Peter Ravenscroft
looks at practical ways of addressing spiritual needs in the clinical setting

INCLUDING SPIRITUALITY IN CLINICAL CARE

key points

- Most people understand that social, psychological and spiritual factors affect their health and recovery from illness, even if they do not use those terms.
- Spiritual distress is a distinct form of suffering and needs distinct diagnosis and interventions – some of which require specialist skills. However, all health professionals can be involved in spiritual care at some level.
- Basic spiritual assessment tools can be a part of clerking and assessing all patients and the article outlines some simple tools.

Christian healthcare professionals may wonder how they might effectively interact spiritually with their patients. There are many ways to do this, the one presented here provides a way that will cover different modes of spirituality that might be encountered in clinical practice. This method aims to include people who do not understand what spirituality is, or reject spirituality, yet suffer the spiritual distress that often accompanies severe illness.

Spirituality can be thought of as a generic term that covers many concepts outside biopsychosocial parameters. Although spiritual issues have been considered by health practitioners since ancient times, in modern times they were highlighted by Cicely Saunders, who started the modern hospice movement. She included spirituality as a component of 'total care' that she aimed to provide to those in a hospice setting.[1] Viktor Frankl, after his experience of suffering during World War II, wrote, 'Man is even ready to suffer, on the condition, to be sure, that his suffering has a meaning'.[2] That is an affirmation that spiritual values are critical to our well-being.

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A study of our patients in Mercy Hospice, in Newcastle (Australia) revealed that about 30% of those patients being admitted to a hospice acknowledged that emotional suffering was the major reason for their admission.[3] The development of spiritual care has been reviewed by Kelly and Morrison[4] and positive outcomes for quality of life have been shown using spiritual support for patients with advanced cancer.[5]

Definition

More recent models of healthcare include spirituality (Fig. 1). There are numerous definitions of spirituality, but here are two useful examples:

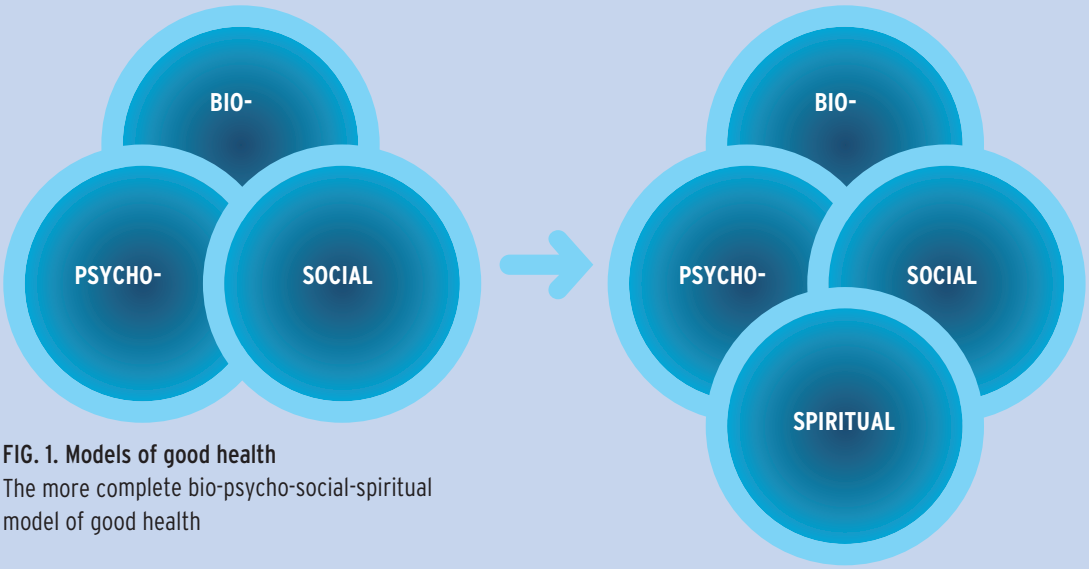

FIG. 1. Models of good health
The more complete bio-psycho-social-spiritual model of good health

(1) Allan Kellehear[6] defines spirituality as three groups of needs:

- **Situational needs**, including needs for purpose, hope, meaning and affirmation, mutuality, connectedness, and social presence.
- **Moral and biographical needs**, including need for peace and reconciliation, reunion with others, prayer, moral and social analysis, forgiveness, and closure.
- **Religious needs**, including need for religious reconciliation, divine forgiveness and support, religious rites/sacraments, visits by clergy, religious literature, discussion about God, eschatology, or eternal life and hope.

(2) Relationships are key to spirituality, so spirituality can be expressed as a relationship:

- **to self** (self-worth, dignity, meaning and purpose, guilt and shame).
- **to significant others** (love for family and friends, loneliness, reconciliation, gratitude, being remembered).
- **to the community** (status, dignity).
- **to places and things** (that represent precious values or give special pleasure).
- **to transcendence** or what is beyond this physical life (faith in God, anger towards or perceived abandonment by God, being remembered and leaving memorials).

An individual's spiritual needs may spread across these groups. We also need to consider and manage those who are not religious by considering their needs as well. They often have spiritualty not focused on a supernatural being or doctrine, but they share many of the situational and moral issues listed above.

