folta, 1993, p. 29), if nurse and patient find it meaningful. Music has been identified as a “therapeutic intervention for healing” by Young and Koopsen (2011, p. 175).

Anna, a 13-year-old Ewing’s sarcoma patient from a Christian missionary family, loved the traditional hymns of her church. Anna was very ill and experiencing severe pain from her disease; she also required periodic painful bone marrow exams to determine the side effects of her chemotherapy. Anna’s mother and the nursing staff decided that singing hymns would be a good way to distract her during the procedure. It was deeply moving to hear the gentle singing of “Abide with me, fast falls the eventide” coming from the pediatric clinic treatment room during Anna’s “bone marrows.”

If a nurse believes that a patient of any religious tradition might find comfort and support in sacred music, yet the ill person has little experience with religious music, one suggestion might be the beautiful ecumenical chants of Taize, known throughout the world. The community of Taize, founded by Lutheran Brother Roger Schutz, has become a center of ecumenical prayer and reconciliation for people from all countries and of all religious traditions. The simple and beautiful chants were created so that Taize visitors of all cultures and religious persuasions might be able to sing together as one choir. Recordings of the Taize chants, which include a short scripture verse or brief prayer, with refrains such as “Alleluia,” “Bless the Lord,” and “Stay with us O Lord,” are available at most religious bookstores.

This chapter describes the importance of the nurse’s role in spiritual care. Many contemporary nurses find assessment, and in some cases intervention, relative to patients’ spiritual needs to be a treasured part of their clinical practice. It is

nevertheless important to reiterate that not all nurses will feel competent or comfortable undertaking nursing therapeutics in the area of spiritual care. These nurses should, however, be sensitive to the importance of nursing assessment of patients' spiritual needs; referral to a pastoral caregiver for support or intervention is always an acceptable option.

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