Spirituality in Nursing Practice
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Spirituality in Nursing Practice

The Basics and Beyond

Doreen A. Westera, MscN, MEd, RN

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This book is dedicated to my parents, Frazer and Pearl Oakley, who provided a strong foundation for my spiritual development; to my husband, Nick, as well as to my children, Aaron and Rachel, who have nurtured my spirit in countless ways; and to God, who daily sustains me, giving me meaning and purpose, hope, joy, and peace.
Contents

Preface ix
Acknowledgments xiii

Part I
Spirituality in Nursing: The Basics

1 The Concept of Spirituality 3
2 Religion, Spirituality, and Health 31
3 Rationale and Challenges for Spirituality in Nursing 61
4 Competencies for Spiritual Assessment and Care 91
5 Spiritual Assessment 125
6 Spiritual Care 167

Part II
Spiritual Assessment and Care in Various Clinical Contexts

7 Spirituality in Serious, Life-Threatening, and Chronic Illness 205
8 Spirituality in Mental Health Care 237
9 Spirituality and the Older Adult 267
10 Spirituality in Palliative Care 295
Appendix A

Boutell's Inventory for Identifying the Nurses' Assessment of Patients' Spiritual Needs 329

Appendix B

Wellness Spirituality Protocol 335

Index 339
Preface

I grew up in a culture that was infused with spirituality, both in terms of the broader culture and also with respect to various subcultures within that broader culture. Choosing a career in nursing arose out of my spiritual roots. My interest in spirituality in nursing began very early in my nursing career. Being acutely aware of the importance of spirituality and religion in my own life primed me to be curious and attentive to the place of spirituality/religion in the lives and situations of clients I have encountered throughout my nursing practice. While working on a crisis team in the emergency room of a large general hospital, I specifically asked to be assigned to clients for whom spiritual/religious issues were of concern. I increasingly incorporated spiritual assessment and care into my practice as a community health nurse and then did the same in my counseling practice in response to my clients’ needs. As a nurse educator, I incorporated spirituality into the courses that I taught. I developed a complete course on the spiritual dimensions of practice to address what I perceived to be a gap in nursing education. As a nurse educator, I found myself to be constantly advocating for the inclusion of the spiritual dimension in nursing curricula through a variety of forums: faculty meetings, faculty/nursing education committee work, nursing education conferences, presentations focused on nursing education, and more. Many of the scholarly activities in which I have engaged by way of writing, research, and presentations at conferences have focused entirely, or in part, on spirituality in nursing/health care and/or counseling. I developed 13 videos focused on spirituality in various clinical contexts to allow the voices of clients and practicing health care professionals to be heard on the topic. While developing these videos, I was constantly amazed at how the comments of the people featured in the videos verified and corroborated much of what was written about the place of spirituality/religion in health and illness.

All of these professional experiences, and a host of personal life experiences, have transformed an initial interest in spirituality in nursing into a passion. This passion has developed a strong sense of the need to advocate for spirituality in the large context of nursing practice. Although my efforts to advocate in this area of practice have been fueled by many sources, they are driven primarily by my subjective experiences with clients and a realization of the potential for inclusion of spirituality in nursing care to result in better health outcomes for clients—and their families. This book is a tangible piece of this advocacy effort. I hope that it will not only inspire interest and passion for the inclusion of spirituality into nursing practice, but will also prepare nursing students and
nurses to better attend to and provide spiritual assessment and care. As such, the overall goal is that truly holistic nursing practice, one of the key pillars of nursing, will be realized.

**FORMAT OF THE BOOK**

In terms of the overall focus of the book, the comments by Miner-Williams (2006) are very appropriate:

Spirituality . . . must be understood as part of the holistic vision of the person’s health, and not simply as just another “dimension” of the person. The ability to understand something, however, is sometimes limited when viewed only in its wholeness. If one can grasp an identity with smaller aspects of the whole, one can appreciate the whole better . . . we appreciate the phenomenon of spirituality by examining its inherent concepts, realizing that it is only by their “interrelatedness” [that we can] begin to understand the whole. It is seeing the picture of the puzzle by examining its pieces and putting them together. (p. 814)

Miner-Williams is writing about examining the general concept of spirituality. However, her comments are also true with respect to how spirituality in nursing practice is approached in this book. Aspects of spirituality in general and spirituality in the context of nursing practice are explored, examining all these aspects and interconnections “under a microscope” so as to better understand the whole. However, recognition of the client as a whole being and spiritual care as total care of the client should always be the lens through which each aspect of spirituality in nursing practice is viewed.

The title of this book, *Spirituality in Nursing Practice: The Basics and Beyond*, was chosen for a couple of reasons. First of all, no single work can contain everything there is to know about a given topic, including spirituality in nursing practice. This book attempts to provide the basics needed to attend to this dimension of care. Yet, throughout the book, there are directives to explore further—to go beyond the basics. This occurs through the many reflections interspersed throughout each chapter; through encouraging exploration of select literature resources/websites; through a wide range of suggested activities; and through exploring case studies. Additionally, the 14 video programs I have developed (including the 13 on spirituality, plus one on resilience, for which spirituality is a theme) can be accessed. Ten-minute preview segments from each of these videos can be viewed at www.ucs.mun.ca/~dwestera (the full length for each video is about 30 minutes). Facilitator’s guides for each of the videos can also be obtained in an ancillary instructor’s manual. **Qualified instructors may obtain access to ancillary materials by e-mailing textbook@springerpub.com.**

The book consists of two parts: Part I, “Spirituality in Nursing: The Basics,” comprises the first six chapters, and it provides the basis from which to proceed to Part II. Part II, “Spiritual Assessment and Care in Various Clinical Contexts,” comprises the last four chapters and focuses on the importance of spirituality in various clinical settings and contexts.
FEATURES OF THE BOOK

Several features in the book serve to expand knowledge and reflection about spirituality in nursing practice. Each of the chapters in the book contains a number of reflections scattered throughout. These reflections encourage the reader to engage personally (and professionally, in some cases) with the chapter material. This feature was included in recognition of the importance of self-reflection in learning about nursing practice, including spiritual care practice. Tables, illustrations, and boxes highlight various aspects of the discussion and provide examples. At the end of each chapter in Part I, there is a concise summary of major points related to the chapter focus (“The Bottom Line”). There are also a number of activities that can be undertaken individually or in groups (“Taking It Further”). Such activities should serve to further expand learning relevant to the chapter focus. Inclusion of these activities stems from my commitment as a nurse educator to experiential learning as being essential in the development of nursing practice. At the end of each chapter in Part II, information pertaining to case studies is included along with a list of questions pertaining to each case study. These case studies are focused on the clinical area of concentration for that particular chapter. The reader should access the references given for each case study in order to read the case study and to engage in the exploration that the questions stimulate. This method has been chosen in keeping with my philosophy of teaching, which is to be a catalyst for students and nurses who are assuming responsibility for their own learning. Case studies have been chosen because of their inherent value to learning by focusing on “real clients” and examining relevant issues related to spirituality/religion within that context. Accessing the case studies and engaging with them will further expand knowledge pertaining to the chapter material. It should also facilitate the transfer of that knowledge into actual practice.

Each chapter contains a reference list of literature resources that can be accessed for further information and examination. Although direction is provided throughout each chapter to explore specific references, the reader is encouraged to consult all of them—and to expand the reference list further as each topic is explored. There are thousands of references pertaining to spirituality in nursing and health care to explore. Continually reading in this area of practice will be key in developing a strong knowledge base for incorporating spirituality into nursing practice.

REFERENCE

Acknowledgments

I would like to acknowledge and thank the many nurse scholars and nurse colleagues who, through their writing, research, and conversations, have substantially contributed to my interest and thoughts about the place of spirituality in nursing practice, education, and research. The clients in my clinical practice also deserve to be acknowledged as they have made much of the theoretical information about spirituality in health and illness “come alive” as they have discussed the place of spirituality/religion in their lives and situations. I have enjoyed each and every conversation with them about spiritual matters and concerns. Nursing students whom I have been privileged to teach have also encouraged me with their questions and comments about issues and concerns pertaining to the spiritual dimension in nursing practice.

I would also like to thank the editorial staff at Springer Publishing Company for their assistance in bringing this book into existence. A special thanks goes to Joseph Morita, Senior Acquisitions Editor, for his encouragement with developing the proposal for the book, and also for his ongoing encouragement during the writing of the book. Locally, I would also like to thank Jenna Flogeras, copy editor, for her assistance in the organization and formatting of the book.

Finally, a special thanks goes to my husband, Nick Westera. Not only has he provided encouragement and support during the genesis and development of this book, but he has also painstakingly read every word of the manuscript, providing invaluable editorial advice and help. Without his help, this book would not exist.
What do you think of when you hear the word “religion?” Some may think of a particular Christian denomination or of one of the major world religions such as Islam or Buddhism. Others may think of a place of worship such as a church, mosque, or synagogue. For others, the word may be associated with persons who are thought of as religious, such as Mother Teresa, priests, or other religious leaders. Still others may think of various religious rituals such as a baptism, wedding, or funeral. Some may think of the tensions or conflicts that often occur between religious groups, some resulting in wars. Not only could the word “religion” evoke one or more of the images described, but it can also engender strong emotional reactions, particularly if there has been some conflict or trauma associated with religion in a person’s background.

**Reflection 2.1**

Reflect on the word “religion” in terms of its personal meaning to you. What images or thoughts come to your mind? What is your personal definition of “religion?” Are you aware of any emotions evoked in you as a result of this word? If so, then what is the origin of these emotions?

Chapter 1 explored the concept of spirituality, which is considered to be a broader concept than religion. In fact, religion is usually seen to be subsumed under the concept of spirituality. However, a point made in Chapter 1 is that for some people, their spirituality is so intricately connected to religion that they are considered as one and the same. For example, I had a conversation with a nurse who works in an intensive care unit and when she was asked what spirituality meant to her, she replied, “My spirituality
and my religion are one.” As a demographic, Muslims generally consider spirituality and religion to be one. For example, Markani, Yaghmaei, and Fard (2013) state, “In the Islamic contexts there is no spirituality without religious thoughts and practices; religion provides the spiritual path for salvation and a way of life (Karimollahi, Abedi, & Yousefi, 2007)” (p. S23). Yet, the common assumption that spirituality and religion are the same, an assumption held by many health care professionals, is not necessarily accurate for all people. As stressed in Chapter 1, even if people do not indicate an overt connection to religion, they may still have a desire to believe in something beyond themselves and they have spiritual beliefs (Kevern, 2012; Timmins & McSherry, 2012). However, it is important and appropriate to look more closely at the concept of religion because of its importance in many peoples’ lives in some form, and because it can also impact their health and well-being.

THE CONCEPT OF RELIGION

The word “religion” has its roots in the Latin religare, which means “to bind together” (Wasner, Longaker, Fegg, & Borasio, 2005, p. 100). This bond can be between people themselves, and/or between people and a higher power. It is appropriate to examine some definitions and descriptions of religion in the literature as summarized in Table 2.1.

Reflection 2.2

Reflect on each of the descriptions or definitions of religion in Table 2.1. Which comes closest to your own understanding of religion that you constructed in Reflection 2.1?

- What common themes do you see in the definitions?
- Appraise each definition for its applicability to nursing practice. What might be the possible implications for assessment and care of clients?

Some people may declare themselves to be affiliated with or committed to one of the major world religions such as Christianity, Hinduism, or Islam. Others may refer to other species of spirituality such as aboriginal spirituality, Wicca, Celtic spirituality, or New Age spirituality (Pearson, 2002) and they may consider one of those worldviews as their “religion.” Others may refer to particular causes such as environmentalism, humanism, or feminism as their “religion.” As with spirituality, it is important in a clinical setting to determine how each client describes his or her religion. In comparing the definitions and descriptions of spirituality with those of religion, it should be apparent that religion can be more easily observed than spirituality. This may be due to observable religious rituals and practices.