Diagnosing spiritual distress in the dying

Spiritual distress is the distress that comes from unresolved spiritual issues. The symptoms of spiritual distress (Table 1) may seem like those resulting from psychological issues, but most patients we care for do not have psychological disorders. They are reacting to the stress that is a normal part of dying. Psychoactive drugs are not indicated in spirituality distressed patients, at least initially, unless there are clear indications to do so.

Table 1.
Some typical ideas suggesting spiritual distress

- Why is this happening to me?
- Why are my beliefs being challenged?
- What hope do I have?
- What is the purpose of living?
- Am I being punished?
- What is my value or self-worth?
- What will happen after death?
- How can I transcend this suffering?

Listening for clues in patient interviews

Emotions or expressions of deep personal disturbance are reactions to inner turmoil. Emotions may be expressed directly (I am angry or I am anxious about the future) or indirectly (the care is poor, the food is dreadful, the bed is uncomfortable) (Fig. 2).

FIG. 2. Effects of spiritual distress

Underlying these expressions there may be troubling thoughts about hope, meaning, guilt, or relations with family members occurring during a review of life. Empathetic listening and assessment skills will allow a clinician to detect distress expressed directly or indirectly during the conversation with the patient.

Acknowledging these emotions and deeper issues is the first step in assisting the patient to process them. For example, expect that it will take some time

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and several conversations for the patient to begin to appreciate the different relationships, expectations and changes in body image, that life with a terminal illness can bring. Many patients, given the time and help they need, do a pretty good job of dealing with their changed circumstances and their forthcoming death. Family have an important role in this process and bringing the family members together and helping them share the issues can be pivotal in assisting the patient.

Some patients are unable to express their spiritual distress either because they cannot find the words or are too sick. This is the time when just being with the patient, particularly if they are alone, is so important. Arrange to do this yourself, or arrange for a staff member or family member to be there. If you talk about the patient, always remember they may be able to hear you even though they do not reply.

What do I do when a patient asks me, 'What are your own spiritual beliefs?'

Medical students have told me that one of their major concerns when talking about spirituality to patients is that of the patient asking them, 'Do you believe there is a God?' How do we answer? Consider this situation very thoughtfully.

A patient who is terminally ill is generally unlikely to ask a recent graduate about their spirituality, whereas it is more likely if the health professional is a more mature and empathetic person who has a good relationship with the patient. If a patient asks early in the relationship, it is more likely to come from their spiritual distress than a genuine concern about spiritual issues. A good question to ask yourself is, 'Do I know this patient really well or not?' Explore with the patient why they are asking these questions. Most of the time they are rhetorical questions coming from a need for more meaningful communication. Be sure that you are answering the patient's questions and not putting forward your own spiritual views.

Christian or other religious witnessing is often done out of concern for the patient's spiritual well-being or out of felt responsibility to spread the gospel. Junior staff and students are generally not in a good position to do this, whereas a GP or specialist who knows the patient well may be. We need to remember that attempts at evangelisation when the patient has a terminal illness are complicated by the beliefs of family members or the views of other staff. Also, the patient may listen to you, not out of interest in your spirituality, but out of respect for you, or to maintain your attention at a time of crisis.

Ethics involved in the doctor-patient relationship suggest we should not use the power differential in relationship between the practitioner and the patient to influence the patient at a time when they are vulnerable. If the distress is coming from religious concerns, eg. is God punishing them? It is important that a representative of the person's religion or a pastoral care person be involved.

Medical students and interns often ask me about how they should engage with spiritually distressed patients when their time is limited by heavy medical commitments. I suggest that they listen empathetically to the patient for as long as possible and acknowledge their distress, then explain to the patient that you will bring it to the notice of the team, talk to the practitioner-in-charge, or come back later. Some issues run very deep and other consultants may need to assist the patient.

Some means of introducing spirituality into clinical practice

1. Include a spiritual history at the first encounter

It is an advantage to document spirituality as part of the history of the illness. This allows us not to have to ask the same questions repeatedly and allows your colleagues to refer to your notes as care for the patient continues. There are several formats you can use. I keep the key issues in mind by using the **HOPE** questionnaire.[7] Different approaches are provided by Puchalski and Ferrell.[8]

H **Sources of hope, strength, comfort, meaning, peace, love and connection**
eg. How do you gain hope and comfort during your illness?

O **The role of organised religion for the patient**
eg. Does worship have a place in your or your family's way of life?

P **Personal spirituality and practices**
eg. Do you have any spiritual beliefs or practices that are important to you?

E **Effects on medical care and end-of-life decisions**
e.g. Would your personal beliefs affect your management if there was a health crisis?

2. Introduce spiritual issues at an appropriate time in the conversation by beginning like this:

'We know that many people have spiritual or religious beliefs that influence their understanding of their illness and their preferred management. Would you like to tell me about any beliefs or practices that you may have, that we might keep in mind as we plan your care?' If the patient responds affirmatively, follow-up questions can be used to elicit further information. If the patient responds negatively, move on with the interview, but bear in mind they may want to approach the topic later.[9]

Conclusion

For some Christians, this process outlined above may seem indirect, but having a method for all patients will help you get to know the basic spirituality of all your patients. This can lead to amazing opportunities to assist patients in their spiritual journey and enhance overall patient care.

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