The terminology associated with religion can mean different things to different people. For example, when asked, “What religion are you?” some people may identify that they are Roman Catholic, Baptist, or Muslim. In this sense, they are identifying with a
“system,” a term used to describe many religions. However, they may be only loosely affiliated with such a system as opposed to being committed to the beliefs, values, and practices associated with that system. Sometimes such identification with a religion is based solely on heritage or culture without any comprehension, understanding, or overt acceptance of the belief system. If asked, “Are you a religious person?” then one might answer, “No, I never attend church,” or, “Yes, I attend church quite regularly.” Such a response is indicative of that person equating the word “religious” with an institution. Another response such as “I don’t consider myself religious, but I do have a personal relationship with God” is demonstrating a differentiation of religion from faith. The point here is that it is important to be aware that words can have a variety of meanings—including ones that are in variance to literal definitions and/or the understanding of the

<table>
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<tr>
<th>Table 2.1 Definitions/Descriptions of Religion</th>
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<td>(Religion is) 1. Belief in and reverence for a supernatural power or powers regarded as creator and governor of the universe. 2. A system grounded in such belief and worship . . . . 3. A set of beliefs, values, and practices based on the teachings of a spiritual leader. 4. A cause, a principle, or an activity pursued with zeal or conscientious devotion (Green &amp; Harkness, 1997, p. 1158).</td>
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<td>. . . religion offers a participant a specific worldview and answers to questions about ultimate meaning. Religion can also offer guidance about how to live harmoniously with self, others, nature, and god(s). This direction is presented through a religion’s belief system (e.g., its myths, doctrines, stories, dogma) and is acknowledged when one participates in rituals or other religious practices and observances (Taylor, 2002, p. 10).</td>
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<td>Religion means the organized beliefs, rituals, and practices with which a person identifies and wishes to be associated. It generally involves worshipping a deity or Supreme Being and gathering with those of like faith or similar beliefs (Mauk &amp; Schmidt, 2004, p. 3).</td>
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<td>“A religion organizes the collective spiritual experiences of a group of people into a system of beliefs and practices” (Wasner et al., 2005, p. 100).</td>
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<td>“Religion refers to an organized system of beliefs regarding the cause, purpose, and nature of the universe that is shared by a group of people and to the practices, including worship and ritual, related to that system” (Burkhardt &amp; Nagai-Jacobson, 2002, p. 13).</td>
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<td>“Religion involves public and private practices and rituals, beliefs, and a creed with dos and don’ts. It is community-oriented and responsibility-oriented” (Koenig, 2008, p. 33).</td>
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<td>“[Religion is] . . . an organization that binds people together in many ways. Part of the binding comes from its shared beliefs, part from communal membership, and part from shared rituals. Among its parts, for many members, will be that component we call spirituality” (Barnum, 2011, p. 3).</td>
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listener. In practice settings, therefore it is imperative to ascertain the intended meanings attached to certain words by clients, and not to assume that clients have the same meanings as that possessed by the nurse.

**COMPARISON OF RELIGION AND SPIRITUALITY**

A perusal of the health care literature will reveal that there have been many attempts to analyze spirituality and religion, each in relation to the other. Examination of a few examples will bring about an understanding of the connection between these two concepts.

Hillet and colleagues (2000) define spirituality and then add a definition of religion. They provide a summary of the definitional criteria for religion and spirituality. For example, the criterion for both spirituality and religion includes

> the feelings, thoughts, experiences, and behaviors that arise from a search for the sacred. The term “search” refers to attempts to identify, articulate, maintain or transform. The term “sacred” refers to a divine being, divine object, Ultimate Reality, or Ultimate Truth as perceived by the individual. (p. 66)

One criterion for religion that Hillet and colleagues add, which is in addition to the aforesaid criterion, is “A search for non-sacred goals (such as identity, belongingness, meaning, health, or wellness) in a context that has as its primary goal the facilitation of [the above criterion for spirituality and religion]” (p. 66). A second criterion for religion that Hillet and colleagues add, which is also additional to the aforesaid criterion, includes “The means and methods (e.g., rituals or prescribed behaviors) of the search that receive validation and support from within an identifiable group of people” (p. 66).

Rankin and DeLashmutt (2006) describe the relationship between religion and spirituality: “spirituality is more basic than and precedes religious expression (religiosity) because it is an inherent human quality. Religion and religious needs are tradition and practice specific, whereas the existential need of spirituality exists regardless of religious practice or affiliation” (p. 283).

Pesut, Fowler, Taylor, Reimer-Kirkham, and Sawatzky (2008) acknowledge complexity in the relationship between spirituality and religion. They note in the nursing literature that spirituality is portrayed as separate from religion but related to it. Spirituality is also portrayed as an umbrella under which religion can be subsumed. This demonstrates the importance of being sensitive to the manner in which the connection between spirituality and religion is described when reading the nursing literature.

Moberg (2008) notes that spirituality and religion can be distinguished, but they also can be addressed together. Moberg describes “religiosity,” a term often discussed in the literature on religion and health, as “membership and participation in the organizational structures, beliefs, rituals, and other activities related to a religious faith like Judaism, Hinduism, Islam, or Christianity” (p. 101). He describes spirituality as having “a more existential and experiential focus upon an individual’s internalized faith, values, and beliefs, along with their consequences in daily behavior” (p. 101). In this sense, both terms enjoy significant overlap and both can be part of a person’s everyday life, as well as in his or her response to illness and other adversities. Religiosity is further described by Ellor (2011) as a characteristic of an individual or as the importance of religion in an
individual’s life. Larson, Swyers, and McCullough (1998) also discuss religiosity as connected to religion in terms of religious systems, beliefs, practices, and rituals, but they also include the feelings, attitudes, and responses that a person has toward a higher power as being relevant to this term.

The concepts of spirituality and religion are significantly interconnected, but there can be distinctions made between the two that are important to consider in nursing practice. It is also important to remember that a person’s spirituality and/or religion cannot be separated from other dimensions of his or her personhood due to the holistic nature of persons. Any examination of one to the exclusion of the other is merely for the purposes of focused analysis.

**RELIGION IN THE WORLD, THE UNITED STATES, AND CANADA**

Religion is important to many people. Considering the place of religious adherence from a worldwide perspective, there is evidence that it is growing (Fowler, 2009b; Ross, 2008). It is beyond the scope of this chapter to provide a detailed analysis of geographic variations of religious affiliation. However, it is interesting to touch upon a few statistics to springboard further independent exploration (a good resource is www.worldreligiondatabase.org).

More than 85% of the world’s population identify adherence to some religious affiliation. The religion with the largest number of adherents is Christianity (33%) followed by Islam (22.5%) and Hinduism (13.6%; Turner, 2010). It is important to remember when looking at such statistics that adherence to a particular religion is not synonymous with overt commitment to its doctrines, beliefs, and practices, that is, an internalization of the religion. For example, in North America, many people may say that they are “Christian” when asked what their religion is, but Christian beliefs and practices may play no part in their everyday lives. In fact, many professing Christians may not even know much about the basic or essential tenets of Christianity. However, I have noted in my own practice, and it has been substantiated in the health care literature, that when faced with illness or some other significant life event, many people will return or engage in enhanced attention to some of the beliefs and practices of the religion with which they affiliate. Thus, in nursing practice, when clients may present themselves in the context of such a significant life event, it is important to conduct a more in-depth assessment. The nurse practitioner should explore beyond the mere identification of religious affiliation, but further consider how the person’s religion may or may not impact his or her health or how he or she perceives and experiences illness. Knowing the place, scope, and importance of religion in a client’s life is essential to providing effective religious care.

Recently, North America has become very pluralistic with respect to a multiplicity of religions—a function of enhanced immigration to North America from other countries. There is more variation in both clients’ and nurses’ religious orientations than in the past, and there is the possibility of enhanced polarization in terms of each other’s religious perspective. In the mid-2000s in the United States, Christianity was the dominant religion, with 85% claiming adherence (Encyclopedia Britannica Online, 2010). The Canadian percentage is lower: 67%. The percentage of Muslims in the United States and Canada is low, 2% to 3%, with a recognition that this religion is growing (Hasmain,
Approximately 24% of the Canadian population claim to not be affiliated with any religion (Statistics Canada, 2011), which constitutes a higher percentage than the 8% in the United States who claim to be “nonreligious” (Turner, 2010). Within Canada, there has been a trend toward a greater number of the population indicating “no religion” on census surveys (Reimer-Kirkham, 2009). However, Reimer-Kirkham notes that other than for church attendance, other measures of religiosity in Canada are stable. This observation suggests that people may be engaging in religious practices outside of organized religion. In addition to the growth of non-Christian religions in Canada, Reimer-Kirkham also notes an increased affiliation with evangelical and charismatic Christian churches due to the influx of immigrants with these religious traditions.

**RELIGIOUS DEVELOPMENT**

Fowler’s stages of faith development, discussed in Chapter 1 (see section on Spiritual Development), can be applied to religious development as well as spiritual development. Peck’s spiritual development stages are similar to Fowler’s in terms of their connection to age groups, but Peck’s stages are more closely related to religion, and, in particular, to the Judeo-Christian tradition (Peck, 1987, 2003). Carson (1989) describes religious development as related to a person’s acceptance of a particular religion and its beliefs, values, rituals, and so forth. In this sense, religious development can occur at any age.

**Reflection 2.3**

- Review Fowler’s stages of spiritual development in Chapter 1 (see section on Spiritual Development). If you identify with a particular religion, then apply these stages to your own religious growth and development.
- Reflect on your own spiritual development in terms of what factors contributed to your religious growth, and whether this growth was a gradual process or a sudden occurrence. If you identify with a Judeo-Christian faith perspective, then you may also want to consult Peck’s stages of spiritual development as part of your reflection (Peck, 1987, 2003).

**RELIGION AND CULTURE**

As in the case of spirituality, religion can also be connected to culture. For example, a person can become affiliated with a particular religion simply because of the dominant culture around him or her. As Fowler (2009b) states, “religion and culture interpenetrate so that culture may shape the symbols of religious tradition . . . some cultures are suffused with religious influence where adherence may not be widespread” (p. 394). Fowler goes on to state, “some religious traditions may so co-mingle with culture that the actual religious content may, in an accommodationist syncretism, become a variant
form of nationalism (Reimer-Kirkham, 2009)” (p. 395). Culture can influence the development of religious beliefs, values, and practices.

An example of culture shaping religious symbols can be found in the culture of the province of Newfoundland and Labrador, Canada. Newfoundland has a rich history of fishing as the main source of employment for its population, particularly in coastal regions. Most people in the province also adhere to the Christian faith. A local woodcarver recently completed a nativity scene depicting the birth of Jesus Christ: Joseph (Jesus’s father) was carved in the likeness of a local fisherman; Mary (Jesus’s mother) as a locally dressed woman; the “stable” where Jesus was born was carved as a typical Newfoundland fishing shed; and the “wise men,” who from the biblical account came to visit Jesus and who brought gifts of gold, frankincense, and myrrh, were carved presenting “fish” to the family. The entire religious tradition of the nativity scene was infused with local cultural overtones.

Culturally appropriate care is an integral part of religious nursing care. Clients who are connected to various religions can be seen as belonging to subcultures within the dominant culture, and knowledge of such subcultures is important for nurses (Miller, 1995). For example, gender issues may be important and distinctive in various religious contexts and such issues will necessarily have to be considered in nursing care.

**RELIGION AND BELIEFS/PRACTICES**

All religions have distinctive beliefs and practices—many of which relate to health, illness, and health care. It is beyond the scope of this chapter to identify such beliefs for all the major world religions as well as how these are interconnected to health and illness. Some religious practices are common to all religions. For example, prayer is commonly practiced by all religions whether they are theistic or nontheistic (Fowler, 2009a). However, to whom the person prays, and other logistics of how prayer is carried out, may vary widely from religion to religion (and indeed, may vary significantly within a given religion).

Religious practices related to health, illness, and health care may vary widely among different religions. Some examples include the lighting of candles as part of a prayer practice; blessing the throat to prevent illness; circumcision, which demonstrates a covenantal relationship between God and man (DeFazio Quinn, 2006); various practices associated with birth and death; dietary restrictions; and so on. Fowler (2009a) maintains that when a person is committed to a particular religion, religious practices that are rooted in the person’s inner life are foundational to how that person understands and lives his or her life in terms of the meaning, beliefs, and values that stem from that commitment.

An important point with respect to a particular religion and the beliefs and practices that accompany that religion is that there may be significant variation among people associated with that religion in terms of what they believe and practice and how such are expressed in their lives. One cannot assume that a person who is committed to the Christian faith will hold the same beliefs as all others committed to this faith, engage in the same practices, or carry out these practices in the same manner. Within any religion there will invariably be distinctive subgroups. For example, in Christianity, there are such traditions as Orthodox, Protestant, and Roman Catholic—each again with multiple subgroups and further divisions. In Judaism, there are groups that are Orthodox, Conservative, Reform, and so on. While each subgroup of a religion will generally identify with the basic tenets of its religion, how that religion is “lived out,” and the application of
the beliefs and practices that accompany it may be quite distinctive for each subgroup (Fowler, 2009b). As previously emphasized, assessment of individual clients and any relevant religious context is crucial.

Religious beliefs and practices have been used in health promotion, and in particular, in terms of health education. For example, in the eastern Mediterranean, a series of eight booklets on the Islamic position with respect to various health issues (e.g., smoking and healthy lifestyle) have been produced. One of the eight booklets, the one on AIDS, was jointly developed by Muslim and Christian leaders (Khayat, 1998).

Reflection 2.4

- What religious beliefs, values, and practices do you hold, if any? Which of these would correspond to the common beliefs, values, and practices of the religion with which you are connected? Which, if any, might be at variance to the common beliefs, values, and practices?
- What purpose(s) do your religious beliefs, values, and practices serve in your life?

RELIGION/SPIRITUALITY IN HEALTH AND ILLNESS

Much has been written about the relationship between spirituality/religion and health/illness. Studies exploring the connection between the two are prolific and growing, including the nature of this connection (Koenig, 2008). Entire journals have been devoted to the topic. For example, the Journal of Religion and Health, the Journal of Religion and Spirituality in Social Work, and the Journal of Religion, Spirituality and Aging, and multiple other journals on spirituality/religion specifically include information on health/illness in their articles. Discussions/studies on the topic include a variety of aspects related to spirituality/religion and health/illness and health/nursing care. Examples include the examination of the values and beliefs of particular religious groups with the corresponding implications for nursing practice (Charles & Daroszewski, 2012; Glick, 2012; Lawrence & Rozmus, 2001); what sacred writings such as the Bible and the Quran say about clients’ health rights with respect to care from health care professionals (Hatami, Hatami, & Hatami, 2013); how spirituality/religion impacts clients’ experiences, including coping, with various illnesses or health experiences (e.g., perioperative care by DeFazio Quinn, 2006; HIV infection by Walulu, 2011, and breast cancer by Schreiber, 2011). Some of the discussion and studies pertaining to specific health problems/illnesses are covered in the later chapters of this book; at this point, only a brief overview of the role of spirituality/religion in health and illness is sufficient.

RELIGION/SPIRITUALITY AND HEALTH

Religiosity is a social determinant of health (Maselko, Hughes, & Cheney, 2011). It is also related to other social determinants of health. Some of these determinants include the following:
• **Poverty**—The research on poverty and health shows the faith of the poor as being instrumental in their dealing with all the ramifications of poverty, finding meaning and purpose, developing hope and empowerment, and transcending their circumstances (Delashmutt, 2007).

• **Social support**—Having social support from others in one’s faith community and from God or a higher power is known to contribute to health and well-being, and to promote spiritual growth, which contributes to overall personal growth (Koenig, 1997; Taylor, 2012).

• **Culture**—The connection between culture and religion has been described earlier in this chapter.

• **Personal health practices** (related to physical and mental health)—These can be impacted by religious beliefs and values (Koenig, 1997), and religion/spirituality has been shown to be intricately connected to coping skills, in particular coping with illness, loss, and other adversities (Koenig, 2008).

• **Child development**—Spirituality is part of overall child development.

Religion is also related to a number of components and concepts of health promotion, which is defined by the WHO as “the process of enabling people to increase control over, and to improve, their health. It moves beyond a focus on individual behavior towards a wide range of social and environmental interventions” (WHO, 2016). For example, health promotion may involve increasing a person’s resilience, which is the ability to not only deal with adversity but also grow in the face of it. Studies have shown that clients identify spirituality as one way to enhance their resilience. Spirituality/religious practices are also connected to a number of positive health indicators such as experiencing peace, joy, a sense of wellness, optimism, and hope (Narayanasamy, 2004; Shoqirat & Cameron, 2013; Taylor, 2012). Religious beliefs and practices have also been linked to avoidance of smoking and alcohol abuse, dietary practices that support health, social support, and enhanced mental well-being, all of which are known to contribute to good health (Astedt-Kurki, 1995; Koenig, 1997; Taylor, 2012). Religious involvement is seen as a protective factor with adolescents, as those who are religiously committed are less likely to smoke, abuse alcohol or other drugs, engage in less risky behaviors, and have a better attitude toward life (Cotton, Larkin, Hoopes, Cromer, & Rosenthal, 2005; Rew & Wong, 2006). Studies also show spirituality/religion to be associated with increased quality of life, effective coping skills, and better mental health (decreased anxiety and depression, greater hope and optimism, lower rates of suicide, greater marital satisfaction, and less substance abuse) (Koenig, 2008; Mueller, Plevak, & Rummans, 2001; Post, Puchalski, & Larson, 2000; Townsend, Kladder, & Ayele, 2002; van Leeuwen, 2008).

It is interesting to note that in 1985, the executive board of the WHO adopted a resolution to modify the preamble of the WHO constitution to contain a definition of health that included spiritual as well as physical, mental, and social well-being. The WHO also included spirituality as a component of quality of life (Khayat, 1998). Furthermore, in May 1984, the 37th World Health Assembly adopted a resolution that made the spiritual dimension a part of the health strategies of the WHO member states (WHO, 1985). Well-being has been described as “a state of being in balance and alignment in body, mind and spirit. It is a state in which people describe themselves as feeling healthy,
content, purposeful, peaceful, energized, in harmony, happy, prosperous, and safe” (Kreitzer, 2012, p. 707). In Chapter 1, spirituality was presented as being an integrating force in terms of the physical, emotional, and social dimensions of a person. Religiosity is a dimension of well-being (Astedt-Kurki, 1995). Spiritual well-being and religious well-being are commonly referred to in the health care literature as “measurable constructs.”

Koenig (2008) and Taylor (2012) identify religious beliefs as assisting people to cope with or make sense of life in general, and of dealing with changes and stressful events that occur in their lives. Religious practices such as prayer or reading sacred writings can provide hope and consolation in the face of illness or other adversity. The support of a religious community can be very helpful. An example that comes to mind is that of a Christian family that immigrated to Canada from a war-torn country. In conversation with this family, they readily identified their religious faith, their religious practices, and their faith community as all helpful in not only dealing with past trauma, but also in enabling them to adjust to life in Canada.

Drawing from a variety of sources, Coyle (2002) concludes that spirituality can provide us with a mental attitude, which promotes health either through our actions (behaviour) or our way of being (calm and balanced); or, if things don’t go well, spirituality appears to help us to accept adversity and cope with change. Studies suggest that this type of spirituality fosters a positive calm, peaceful, harmonious state of mind, a belief in oneself through connectedness with the divine that has given one’s life meaning, purpose, and hope. From an intrapersonal perspective, it may well provide us with a resource or reserve, which we can draw on in times of need. (p. 596)

Coyle also identifies connection to God or a higher power as providing meaning and purpose for religiously committed people. However, one must be careful in ascribing only “positive emotional states” to a description of spirituality, as suffering, a basic human experience, may then be seen as a pathological state (Pesut, 2008).

What aspects of religion are most closely associated with positive health? There has been significant research on the practice of prayer as a coping mechanism (e.g., McCaffrey, Eisenberg, Legedza, Davis, & Phillips, 2004). Attendance at religious services or gatherings is also strongly connected to positive health outcomes and support during illness (e.g., Koenig, McCullough, & Larson, 2001). Taylor (2011) identifies religiosity and intrinsic personal spirituality as being the most adaptive healthful aspects for clients. Personal devotion and a relationship with God or a higher power have also been identified as salient factors that promote health (Hackney & Sanders, 2003; Krause, 2006; Polzer & Miles, 2007; Siegel & Schrimshaw, 2002). Harris, Allen, Dunn, and Parmelee (2013) suggest that the ongoing presence of spirituality/religion in a person’s life is key: “It might be that the daily, lived experience of engaging in the coping practice (guided by one’s religion/spirituality) is what imparts emotional benefit” (p. 778). As Koenig (1997) states:

Research has shown that persons who use religion as a means to an end do not experience the psychological benefits of religious practice (Alvarado, Templer, Bresler, & Thomas-Dobson, 1985; Batson & Ventis, 1982). Rather it is those who involve themselves in religion as an end in itself (i.e., persons with intrinsic faith) who are more likely to experience mental health, greater life satisfaction, and less worry and anxiety. (p. 126)
From these brief comments about the role of spirituality/religion in health, one can see that these concepts need to be considered by nurses as factors that contribute to the resilience and the health of people. Asking “What makes people healthy?” is just as important a question as “What makes people unhealthy?”

**Religion/ Spirituality and Stress/ Illness**

There is a growing body of evidence that spirituality and religion impact not only health and well-being, but they are also operant in times of illness and other health concerns (Loeb, Penrod, Falkenstern, Gueldner, & Poon, 2003; Tyler & Raynor, 2006). Spiritual/religious beliefs and/or supports are drawn upon by people to help them cope and make sense of illness and loss (de Jager Meezenbroek et al., 2012; Narayanasamy, 2002; Surbone, Konishi, & Baider, 2001). Religion has been seen to contribute to the creation of a sense of control during illness (Mueller et al., 2001) as well as contributing to the development of meaning in and of the illness (Thuné-Boyle, Stygall, Keshgtar, & Newman, 2006). Koenig (2008) notes that, when compared to nonreligious people, religious people experience faster recovery from illness, fewer heart attacks, are more likely to recover from heart surgery, experience less disability and slower cognitive decline as they grow older, and generally live longer (especially if they are involved in a religious community). Koenig goes on to identify some mediating factors with respect to the impact of religion during illness: immune, endocrine, genetic, cardiovascular, central nervous system influences, and supernatural mechanisms. With respect to mental illness, religion has been known to enable coping with stress, anxiety, and despair; and a religious faith is a protective factor in the occurrence of depression (Koenig, 1997). Koenig (1997) also notes that, for clients who are experiencing anxiety or depression and who identify with a religion, incorporation of religion into their treatment plan was more effective than if only non-religious approaches had been used. It is uncertain whether the specific findings from the research that Koenig examined on religion and illness can be more generally applied to the broader concept of spirituality, pointing to the need for further research.

For both acute and chronic illness, it is the case that the nature of illness itself is known to stimulate questions related to life, mortality, suffering, and death. These questions may include:

- Why is this happening to me?
- Where is God in the midst of all of this?
- What does all of this (illness) mean for my life?
- Why is God allowing this suffering?

These, and many others like them, are questions intricately related to spirituality and religion (Molzahn & Shields, 2008). Furthermore, in the midst of illness, suffering, loss, and grief, many people examine beliefs, including religious and spiritual beliefs that they may have had since childhood (Mauk & Schmidt, 2004). There will be a closer examination of religion and spirituality as they relate to specific client contexts in later chapters, but here it is appropriate to offer just a few general comments about the connection between spirituality/religion and illness.

Ano and Vasconcelles (2005) conducted a meta-analysis of 46 empirical studies on religious coping and psychological adjustment to stress. They concluded from their
analysis that spiritual/religious resources were connected to significant positive health outcomes. Overall, the body of literature on religion as an aid to coping with stress is impressive in terms of positive outcomes (e.g., Folkman, 2008; Harris et al., 2013; Koenig, 2008; Pargament, 1997).

From a literature review of the findings examining the impact of spirituality/religion on pain, Unruh (2007) concluded that spirituality/religion is part of daily life for many living with pain. Spirituality/religion can impact a client’s beliefs about pain, his or her preferences for pain management strategies, and is an important resource in his or her coping with pain. Unruh noted that a wide variety of spiritual/religious practices are often incorporated into pain management, such as meditation, spiritual/religious music, prayer, and sacred readings. Spirituality has also been linked to acceptance of chronic pain (Risdon, Eccleston, Crombez, & McCracken, 2003).

Religious belief is also connected to healing. Mystical experiences that are associated with many religions can activate a healing energy in people. For example, experiences such as prayer, music, and the “laying on of hands” can be accompanied by feelings of joy and well-being, which can contribute to the healing response. Divine intervention that leads to healing is also accepted by many religious believers, although interpretations of how this occurs vary with religious tradition (Taylor, 2012). One does not have to be affiliated with the health care system for very long in order to encounter instances in which medical science cannot explain a positive change in the health status of a client after prayer had been offered up on behalf of that client.

**Reflection 2.5**

- Reflect on your own health. What spiritual/religious beliefs, values, and practices contribute to your health and well-being? How/why do they do so?
- Reflect on the impact of religion on health, both positively and negatively. If you are connected to a religious framework, what has been the impact of your religious beliefs and practices upon your health in times of illness or during some other significant life event? What spiritual/religious beliefs, values, and practices enabled you to cope or even grow in the midst of your adversity? What effects of religion have you witnessed on the health of family, friends, and clients?

**Religion/Spirituality as a Source of Struggle**

It is important to note that religion and spirituality can be a source of struggle for those facing illness and loss. For example, Pargament and Ano (2006) identify several such struggles associated with spirituality/religion during illness:

- The questioning of previously held spiritual/religious assumptions
- The questioning of one’s relationship with God or a higher power

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• Strain in relationships within one’s faith community
• Doubting spiritual/religious beliefs and values previously held

For example, a person who is committed to the Christian faith and who is experiencing an illness (either his or her own, or in a loved one) can believe that God has abandoned him or her or perhaps that the illness is caused by some sin in his or her life (Pulchalski, 2001). He or she may feel that his or her prayers “don’t go beyond the ceiling of the room” and may not be able to concentrate on reading the Bible as he or she had previously. Such struggles can cause spiritual distress, which can be just as crippling—or even more crippling—as the illness itself. Nurses need to be alert to signs of spiritual or religious struggle in clients’ lives in order to open up conversations about such struggle and take appropriate measures to resolve or alleviate it.

RELIGION/SPIRITUALITY AND SUFFERING

Suffering is common when people experience physical and emotional pain. It is also important to note that spiritual pain and distress is a type of suffering in and of itself. Raholm, Lindholm, and Eriksson (2002) explored the essence of suffering, noting that suffering can be a path to spirituality, while at the same time, spirituality can make suffering bearable, meaningful, and understandable. Raholm and colleagues developed a model to illustrate the connection between spirituality and suffering for appraisal and discussion by clinicians, nurse educators, and researchers. McSherry and Jamieson (2013) also found that spirituality was connected to suffering and that nurses perceived part of their role as supporting those who suffer.

Religion in particular has been noted to assist people to interpret suffering in meaningful ways (Koenig, 2008). For example, I spoke with a client who was dealing with severe fibromyalgia. She was very active in the local Fibromyalgia Association and told me that she believed that God had allowed her suffering so that she, in turn, could offer more relevant help to others struggling with the condition. As Pesut, Fowler, Reimer-Kirkham, Taylor, and Sawatzky (2009) state, “Spiritual health and suffering are no longer antithetical states but can co-exist with the potential for the personal interpretation of suffering to contribute positively to the spiritual journey” (p. 341).

Reflection 2.6

• Have you ever experienced struggle related to your spiritual/religious beliefs during illness or some other significant life event? What was the nature of that struggle? What was (or what might have been) useful in helping you deal with the struggle?
• What have you witnessed about the impact of spirituality/religion on suffering, either in your own life or another’s life in terms of spirituality/religion being a resource during suffering or in the development of meaning in and of the suffering?
RELIGION AND NEGATIVE IMPACT ON HEALTH/WELL-BEING

No discussion of religion and health would be complete without reference to the potential negative impact that religion can have on health. We will look more closely at the “neurotic” uses of religion (Koenig, 1997) in Chapter 8. In that chapter, we look at how mental illness can sometimes create bizarre religious beliefs. Suffice to say that the nurse must be aware of uses of religion that do not contribute positively to a person’s health. For example, an individual may cite statements from religious writings out of context to support a particular position on health and illness. Or, a person may believe that God will take care of him or her and conclude that there is no need for medical treatment.

How does a nurse decide whether the particular beliefs and practices of a given religion are “healthy” or “unhealthy?” Although one must proceed with caution in answering this question, there are some general guidelines to follow in terms of deciding whether a particular religious perspective is “healthy” or “sick.” For example, Pesut, Fowler, Taylor, Reimer-Kirkham, and Sawatzky (2008) indicate:

A healthy spirituality or religion will transcend itself in compassion; recognize the inevitability of suffering; seek to redress that suffering at the individual and societal level; make room for difference while searching for commonality; and refuse to reduce discourse to an idolatrous search for personal, political or economic gain. (p. 2809)

Furthermore, if the religious practices and beliefs of the client result in feelings of false guilt, anxiety, or some other emotion that is psychologically distressing for the client, then Pesut and colleagues (2008) would deem the particular religion (or the client’s interpretation of it) is “unhealthy.” The point about the client’s interpretation of the religion is an important one. The guidelines given by Rao and Katze (1979), quoted in Schnorr (1983) and Graves (1983), are still relevant today in terms of discerning a “healthy” from a “sick” religion: whether the religion acts as a vice; whether the religion deviates from a client’s premorbid religious belief system (i.e., deemed to be normative for people in that belief system); whether the client’s religion differs significantly from others in the same religion; whether the religion overwhelms the client with guilt that is not based in reality; whether false humility is manifested by the client or he or she denies personal abilities and resources; and whether the religion urges the client to deny feelings, especially negative feelings. Shelly and John (1983), again, a classic work on mental health and spirituality, add to the guidelines provided by Rao and Katze, in their description of what constitutes a healthy versus an unhealthy spiritual life (pp. 61–71; seen on a continuum). As can be seen, there is somewhat of a bias toward the Christian religion in some of the items on the continuum. On the unhealthy end of the continuum of spiritual life, the following can be present:

- Beliefs that separate/fragment the person and that create separation from others by withdrawal
- Beliefs that cause a person to be absorbed into a group identity, with no personal identity present, that cause the person to manipulate others, and that see God as a “magical being”
• Preoccupation with wrongdoing and an inability to forgive or to be forgiven—or, an absence of a sense of wrongdoing and lack of values and standards of what is right and wrong
• Total freedom without sanctions, or lack of freedom with no responsibility for one’s actions
• Legalism
• A feeling of being driven with no enjoyment of life
• Repressed feelings and thoughts
• Poor self-esteem or grandiosity
• Unhealthy view of suffering, for example, that it is a form of punishment stemming from the person’s “not being good enough”

On the healthy side of the continuum of spiritual life, the following are characteristics:

• Beliefs that contribute to a sense of wholeness; that strengthen one’s view of self as a person of worth and value as well as the ability to accept oneself; that see God as good and controlling the universe, but giving people free choice and responsibility; and that build bridges, not barriers between people and foster interdependence with others; supportive, mutual relationships are normative
• Acknowledgment of wrongdoing and an ability to be forgiven as well as to forgive and to reconcile with others
• Living with the freedom of a full range of emotional expressions, tolerating ambiguity, appreciating humor, and expressing spiritual feelings and thoughts honestly
• A healthy view of suffering, that is, that suffering is part of the human condition (Drawing on resources such as God’s strength to deal with suffering is also characteristic, resulting in growth in suffering.)

Reflection 2.7

Review the indicators of a “sick” and “healthy” religion, as well as a “healthy” and “unhealthy” spiritual life.

• Appraise each indicator in terms of its applicability to your life. For example, you may not identify with a particular world religion so items dealing with religion may not be as relevant for you. However, in some instances, you may be able to modify the indicator to apply to yourself.
Taylor (2012) also writes about the negative impact of religion on health. Citing the works of several authors, she gives several examples of how religiosity can have a deleterious impact on health. It can cause “confusion, despair, isolation, helplessness, meaninglessness, detachment or resentment . . . unhelpful guilt or shame . . . passivity . . . a sense of abandonment . . . ” (p. 11). These are states that are known to be associated with poor health and religiosity may be a catalyst for such negative results in multiple ways (Taylor, 2012):

- Attributing health events to demonic forces
- Abdicating any personal responsibility for a health outcome but instead believing that God will magically solve the problem
- Engaging in beliefs and practices that are significantly at variance with the normative beliefs and practices of the person’s particular religion
- Being connected to a religion that, in and of itself, isolates the person from others and engages in practices known to be harmful to the person’s well-being, such as can be found in some cults

Taylor concludes that when someone who is religious has beliefs that do not comfort or assure him or her, that result in him or her feeling guilt or shame, that create passivity within him or her or make him or her feel abandoned, then such religious beliefs are harmful to the person. Koenig (2008) also comments upon the negative impact of religion in situations where religions engender fear, and when persons use religion to avoid issues and to resist making changes. If a nurse is unfamiliar with a particular religion in terms of its beliefs, tenets, values, and practices, it would be wise to consult with a religious leader of that particular religion in order to obtain information about the religion so that the nurse can determine whether the client’s interpretation is appropriate and/or healthy.

**RELIGION AND ETHICAL/LEGAL ISSUES**

There are a number of factors related to religion and the law within the context of health/nursing care. These factors overlap with multiple ethical issues and dilemmas. This topic is not extensively explored within this work, but two excellent books that cover...
the area in a comprehensive manner are recommended: *Religion: A Clinical Guide for Nurses* (Taylor, 2012) and *Religion, Religious Ethics, and Nursing* (Fowler, Reimer-Kirkham, Sawatzky, & Taylor, 2011). A few comments are offered here to whet appetites.

Taylor (2012) identifies several aspects of religion and the law in terms of nursing practice (within the context of U.S. health care). Some of those aspects covered by Taylor include the following:

- The legality of nurse behaviors related to religious beliefs and values
- Laws that protect the rights of nurses who are religious persons
- How religious nurses can avoid conflict with the law and yet remain true to their religious beliefs

This work cannot authoritatively canvass the relevant law operant with respect to health care issues but it is important for nurses to know such laws in the respective countries in which they practice. Taylor discusses such law in the United States, and concludes that there are provisions within ethical codes of nursing to protect religious nurses. However, such protections are limited. For example, Taylor points out that proselytization, or the attempt to convert the client to the nurse’s own religion, is not appropriate from a legal as well as ethical perspective; nor is the withdrawal of safe and compassionate care. In her book she outlines practice guidelines and obligations for religious nurses.

Another context in which law and ethics may be pertinent is when certain religious groups hold views that conflict with health care practices. Perhaps the most widely known group in this regard is the Jehovah’s Witnesses, who refuse blood transfusions based on their interpretation of certain Biblical texts. Another group, the Scientologists, believes in faith healing (Taylor, 2012) and may generally refuse modern medical interventions such as drug therapy. An important point to remember in caring for such clients is that persons who are committed to such groups may experience spiritual distress when faced with a medical choice that violates their religious beliefs. Often, the client’s spiritual leader or a pastoral care professional/chaplain can be helpful in such situations. For example, Jehovah’s Witnesses representatives can give information about alternate medical care, which is acceptable to their faith perspective and thereby assist the health care team to manage the situation. Sometimes, in the case of children, temporary custody can be awarded to the state in order for medical treatment to occur over the religious objections of parents or guardians. In the case of adults, however, clients’ decisions generally prevail if they are considered to be of sound mind. If a client dies because of refusal to accept a potentially life-saving treatment or procedure, this loss can be particularly distressing for a nurse who does not share the same religious perspective. In this case, the nurse can proceed in a manner consistent with any ethical dilemma, for example, consulting with other members of the health care team (Taylor, 2012).

Sometimes, a client’s religious beliefs and practices may cause him or her to prefer, or even insist upon, being cared for by a nurse with similar beliefs and practices. For example, nurses have advised that many female Mormon clients ask to have a nurse assigned to them from their own faith because of their particular religious beliefs about undergarments. It is less stressful for such clients if the nurse caring for them understands their perspective. Although such preference may not always be logistically possible, if clients do make such requests, and if there is a nurse from the same religion as
the clients, then it does make sense for that nurse, if possible, to care for the clients. Another example would be the case of a Christian client with spiritual/religious concerns who would prefer to be cared for by a Christian nurse who he or she may perceive to be capable of greater understanding of his or her particular situation and concerns.

**Reflection 2.8**

- Are you aware of your ethical decision making being grounded in a spiritual/religious belief system? If not, in what is it grounded?
- Reflect on any clinical situation where the client’s decisions about care were based on religious beliefs. How was the situation dealt with? What feelings did you experience in this situation and how did you deal with these feelings?

**RELIGION IN NURSING PRACTICE**

Fowler (2009a) maintains that the religious dimension of human experience has been largely neglected in nursing. This is an assertion supported by other authors. Taylor (2012) identifies a number of reasons why religion should be considered in nursing care (pp. 3–8), many pertaining to what has already been discussed in this chapter:

- Many clients are religious.
- Religiosity is associated with health outcomes.
- Regular religious fellowship benefits health by offering support that buffers the effects of stress and isolation.
- Participation in worship and prayer benefits health through the physiological effects of positive emotions.
- Faith benefits health by leading to thoughts of hope, optimism, and positive expectation.
- Mystical experiences benefit health by activating a healing bioenergy, or life force, or altered states of consciousness.
- Divine intervention allows healing.

Nurses need to assess how clients perceive religion to be operating in their lives, and they should also be sensitive to both positive and negative overtones from clients. Spiritual/religious assessment is discussed in Chapter 5. There will be particular nursing interventions that may be pertinent to specific world religions. Referencing Taylor (2012) for information in this regard will be informative.

Unruh (2007), Taylor (2002), and Koenig (1997) identify more general practice guidelines for nurses in dealing with the religious aspects of care:
• The nurse needs to inquire about the religious background, beliefs, values, and practices of clients, including how they perceive these aspects may impact their health. A person-centered approach is imperative in such an inquiry.

• The nurse needs to be supportive and respectful of clients’ religious beliefs, values, and practices, even if they are at odds with what the nurse subjectively believes. This is part of the nurse’s ethical practice. It also implies that the nurse needs to be open to discussion about religion with the client.

• The nurse should affirm the religious beliefs and practices that clients identify as being sources of strength and hope for them, providing that such beliefs or practices are not known to be harmful to clients.

• For clients who are committed to a particular religion, the nurse needs to encourage them to actively participate in their faith community as a way of gaining social and spiritual support. When clients are unable to participate with their community due to illness or hospitalization, the nurse can refer them to pastoral care professionals/chaplains, if clients so desire. Members of the faith community can also be encouraged to visit clients, assist them with religious practices, and provide other supports. Faith communities can be invaluable resources to the physical, emotional, and spiritual care of clients and their families.

• The nurse can integrate religious beliefs and practices into treatment/nursing care strategies if clients so choose. Of utmost importance is that input from clients and their families is crucial in this regard so that what is integrated is compatible with the clients’ faith perspectives.

• Pastoral care professionals/chaplains need to be seen as integral members of the health care team. Nurses need to develop collegial relationships with these professionals so as to adequately meet the religious needs of clients.

• The nurse needs to be aware of any personal subjective biases with respect to religion in general, and any specific biases toward a particular religion. These biases may adversely affect the assessment and care of clients.

• If the situation warrants it, the nurse needs to assist clients in thinking about potentially harmful religious beliefs, values, and practices. Consultation with religious leaders, pastoral care professionals/chaplains is advisable in such a situation.

Reflection 2.9

Reflect on the aforementioned guidelines for nurses in dealing with the religious aspects of care. On a scale of 1 to 10, with 1 being “not at all effective” and 10 being “very effective,” how many of these guidelines do you incorporate into your current nursing practice? How might you improve in this area?
RELIGIOSITY IN THE NURSE’S LIFE

The role of religiosity in the nurse’s life is important to consider. After all, nurses are people, and, as such, are spiritual beings who may choose to express and nurture their spirituality through a particular religion. As Taylor (2012) states, “we all bring who we are to the bedside” (p. 88). You may be concerned that because religion has not played a significant role in your own life, you will not be able to attend to the religious expression of spirituality in a satisfactory manner. If you have had negative experiences with religion, then you may fear that such experiences may impede your ability to engage with clients who are religious. Or, you may describe yourself as being “religious” and fear that you may inadvertently “push” your religious views on clients. These are all natural and normative concerns.

Cusveller (1995) presents an interesting discussion with respect to the presence and function of religious commitment in the nurse. He questions the claim by some that nursing care is “morally and religiously neutral” (p. 973). He maintains that nurses bring their own particularities to nursing, and rather than perceiving them as “private matters,” he suggests that accounting for them is perhaps the better alternative. Operating from this premise, Cusveller believes that it is possible and justifiable for certain nursing decisions to reflect religious convictions. He gives an example of a client with terminal cancer who wished to stay alive to celebrate the upcoming Christmas, which presented as an important time for that client. The physician had decided to discontinue treatment, which could have resulted in the client’s imminent death. A religiously committed nurse saw it within her professional duty to advocate for continuation of care to try to keep the client alive until after the celebration of Christmas. In this instance, the options for care were affected not only by a client-centered stance, but also affected by the nurse’s religious commitment.

In addition to religious commitment impacting various options in nursing care, Cusveller (1995) maintains that religious commitment may give some nurses a sense of what care or for whom care is important. For example, on the basis of their religious commitment, the nurses in Mother Teresa’s order, the Missionaries of Charity, have decided to focus on care for the poorest of the poor. Cusveller goes on to identify that religious commitment may also influence a nurse’s perception of situations, a nurse’s motivation, a nurse’s sensitivity to spiritual needs, and a nurse’s ethical position(s) on various health care matters. Of course, it is never appropriate to proselytize or to attempt to “convert” the client to the nurse’s subjective religious views and beliefs as it would be in direct violation of codes of ethics that direct the nurse to respect clients’ religious perspectives. Cusveller concludes:

Just as scholars cannot rid themselves of their particular points of view, but have to discuss them in order to develop the best theories, so nurses have to bring their particular points of view to nursing and to discuss them in order to provide the best possible care. Moral, philosophical and religious convictions are not just bias, although they may be, but they can also have a positive function. (p. 977)
Like Cusveller, Pesut (2008) identifies as problematic the assumption that nurses should lay aside their developed spiritual worldviews as potential biases in caring for clients. Pesut states, “We need to move from the naive view that [the nurse’s] personal beliefs have little or no place in spiritual care to a more sophisticated understanding of how those beliefs should be negotiated within a profession that has a public trust with patients in positions of vulnerability” (p. 172). Markani and colleagues (2013) also support the view that there is room for the personal convictions of nurses in terms of providing care and they propose that the ability of nurses to care holistically is connected in part to their spiritual development. Taylor (2012) should be referenced for a more in-depth discussion of integrating personal religiosity with professional nursing practice.

A final point with respect to religion and nursing practice is the importance of knowing how to converse with clients about their religious beliefs and practices. This is discussed later in this work. The information in this chapter not only provides knowledge about the religious aspects of care, but it also provides a foundation from which to explore religious aspects of care with clients.

**The Bottom Line**

- You should know the basic tenets and practices of major world religions, especially those that may be specifically relevant to health/illness.
- You should be aware of your own religious positioning and biases.
- You should know and comply with ethical practice that includes respecting clients’ religious beliefs, values, and practices.
- Supporting clients’ religious beliefs and values and facilitating their religious practices is part of good religious nursing care.
- Referral of clients to pastoral care professionals/chaplains/other team members may be warranted.
- You should be open to discussion of religion with clients as such is foundational to good religious nursing care.
- Assessment of the religious perspectives of clients is necessary to ensure appropriate nursing care.

**Reflection 2.10**

What do you think of Cusveller’s ideas? Are you aware of your own or some other nurses’ religious convictions impacting on nursing care in some manner; or how nursing itself is viewed? What have been the impacts of such convictions, both positive and negative?
• Because culture and religion are intricately connected, culturally appropriate care is relevant to good religious nursing care.

• Proselytization is never appropriate or ethical in a nursing care context.

• Client-centered care is critical.

Taking It Further

1. Research each of the major world religions (Christianity, Judaism, Islam, Buddhism, Hinduism), noting the basic beliefs, values, and practices of each. Imagine, in sequence, that you are a member of each of these religions. What benefits and issues might you experience in terms of your own health and health practices? How might you envision this religion helping you if you were experiencing illness or some other adverse life event? How can this reflection serve to enhance your clinical practice with various religious groups? (If this reflection is done as a group activity, each group member can choose one religion, research it, and report findings back to the group. The entire group should discuss the benefits and issues pertaining to each religion in terms of health and illness, and how the learning attained from this exercise can benefit clinical practice.)

2. Review the major world religions to determine how each would describe spirituality and the spiritual dimension of personhood. What are the implications for nursing practice for clients who may be committed to each of these religions?

3. Have a conversation with a client this week who has identified with a particular religion. Ask him or her how his or her religious beliefs and practices impact on his or her health, including how it helps him or her cope with his or her illness or health problem. Compare the client’s responses with findings identified in this chapter and in any other readings that deal with the area of religion and health.

4. Choose a spiritual leader who is important to you in terms of the values/teachings of this person in guiding your life (e.g., Jesus Christ, the Dalai Lama, Mohammed, Confucius):
   a. Identify aspects of this person’s philosophy that are congruent with those of the nursing profession.
   b. Identify qualities/values associated with spirituality that this particular leader may advocate. Which parallel those found in professional nursing?
   c. Envision yourself as possessing the qualities/values in (b). How might these enhance your nursing practice? How can they assist you to cope and even flourish in today’s health care system (Hermann, 2003)?

5. Review the major world religions (e.g., Christianity, Judaism, Islam, Buddhism, Hinduism). Postulate what you would include in a nursing education program pertaining to each of these religions to increase awareness in nursing students/nurses about the religious/cultural aspects of care for clients from each of these groups. (This exercise can be completed as a group, with each group member...
researching a particular religion, and then collectively discussing aspects to include in an education program.)

6. If you identify with a particular religion, reflect on how you might handle your own faith perspective when encountering clients in various nursing contexts. Do you have particular beliefs, values, or convictions that could pose challenges for you? How might your beliefs, values, or convictions be supportive to you in your role as a nurse? What beliefs, values, and convictions of clients would prove to be challenging for you? And how might you handle these challenges? (This exercise can be completed in a group of people with mixed religions or of the same religion.)

7. What religious experiences have you had that might impact your work with clients, both positively and negatively? For those experiences that have engendered a negative impact for you, how can you deal with them in order to better care for clients who are religious?

8. VanLeeuwen, Tiesinga, Jochemsen, and Post (2009) describe the regulative side of nursing practice as the personal beliefs, motives, objectives, and expectations of the nurse. What beliefs, motives, objectives, and expectations do you have that are connected to religion or spirituality in general? How do these interact with the religious/spiritual care of clients?

9. It has been argued in this chapter that nursing has largely neglected the religious/spiritual dimension of care. Do you agree? If so, then why do you think this is so? How might the study of the religious domain of care be incorporated into nursing in an ethical and responsible manner?

10. If you were to incorporate the religious aspect of care into the nursing practice setting in which you currently operate, what principles would you suggest for nurses to follow? What aspects of nursing care would be affected (e.g., dietary implications, decisions about medical/nursing care, cultural aspects)?

11. If you identify with a particular religion, or have strong religious beliefs, reflect on the following questions:

   a. How did your faith influence your choice of nursing as a career?
   b. How has your faith helped you in your nursing career so far?
   c. Has your faith hindered you in any way in your nursing career to date? If so, in what way(s)?
   d. How have clients/colleagues reacted to your religious beliefs/values?
   e. Has your faith ever caused conflict in terms of nursing professional codes of ethics? If so, what was the nature of this conflict, and how did you resolve it (Timmins & Narayanasamy, 2011)?

12. How does viewing religion as a social determinant of health legitimate its place in health/nursing care? How does such a view of religion impact its place as a focus on population health? How might this determinant of health impact the
health of a population as a whole and for any subgroups within the population (Maselko et al., 2011)?

13. Reflect on various world religions, or on particular subgroups within a religion. Are there any toward which you are biased, either positively or negatively? What factors contribute to your bias (e.g., their beliefs, media reports, personal experience)? How might your bias potentially impact your nursing care of clients from that religion/group? How might it potentially impact your work with colleagues who are from that religion/group?

14. What are the religious/spiritual aspects of the dominant culture and subcultures of which you consider yourself to be a part? Which of these would you desire and/or expect a nurse to consider if you were a client? What would you want them to do (Giger & Davidhizar, 1990)?

15. Discuss with a group of colleagues how religious/spiritual beliefs and values facilitate or constrain the development of a therapeutic relationship with clients (Olson et al., 2003).

16. Review a number of studies reported in the literature on religion/spirituality and health/illness. Record the following about each study: weaknesses and strengths of the various measures of religion/spirituality; quality of study design; study outcomes; and the study’s limitations. Report your findings to a group of peers and discuss the implications for nursing practice as well as any directions for further research.

17. Interview pastoral care professionals/chaplains about the following:
   a. Their role in terms of the religious/spiritual care of clients as well as of staff in the institution/agency
   b. Their experiences as part of the health care team and what they feel they contribute to the team
   c. Their educational preparation for their role
   d. Their perspectives on the role of nurses in religious/spiritual care and in the referral process
   e. Their experiences in working with nurses in terms of religious/spiritual care, including what factors contribute to an effective working relationship

   (Alternatively, you can convene a panel of pastoral care professionals/chaplains to address these topics with a nursing class or a group of practicing nurses.)

18. Research the major world religions (e.g., Christianity, Judaism, Islam, Buddhism, Hinduism) to determine how ethical decision making is impacted by the beliefs and values of that particular religion. Identify specific examples to illustrate. (This exercise can be completed in a group with each group member researching one religion and reporting back to the group for information and collective discussion.)

19. Convene a panel of nurses to discuss how they deal with situations where clients may have very different religious/spiritual values from their own. Ask them
to describe specific clinical examples, and also to discuss helpful guidelines that they endeavor to follow to deal appropriately with such situations.

20. Reimer-Kirkham and colleagues (2011) outline several recommendations for health care providers and health care organizations from their study on the negotiation of religious and spiritual pluralism in health care: creating and maintaining designated ecumenical spaces as well as creative informal sacred spaces in health care institutions; intentionality on the part of health care providers to “nurture relational spaces for enhanced healing” (p. 210); attending to spiritual practices at the organizational level; supporting pluralistic religious and spiritual expressions by providing diverse services with broad mandates; employing specialists in religion; ensuring that representatives of specific religious/spiritual traditions are present in an institution. Discuss the following questions with respect to the above recommendations:

a. In the health care institution/agency in which you practice nursing, how many of these recommendations are currently being implemented? How many are being deliberately or inadvertently ignored?

b. If any recommendations are not being currently implemented in your health care institution/agency, what role can nurses and other health care professionals play to ensure that they are duly implemented?

c. Would you add other recommendations based on your own experience or readings?

21. Cockell and McSherry (2012) indicate that nurse managers need to be proactive in supporting and educating nurses to understand spirituality and the influence of religion on clients. This would include the impact on their spiritual needs, and how clients’ beliefs may influence nursing care. Which specific strategies can you identify for each of these responsibilities? What resources are available to ensure that these responsibilities are adequately carried out?

22. If the spiritual/religious dimension of care were to be adequately addressed in the geographic region in which you practice, what would need to change in terms of the delivery of health care in your region? What particular groups, agencies, or interested bodies could possibly work together to ensure adequate spiritual/religious care? For what health issues could religious leaders be of assistance to health care professionals; and how might this be accomplished (Khayat, 1998)?

23. Research the concept of “person” in various nursing theories/models and in various religions. How congruent is nursing’s view of personhood with each religion’s view? Are there aspects of personhood in various religions that could inform nursing practice in a positive way? What are the implications for nursing for each view of personhood in each of the religions?

24. Interview a person, or several people, who are involved in a local religious community. Ask them the following questions:

a. How does involvement in your religious community influence your own sense of health and well-being and/or the health and well-being of the community?
PART I  Spirituality in Nursing: The Basics

b. What aspects of the experience in a religious community are particularly important for you with respect to your health and well-being?

c. If you were ill and unable to be physically present in your religious community, how might they still be of help to you? How might you still be able to be involved in the activities of the community?

Share your findings with a group of peers and discuss the impact of involvement in a religious community on health and well-being.

25. Consider the following options in order to raise awareness of the research on religion/spirituality in the institution or agency in which you practice:

a. Organize a discussion group on the topic, or have someone who does research in the area provide a presentation on the subject.

b. Organize a workshop or conference on the topic.

c. Develop a special interest group focusing on the topic.

d. Engage researchers to conduct research in your institution/agency on the topic, perhaps with you as part of the research team.

e. Obtain further education and training on conducting research on the topic (e.g., at the Center for Spirituality, Theology and Health at Duke University Medical Center; Aten & Schenck, 2007).

REFERENCES


CHAPTER 2 Religion, Spirituality, and Health


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60 PART I Spirituality in Nursing: The Basics


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Having examined the concepts of spirituality and religion, as well as how these two concepts are connected to illness, health, and well-being, it is appropriate to explore how they are relevant to health care professionals and, in particular, nurses. A foundational rationale for the inclusion of spirituality into nursing practice is important. The identification and articulation of such a rationale enables nurses to explain why spirituality is important to clients and families, colleagues, and others both within and outside of the health care system. It also enables nurses to more articulately advocate for incorporating spirituality into nursing practice. Challenges to incorporating spirituality into nursing practice are also important to consider and are discussed later in this chapter (see section on Challenges to Incorporating Spiritual Care Into Nursing Practice, Education, and Research).

The following is an outline of some of the rationales for integrating spirituality into health care and nursing. Each rationale could have a distinct chapter devoted to it. Some of the rationales are explored in more detail in other chapters of this book. However, the intent here in this chapter is to provide an overview of the rationales as well as to provide references for further exploration.

**RATIONALE FOR SPIRITUALITY IN HEALTH CARE AND NURSING**

**Significant Interest in the Topic on Health Care and Nursing**

The proliferation of articles, books, dissertations, and theses on the topic of spirituality in health care has been profound in recent years, and continues to grow, especially since the 1970s. Not only is this growth evident in the Western world, but also in countries in Asia, such as China and Iran. Spirituality and spiritual/religious care has also been a focus in many recent nursing and health-related conferences. Some conferences, such as the 4th European Conference on Religion, Spirituality and Health in Malta, the 5th...
Conference on Compassion, Spirituality and Health in Australia, and conferences of the National Institutes of Health in the United Kingdom focus totally on the topic of spirituality. Multiple health institutes and centers are devoted to the topic of spirituality in health care. For example, there are the Institute for Spirituality and Health (www.ish-tmc.org) and the Center for Spirituality, Theology and Health (www.spiritualityandhealth.duke.edu) in the United States; and in Canada, there is the Institute of Spirituality and Aging (www.uwaterloo.ca/grebel/academics/continuing/institute-spirituality-and-aging). There are multiple websites that are devoted to spirituality, such as (www.sacredspace.org.uk). As Timmins and McSherry (2012) state, “interest in spirituality within the context of nursing and health care has ‘mushroomed’ internationally” (p. 951). All of this interest in spirituality, religion, and health is evident not only in the nursing context, but also in other health-related professions, such as medicine, social work, occupational therapy, and rehabilitative therapy.

Within nursing education, electives on the spiritual dimension of nursing care have been developed, and spirituality is often a thread in the nursing curriculum. Nursing textbooks have been written on the topic, and many textbooks contain chapters specifically dealing with the topic of spirituality/religion. Special interest groups have been established. Some groups have focused on generic spirituality, whereas other groups consider spirituality from a particular worldview. Examples of the latter type are Nurses Christian Fellowship (an international organization) and the Spirituality, Religion, and Health Interest Group (at the Hospital of the University of Pennsylvania). At least one nursing journal focuses solely on the aspects of spiritual/religious care in nursing (the *Journal of Christian Nursing*) and many other nursing journals are also regularly published on the topic. Sometimes, all issues of a volume are devoted to the topic, for example, the *Journal of Clinical Nursing*, Volume 15 (2006). Critiques of spirituality in nursing are also appearing: for example, Clarke (2009) and Pesut, Fowler, Reimer-Kirkham, Taylor, and Sawatzky (2009). There is also growth in the area of parish nursing as a recognized subspecialty in nursing (Ruder, 2013).

**Societal Interest in Spirituality**

In Western society, there has been a well-documented intensification of interest in spirituality (Davie, 1994; Hufford, Fritts, & Rhodes, 2010; Pesut, 2003). In particular, there has been growth in nonreligious spirituality (Sharma, Reimer-Kirkham, & Fowler, 2012). Pesut (2009a) states that society is “increasingly enchanted with the idea of the sacred” (p. 17). She acknowledges the diversity in views pertaining to spirituality, arguing that this is a rationale for not having a “unified ontology” of spirituality in nursing. Becker (2009) sees such an interest, in North American society at least, as a search for meaning and purpose (a concept connected closely to spirituality). Becker states: “Interest in spirituality is not a fleeting trend . . . . It is becoming increasingly difficult for the academy to ignore these trends, especially among students and faculty members in higher education who value spirituality because it informs their lives” (p. 705). Becker goes on to say: “The freedom to engage (or not) in spiritual beliefs and practices must be honored but not at the expense of silence in the guise of privacy . . . meaningful interdisciplinary dialogue about the issues is warranted to respond respectfully to this contemporary call” (p. 705).
The evidence for interest in spirituality in society can be seen readily. Multiple books on the subject are available at local bookstores. Workshops are often devoted to some aspects of spirituality (e.g., mindfulness workshops). There are many movies and television shows that focus on some spiritually related themes. Even book clubs focusing on spiritual matter are not uncommon. Public interest in alternative and complementary therapies has grown, and spirituality is often integral to such therapies (Barnum, 1996; Canadian Nurses Association [CNA], 2008). In fact, the CNA has specifically identified alternative and complementary therapies as a trend and opportunity for the coming decade. Finally, myriad products have been brought into the market with an emphasis on spirit/soul as part of the marketing approach for these products.

Nursing has long responded to the needs of the broader society within which it is situated, so it is not surprising that in a spirituality-focused society, spirituality has made its inroads into the nursing profession. As Pesut (2009b) states, “The burgeoning interest in spirituality within health care reflects a societal interest” (p. 17). The diversity of understandings of spirituality in society certainly poses challenges for nurses (Reimer-Kirkham, Pesut, Sawatzky, Cochrane, & Redmond, 2012).

**Reflection 3.1**

Reflect on the references to spirituality in society in general; for example: books you have seen in local bookstores; popular magazine articles or advertisements related to some aspects of spirituality; local advertisements in your community for workshops and courses related to spirituality (e.g., mindfulness workshops); websites of popular fitness or health clubs in your community advertising programs beneficial for body, mind, and spirit; websites of local churches regarding programs that are directed at a person’s spiritual life; the presence of aspects of spirituality in broadcast media and in social media. What concepts of spirituality are inherent in each of these examples? Are they a generic, universal spirituality or a spirituality focused on religious beliefs and values?

**The Nature of Being Human**

As discussed in Chapter 1 (see section on Spirituality and Personhood), spirituality is an integral part of being human (Burkhardt & Nagai-Jacobson, 2002; McSherry & Jamie-son, 2013). In fact, some would say that it is the essence of being human. The idea of spirituality as a universal phenomenon means that all people have spiritual needs whether they overtly embrace a religious framework or not. They include the need for meaning and purpose in life or in life events, and the need for love and relatedness (Smith, 2009). Therefore, regardless of the age, gender, cognitive, physical or psychological ability of the client, or the specific health issue at play, it is noted that spirituality is relevant to all.
IMPORy TO CULRUE
The connection between spirituality/religion and culture was also discussed in Chapter 1 (see section on Spirituality and Culture). Spirituality is a well-recognized concept in all known cultures (Olson et al., 2003), although it manifests and presents itself in multiple varied forms and practices. In some instances, spirituality and religion can be the central feature of a cultural identity (Karairmak, 2004; Ozbasaran, Ergul, Temel, Aslan, & Coban, 2011; Tisdell, 2006). Such is the case, for example, in some aboriginal cultures, the Haitian culture, and the African American culture.

Culturally sensitive care is one of the hallmarks of good nursing care, particularly important in today’s increasingly culturally diverse society (CNA, 2008). Such sensitivity extends to the spiritual and religious beliefs, tenets, and practices within each culture. It should also be pointed out here that various religious or spiritual groups can be considered to be subcultures within the broader culture; therefore, awareness and appreciation of these groups is also important so that nurses can be sensitive to clients within such subcultures.

IMPORTANCE IN HEALTH/ILLNESS
The significance of spirituality and religion to health and illness was discussed in Chapter 2 (see section on Religion/Spirituality in Health and Illness). There is strong empirical evidence of a significant link between the two (Baldacchino, 2011; Biro, 2012; Callister, Bond, Matsumura, & Mangum 2004; Maj, 2010; Moberg, 2008; Reimer-Kirkham et al., 2011; Ruder, 2013). In fact, Ribaudo and Takahashi (2008) noted a steady increase in research studies on spirituality and health since the 1980s (14.9 studies per year in the 1980s; 209.5 studies per year in the early 2000s). Discussions on issues related to spirituality and research abound; for example, the discussions by Reinert and Koenig (2013) and MacDonald (2011). Authors who have conducted research reviews generally conclude that there is ample evidence to promote the inclusion of spirituality into health and illness care. For example, Sessanna, Finnell, and Jezewski (2007) maintain that psychosocial, biochemical, and neuroscientific research supports the role of spirituality and religion in health, healing, and well-being. Cockell and McSherry (2012), after reviewing research papers on spiritual care in nursing from 2006 to 2010, conclude: “While there is much still to learn, [about spiritual care] enough is known to provide a solid evidence base . . . A rapidly growing body of research indicates that [spiritual care] is too important to be ignored, for the sake of both practitioners and patients” (p. 966). Narayanasamy (2011), who has published prolifically in the area of spirituality in nursing education and practice, maintains that there is sufficient empirical information to warrant the inclusion of spirituality into nursing care. Many research studies are referenced in this book to support such claims.

If spirituality and religion are positively linked to health, resilience, and healthy lifestyles; if spirituality and religion are positively connected to adaptation to chronic and acute illness, making sense of illness and other adversity; and if spirituality is related to quality of life, including the end of life, then it is definitely the case that spirituality is a powerful resource for nurses in working with clients. In fact, certain clinical contexts are known to be particularly connected to spirituality and spiritual needs, such as life-threatening illness, palliative care, and mental health (Highfield, Taylor, & Amenta, 2000; WHO, 2016). The suffering inherent in those contexts of health and illness often stimulates spiritual exploration (Becker, 2009).
The concepts of health and illness are core to the focus of nursing practice. Each is connected to spirituality. With respect to the concept of health, it is interesting to note that prior to Hippocrates, health was broadly seen as a divine gift (Bonting, 2005), a view that still persists in some people to this day. There are a myriad of descriptions and definitions of “health” by various organizations and authors, many referring implicitly to spirituality, but other health definitions are much more explicit with respect to spirituality. A definition that implies spirituality is one given in Stanhope, Lancaster, Jessup-Falcioni, and Viverais-Dresler (2011): “Community health nursing practice supports the World Health Organization (WHO) definition, which views health positively as a resource for everyday living that is holistic and includes physical, social, and personal capabilities (World Health Organization [WHO], 2006)” (p. 9). Describing health as a resource for living that is holistic would include all of the resources that a person uses to effect health, including spiritual resources. In an example of a more explicit definition, O’Brien (2011) refers to being truly healthy as not primarily related to physical health as much as being “solidly grounded spiritually” (p. 9). O’Brien and many others also refer to “holistic health” as encompassing not only the health of the body and mind, but also the health of the spirit.

As discussed in Chapter 2 (see section on Religion/Spirituality and Stress/Illness), illness is known to stimulate spirituality/religious searching or questioning of the “deeper questions of life.” In fact, a critical illness can be the client’s first awareness of an encounter with the spiritual self. Clients also use a wide range of religious and spiritual beliefs to cope with illness and promote healing (Brady, Peterman, Fitchett, Mo, & Cella, 1999; McCord et al., 2004; Molzahn & Shields, 2008; Reimer-Kirkham et al., 2011). Swinton (2005) sums up the relationship between spirituality and religion well when he states:

Spirituality sits at the heart of . . . [illness] experiences. A person’s spirituality, whether religious or non-religious, provides belief structures and ways of coping through which people begin to rebuild and make sense of their lives in times of trauma and distress. It offers ways in which people can explain and cope with illness experiences and in so doing discover and maintain a sense of hope, inner harmony and peacefulness in the midst of the existential challenges illness inevitably brings. [These experiences] are crucial to the complex dynamics of a person’s movement towards health and fullness of life even in the face of the most traumatic illness. (p. viii)

If health and illness are the “business” of nursing, and if spirituality is inherent in both the concepts, then spirituality is necessarily the “business” of nursing.

**Spirituality as a Factor in Resilience**

Spirituality is one of the protective factors that serve to foster resilience (Battey, 2012; Bonanno, 2004). Resilience is described by Bonanno (2004) as “the ability of adults [and children] in otherwise normal circumstances who are exposed to an isolated and potentially highly disruptive event [such as a health crisis] to maintain relatively stable, healthy levels of psychological and physical functioning” (p. 20). Based on earlier work (Bonanno, Papa, & O’Neill, 2001), Bonanno (2004) goes on to indicate that, although resilient individuals may experience a temporary disruption in normal functioning, they can also
have “the capacity for generative experiences and positive emotions” (p. 21). As Mattison (2006) maintains, spirituality is an internal experience that can transform an external situation that sometimes cannot be altered in any other way. The life and writings of Viktor Frankl illustrate this point well. Frankl was a Jewish psychiatrist who was interned in several concentration camps during World War II. He maintained that people can find meaning regardless of their external situation, an observation he made regarding survivors of the Holocaust. Frankl went on to develop logotherapy, a therapy focusing heavily on the process and nature of meaning making (Frankl, 1985).

Fostering resilience in clients and families is one of the goals of nursing; therefore, the connection between spirituality and resilience cannot be ignored. There is also an interrelationship between resilience and holistic health, discussed later in this chapter (see section on Nature, Values, and Goals of Nursing): “Holistic health affects the patient's resiliency or the ability to recover quickly or move on to a peaceful death” (Battey, 2012, p. 1016).

**Reflection 3.2**

- Would you consider yourself to be a resilient person? If so, does spirituality or the religious expression of spirituality contribute to your resilience? If “yes,” how does it do this?
- Reflect on a time when you felt desperate, hopeless, or troubled and yet felt that you were able to maintain some sense of “well-being” in spite of the situation, perhaps even generating growth as a result of the situation. What role, if any, did spirituality play in working through this situation? How did this occur and what were the specific outcomes?
- Reflect on ways that nurses can use spirituality/religion to foster resilience in clients. What do you need to do in your own practice to consider this factor in promoting resilience in clients/families?

**Economic Factors**

Economic factors related to health care are always first and foremost in the popular and professional media today. It seems as if “cuts” in health-related programs and services occur on a regular basis, and everyone waits anxiously for news about health care with every national and provincial/state budget announcement. The economic concerns and struggles that characterize the current health care system fuel the search for less costly alternatives. Spiritual therapies are one such alternative (Cohen, Holley, Wengel, & Katzman, 2012; Olson et al., 2003). Unruh (2007) also supports this economic interest in spirituality in health care when she identifies the growing aging population in society, with its increasing demand on the health care system as a reason for an enhanced focus on spirituality as a factor that promotes health and resilience.

Another impact of economic factors with respect to spiritual care in health care is related to the place of such care in clinical practice. As Swinton and McSherry (2006)
maintain, the current “political, economic and financial constraints placed on many health care systems inevitably deprioritizes the spiritual and despiritualizes those who work within it” (p. 801).

**Clients’ Perspectives**

According to the research, and further borne out by anecdotal comments by health care professionals and clients alike, many clients want health care professionals to talk about spiritual/religious concerns that the clients may have—as well as to support their spirituality/religiosity (Battey, 2012; Daaleman, Cobb, & Frey, 2001; Molzahn & Shields, 2008; Taylor, 2002). Many nurses encounter clients who are religious or are influenced by religion (Taylor, 2012). Moreover, for many clients, religion is important in maintaining health in the midst of illness or adversity (Pesut, Fowler, Taylor, Reimer-Kirkham, & Sawatzky, 2008; Ross, 2006). Nurses also report regularly encountering (as frequently as on a daily basis) clients with spiritual needs (McSherry & Jamieson, 2011).

If the religious and spiritual needs of clients and their families are not met, then they can experience spiritual distress, which may lead to negative client outcomes (Hexem, Mollen, Carroll, Lancot, & Feudtner, 2011; Taylor, 2003). For example, it is suggested that in some instances, spiritual distress and anguish can actually exacerbate the clients’ perceptions of pain, anxiety, restlessness, and other symptoms that are present during the dying process (Wasner, Longaker, Fegg, & Borasio, 2005). Conversely, when spiritual and religious needs are met, clients are more satisfied (Lind, Sendelback, & Steen, 2011). Evidence of positive client outcomes provides one of the most important rationales for spirituality/religion to be incorporated into client care. There is ample evidence to indicate that the quality of care improves when spirituality/religion is considered in that care (Pesut, 2009c). Not only does this relate to client outcomes, but also to the improvement of client-centered care (Hoover, 2002), which occurs as nurses strive to assess spirituality from the client’s perspective and tailor spiritual care to each client’s situation. It is clear, then, from the client’s perspective, that the client’s spirituality/religion is important to be considered and addressed.

**Reflection 3.3**

- Reflect on clinical situations where clients have given “cues” that they might like to discuss spiritual or religious issue with you, either with respect to themselves or to loved ones. For example, joking about “the man upstairs” (referring to God), or asking “Why” questions, such as “Why is this happening to me (him, her)?” or “What did I (he, she) do to deserve this” or “Why do I (he, she) have to suffer so?”
  a. What feelings or thoughts are evoked in you in such situations?
  b. How do you respond in such situations? Are you comfortable in proceeding to conversation that will focus on some aspect of spirituality, or do you largely

(continued)
PART I Spirituality in Nursing: The Basics

**Historical Roots of Nursing**

The historical roots of nursing provide a foundation for the inclusion of spirituality/religion into nursing practice. Tracing the history of nursing is an interesting exercise. For example, Taylor (2002) describes the history of nursing from the time of Jesus Christ. In her review of the history of nursing, it is seen that the origins of nursing, and also the development of nursing as a profession, grew out of a worldview that saw people as spiritual beings. The writings of early nurse leaders such as Florence Nightingale abound with references to the need of care for the whole person. The spiritual and religious roots of nursing are discussed in more detail in Chapter 6.

**Nature, Values, and Goals of Nursing**

The very nature of nursing supports the inclusion of spirituality into nursing practice. As Highfield and colleagues (2000) state:

> Nursing centers on strengthening patient resources and relationships, facilitating growth and wholeness, and empowering the person and family. In this respect, nursing is a profession that, by its very nature, lends itself to spiritual caregiving—the facilitating of satisfying intrapersonal, interpersonal and transpersonal relatedness. (p. 62)

As can be observed from this quote, nursing is relational in nature, as is spiritual care (Stern & James, 2006). The client is known to the nurse through the nurse–client relationship, and this relationship is at the heart of spiritual care. Critical to the nature of nursing is nurses being available and present to clients. Availability and presence are also crucial in the provision of spiritual care (Hoglund, 2013).

Nursing is also focused on peoples’ experiences as well as their responses to such experiences across their life spans (American Nurses Association [ANA], 2011). These experiences include life events, such as illness, dying, grief, and maintaining or facilitating health. As discussed earlier, spirituality is an intrinsic part of being human, which makes it inevitable that for many peoples’ experiences, spirituality will necessarily play a part in such experiences. Two student nurses summed up the connection between nursing and spirituality well in a study by Callister and colleagues (2004): “Nursing is a career drenched in spirituality” (p. 165); and “Nursing is more than just caregiving; it is nourishing the human spirit” (p. 165).
Values of nursing are connected to spirituality. Curlin and colleagues (2001) observe that nursing values underlie the professional mandate to promote peoples’ health. Horton, Tschudin, and Forget (2007) maintain that nursing values are expressed in behaviors normally exhibited by nurses in their practice. For example, the nursing values of compassion, loving kindness, integrity, autonomy, altruism, social justice, patience, recognition of the sacred, and preserving human dignity are also seen as spiritual values (Cameron, 2003; Fahrenwald et al., 2005; International Council of Nurses [ICN], 2012; Meehan, 2012).

Nursing focus on holistic care is central to its nature and many definitions of nursing include holistic care as a defining feature of nursing (O’Brien, 2011). In fact, Tyler and Raynor (2006) describe holistic care as “the crux of nursing practice in the 21st century” (p. 65). Holistic nursing is seen as a combination of the science of nursing with the art of nursing (Ross & McSherry, 2010; Timmins & McSherry, 2012). As holistic care is so central to the nature of nursing, it is also critical to the practice of nursing (Battey, 2012; Carr, 2010; Jackson, 2011; Lemmer, 2010; Miner-Williams, 2006; Ruder, 2013). Holistic nursing recognizes the unity and balance of the mind, body, spirit, and social dimensions of a person, as well as the interdependence of these dimensions (Narayanasamy & Owens, 2001; Swinton, 2001). In fact, the nursing profession has had a rich history in providing holistic care and has provided a leadership role in promoting consideration of the client’s spirituality as part of holistic care (Burkhardt & Nagai-Jacobson, 2002, 2005). Nursing associations such as the American Holistic Nurses Association (AHNA) and the CNA challenge nurses to have a holistic view of persons and include the spiritual dimension as part of this view (American Holistic Nurses Association, 2009; CNA, 2008). Holistic nursing practice is also central to most nursing theories—for example, Leininger’s theory of cultural diversity and Watson’s human caring theory (Becker, 2009).

Lundberg and Kerdonfag (2010) connect the goal of nursing to a holistic perspective when they identify this goal as “. . . to help people gain harmony in body, mind, and spirit and find meaning in their existence and experiences . . . . Nurses are responsible for creating the most conducive physical, social and spiritual conditions for their patients’ recovery” (p. 1122). Others, for example O’Brien (2011), also connect holistic care to the goal of nursing. Therefore, if nurses ignore spiritual needs, holistic care is actually impaired (Baldacchino, 2011) and the goal of nursing is not achieved. As Plato so aptly put it (Jowett, 1871):

[A]s you ought not to attempt to cure the eyes without the head, or the head without the body, so neither ought you to attempt to cure the body without the soul . . . for the part can never be well unless the whole is well. (p. 11)

**Reflection 3.4**

Reflect on the quotes given in the discussion of the nature, values, and goals of nursing (see section on Nature, Values, and Goals of Nursing). Do you concur with the perspectives of the persons authoring the quotes? Why or why not? How do your views of the nature, values, and goals of nursing direct your nursing practice?
Nursing Codes of Ethics

Codes of ethics in nursing guide nursing actions and also provide “a framework for the standards of conduct” (ICN, 2012, p. 6). They are to be used by nurses along with professional standards, laws, and regulations that guide nursing practice (CNA, 2008). Specifically, codes of ethics “assist nurses in practicing ethically and working through ethical challenges that arise in practice with individuals, families, communities and public health systems” (CNA, 2008, p. 1). Furthermore, codes of ethics provide guidance for ethical relationships, responsibilities, behaviors and decision-making...a means of self-evaluation and self-reflection for ethical nursing practice...[and] an ethical basis from which nurses can advocate for quality work environments that support the delivery of safe, compassionate, competent and ethical care. (CNA, 2008, p. 2)

Nursing codes of ethics refer to spirituality as “an obligation of care” (Pesut, 2009b, p. 16). The ICN Code of Ethics (ICN, 2012) states: “Inherent in nursing is a respect for human rights, including cultural rights, the right to life and choice, to dignity and to be treated with respect. Nursing care is respectful of and unrestricted by considerations of age, colour, and creed” (p. 2). The word “creed” is defined by Green and Harkness (1997) as: “1. A formal statement of religious belief; a confession of faith. 2. A system of beliefs, principles, or opinions” (p. 325). The ICN Code of Ethics goes on to say: “In providing care, the nurse promotes an environment in which the human rights, values, customs, and spiritual beliefs of the individual, family and community are respected” (p. 3). Nurses and nurse managers are to be “sensitive to the values, customs, and beliefs of people” (ICN, 2012, p. 7). Inherent in these statements is the assumption that the clients’ spiritual and religious beliefs are to be ascertained by the nurse. Otherwise, how can there be intentional sensitivity and respect of such beliefs? An important point that Pesut (2008) makes is that the nursing literature goes beyond the “respecting” and “supporting” of clients’ spirituality/religion (as phrased in codes of ethics) to actual intervention in this dimension of care.

The ICN Code of Ethics also focuses on the spirituality of the nurse when it states that nurses and nurse managers are to “monitor and promote the personal health of nursing staff” (ICN, 2012, p. 8). Personal health is defined by the ICN Code of Ethics as: “Mental, physical, social and spiritual wellbeing of the nurse” (p. 11). With respect to a nurse’s own health, the ICN Code of Ethics also directs nursing associations to “promote healthy lifestyles for nursing professionals [and to] lobby for healthy workplaces and services for nurses” (p. 8). Presumably, such directives refer to the fostering of spiritual well-being as well as physical, social, and emotional well-being.

Both the CNA (2008) Code of Ethics in Canada and the ANA (2011) Code of Ethics in the United States have information similar to the ICN Code of Ethics with respect to the spiritual and religious care of clients and with respect to the spirituality of the nurse. Examining these codes will provide specific details.

From the discussion so far, it can be concluded that it is not surprising that ignoring the spiritual dimension in nursing practice would be unethical (Post, Puchalski, & Larson, 2000; Wright, 1998). In fact, referring to the inclusion of religion/spirituality into nursing practice, Sampson (1982) terms it “the neglected ethic”—neglected not due to a deliberate act, but because of a lack of information on this aspect of nursing care.
Nursing and Related Theorists

Because nursing needs to be evidence based and grounded in theory, it is appropriate to observe whether nurse theorists incorporate spirituality into their nursing theories, models, and frameworks. Many contemporary nurse theorists advocate for holistic nursing care, which includes spiritual care. For example, Chung, Wong, and Chan (2007) conducted a review of nurse theorists and concluded that “nursing scholars agree that humans are bio-psycho-social-spiritual beings. Some scholars consider spirituality as the core (e.g., Nightingale, Watson) but others treat it as an isolated dimension without any integration (e.g., Henderson’s)” (p. 160).

With respect to examining the place of spirituality in nurse theorists’ work, there have been several reviews conducted. Oldnall (1996) reviewed 26 nurse theorists examining the inclusion of spirituality into their theories. Twelve theorists were deemed not to include spirituality in theories, whereas some others referred to it implicitly without explanation of terminology used (with the exception of Watson’s theory). Only two theorists, Watson and Neuman, were identified as acknowledging spirituality in a significant way within the development of their theories. Martsolf and Mickley (1998) also examined the concept of spirituality in nursing theories. One of their conclusions was that some theorists do not address the concept of spirituality (e.g., King, Peplau, Orem, & Orlando Pelletier). Others imply or embed the concept of spirituality within their theories as a subconcept (e.g., Levine, Johnson, Roy, Leininger, & Rogers). Furthermore, for some theorists spirituality is included as a major focus so that if the concept were removed from the theory, it would cause a significant theoretical shift (e.g., Neuman, Newman, Parse, & Watson). One important point that Martsolf and Mickley make is that spirituality is viewed differently by nurse theorists who have a reciprocal interaction worldview. This approach perceives people as multidimensional; and spirituality is seen as one dimension of a person, which interacts with other dimensions. Conversely, some theorists embrace the simultaneous action worldview where spirituality is viewed as “patterning focusing on inner experiences, feelings, values, etc.” (p. 300). Martsolf and Mickley classify each nursing theory/model according to the theorist’s worldview and the extent to which spirituality is addressed in the theory/model. Pesut’s analysis of nine nurse theorists (Pesut, 2009b) took a different view. She examined theorists’ writings from a position of theism (Christian perspective), humanism (universal spiritual dimension of personhood), and monism (universal consciousness with the nature of persons seen as energy). Pesut classified nursing theories into each of these three categories, and included the implications of each theory for nursing care. Other authors have also discussed the incorporation of spirituality into nursing theorists’ work, for example, O’Brien (2011), Taylor (2002), and Wright (2005).

A review of each of the references mentioned in the previous paragraph leads to a more in-depth discussion. It is sufficient here to assert that the very foundation of how nursing is conceived by many nurse theorists includes some or significant focus on spirituality. As O’Brien (2011) states, “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)” (pp. 144–145). O’Brien goes on to say that the writings of theorists discussed in her book (Henderson, Abdellah, Travelbee, Neuman, Roy, Parse, Watson, and Paterson & Zderad) contain key words that are
“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” (p. 147).

Taylor (2002) points out that nurses use many theories that are external to the discipline of nursing, but such theories also support the inclusion of spiritual care for people experiencing health challenges. Examples cited by Taylor include grief theories, stress and coping theories, and crisis theories. There is ample support for a theoretical rationale advocating for the inclusion of spirituality into nursing practice.

**The Positioning of Nurses**

Nurses are the largest group of health care providers, have the most frequent contact with clients, and are involved with people at all points across the life span (Battey, 2012; Hoglund, 2013; Iacono, 2011; Kazemipour, Amin, & Pourseidi, 2012; Taylor, 2006). Clients in health care facilities usually have access to nurses on 24–7 basis. This is important, as it has been observed that it is during the late evening hours and night that clients are most vulnerable. It is during those times of the day that “support [including spiritual support] must be offered by a nurse because only that moment exists” (Iacono, 2011, p. 417). Thus, of all health care providers, nurses are seen to be the most accessible to those experiencing illness and other health-related crises.

Not only are nurses accessible to clients, but the nature and context of the nurse–client relationship is also conducive to providing spiritual care. Nurses encounter clients in their most private and intimate moments, and are focused on helping them deal with difficult life situations, such as pain, suffering, and illness. They do this by providing support, encouragement, and guidance (Creel, 2007; Hoglund, 2013; Hollywell & Walker, 2009; Hubbartt, Corey, & Kautz, 2012). As spirituality is often connected to illness and other significant life events, it is logical that nurses should be potential spiritual resources. As Ozbasaran and colleagues (2011) state, “Often, nurses encounter patients during ‘rough parts of the trail’ when spiritual care becomes one of the major components in holistic care” (p. 3103).

Nurses are often trusted by clients, creating a positive environment for conversations about matters, such as spirituality (Taylor, 2003). Nurses are seen as potential spiritual resources by clients (Highfield et al., 2000), but it is also the case, as confirmed by research, that nurses themselves consider spirituality as being integral to nursing care (Lundmark, 2006; Milligan, 2004; Stranahan, 2001; Taylor, 2002). Therefore, from this emic (or insider) perspective of nurses, there is clear rationale for the inclusion of spirituality into nursing practice. Nurses are also deemed to be the liaison people who are responsible for consistent care, including spiritual care (Baldacchino, 2006). In fact, there are some who believe that nurses need to focus on the spiritual needs of clients as the availability and extent of chaplaincy and pastoral care services declines (Battey, 2012).

As can be observed from the discussion, nurses are generally well positioned to be engaged with the spirituality of clients and their families, and, as such, nurses should be focusing on clients’ spiritual needs and resources.
The nursing process is a well-recognized tool in nursing practice, albeit there are some concerns regarding the use of the nursing process within the context of spiritual issues. Part of the nursing process involves the diagnosis of various client concerns, including spiritual concerns. Nursing diagnostic taxonomies (e.g., the North American Nursing Diagnosis Association-International [NANDA-I], 2011) include “spiritual distress” and “potential for enhanced spiritual well-being” as legitimate nursing diagnoses. Practice guidelines can also be found for such diagnoses. The NANDA-I is recognized internationally for its development of standardized terminology that is evidence based and that focuses on the safety and health care of people (Sessanna, Finnell, Underhill, Chang, & Peng, 2011).

A particular response to a client’s needs may impact whether or not a health crisis will result in spiritual distress or spiritual growth (Timmins & Kelly, 2008). Obviously, nurses will want to promote spiritual growth and prevent spiritual distress as their norms. However, if such distress occurs, then the appropriate action is to alleviate such distress.

**Importance in Nursing Education**

Upon perusal of the nursing literature, it is found that there is much discussion not only about the lack of education in nursing on the spiritual dimension of practice, but also about the necessity of ensuring that such education is provided in both foundational nursing programs and continuing (or ongoing) nurse education programs. With respect to spirituality, education is proposed to encourage the growth of the nurse’s own spirituality, to improve the nurse–client relationship, to improve attitudes toward spiritual care, and to improve competence and comfort in providing spiritual care (Cockell & McSherry, 2012; Highfield et al., 2000; Hoover, 2002; Musgrave & McFarlane, 2004; Narayanasamy, 1999; Wasner et al., 2005).

Various nursing education bodies endorse the importance of nursing education on the spiritual dimension of care. For example, the American Association of Colleges of Nursing (AACN, 2008, 2011) has developed an education framework for the education of nurses at both the undergraduate and graduate levels, which has outcomes related to the spiritual dimension of care. A holistic view of care is embedded in nursing curricula (AACN, 2008; Canadian Association of Schools of Nursing, 2015). In Canada, a national nursing framework includes guiding principles and essential components related to
spirituality (Canadian Association of Schools of Nursing, 2015). Accreditation documents identify one of the goals of nursing education bodies is the assessment of the extent to which nursing programs reflect nursing professional standards and guidelines. This is the case in the United States: the Commission on Collegiate Nursing Education (2013) and the National League for Nursing Accrediting Commission Standards and Criteria (2016); and in Canada: the Canadian Association of Schools of Nursing (2014) Accreditation Standards.

If nursing education includes information about spirituality in the curriculum, then there needs to be a means by which nursing students and new graduates apply this knowledge into practice. Nurses in practice are expected to participate in the education of nursing students as part of their professional responsibilities, and are in a prime position to identify learning opportunities related to the spiritual dimension of care. Nurse managers also have a responsibility to ensure that nurses are delivering competent, holistic care, including spiritual care (Speck, 2005). Therefore, they have a responsibility to ensure that nurses are educated about such care. Nurse managers as well as practicing nurses need to create an environment conducive to the transfer of knowledge from theory about spiritual care to practice in spiritual care.

If nursing education frameworks, nursing curricula outcomes, and nursing education accreditation standards all reference and include spirituality and spiritual care, then it provides clear rationale for the inclusion of this concept into nursing education and practice.

**Reflection 3.6**

Reflect on your nursing education to date. What aspects of the nursing curriculum contained information related to the spiritual dimension of nursing practice? What were the topics of focus? How was the education delivered (e.g., a course, a class, a seminar, a workshop)? In your opinion, has this education been sufficiently extensive to contribute significantly to your sense of competency in attending to clients’ spiritual issues and needs? If so, then in what ways? If not, then how can you facilitate your own education in this area of practice, and perhaps the education of your peers?

**Nursing Leadership Role**

The nursing profession is generating an increasingly important body of knowledge and insight into the relationship between spirituality and health/illness care (Hoffert, Henshaw, & Mvududu, 2007; Iranmanesh, Tigrari, & Cheraghi, 2011). In fact, according to Smith (2008), nursing as a profession is seen as the most advanced of all of the health care professions in terms of its focus on spirituality and spiritual care in practice. Swinton and McSherry (2006) agree when they state: “Indeed, of all the caring professions, nursing is probably the most advanced and forward thinking within this area of care . . . . [Nursing has offered] new, rich and challenging insights and clarifications in relation to this vital and sometimes contentious area of research and practice” (p. 801). This
leadership role needs to continue and expand as nursing not only internally impacts its own profession in terms of the spiritual dimension of care, but also externally by positively influencing other helping professions.

If nurses contribute to the knowledge about spirituality and spiritual care through research, theory development, and practice implications, then nursing is validated as an evidence-based profession. Ties between nursing education, research, and practice will also be strengthened. Currently, there are some respectable scholars in nursing who have contributed much to the area of spirituality in nursing practice. Elizabeth Taylor, Verna Carson, Sr. Mary Elizabeth O’Brien, Wilfred McSherry, Aru Narayanasamy, Sheryl Reimer-Kirkham, Judith Shelly, Barbara Pesut, and Lorraine Wright are examples from an impressive list of such scholars. Research into these scholars will yield numerous articles and books devoted to the topic of spirituality in nursing practice, research, and education, which all serve to advance knowledge in this area.

**Nursing Assessment Tools and Intervention Models**

There have been many assessment tools developed by nurses for nursing practice and research. Examples include Stoll’s (1979) Guidelines for Spiritual Assessment and the JAREL Spiritual Well-Being Scale (Hungelmann, Kenkel-Ross, Klassen, & Stollenwerk, 1996). Many more are identified in Chapter 5 on spiritual assessment.

Nurses have also developed models, theories, and frameworks for spiritual care. Examples of these include the Trinity Model (Wright, 2005), the Theory of Spiritual Care in Nursing Practice (Burkhart & Hogan, 2008), and the T.R.U.S.T. Model for Inclusive Spiritual Care (Barss, 2012). More are considered in Chapter 6 in the discussion on spiritual care.

The main point here is that such tools, models, and theories assist nurses in learning how to conduct research in the spiritual dimension of practice and how to educate nurses in this dimension of care, and also provide rationale and guidelines for spiritual care in practice settings. As research, education, and practice continue to develop, more such tools, models, and theories will become available for nursing in terms of embracing this vital aspect of nursing care.

**Professional Mandates**

Codes of ethics for nurses have already been discussed as providing rationale for the inclusion of spirituality into nursing practice. In addition, other professional mandates require spiritual care to be included as part of health care (Hoffert et al., 2007). Examples include hospital/institutional accreditation organizations, such as the Joint Commission on Accreditation in the United States (Lemmer, 2010; Ruder, 2013). Although such accreditation organizations are not focused specifically on nurses, they do focus on the overall provision of health care relevant for nursing.

Other prominent health care organizations include information about spiritual care in their practice directives, and advocate for health care professional education on spirituality. In the United States, these organizations are the National Hospice and Palliative Care Organization and the Oncology Nursing Society; in Canada, the Canadian Hospice Palliative Care Association and the Canadian Association of Nurses in Oncology; and worldwide, the WHO. Professional associations from a variety of
health care disciplines also endorse the inclusion of spiritual care in client care, such as the British Medical Association, the American Holistic Medical Association, and the International Federation of Social Workers.

Various health care policy documents also recognize the spiritual dimension of care. A significant one in Canada is the report by Romanow (2002), *Building on Values: The Future of Health Care in Canada*. Some organizations focus primarily on spirituality in health care, such as The Janki Foundation for Spirituality in Health Care, which have as two of their aims: “To provide an education forum for healthcare professionals by exploring how spirituality can be integrated into current working practices” [and] “To enhance understanding among patients and the public of the value of spirituality in healing and well-being” (The Janki Foundation for Spirituality in Health Care, 2016).

Professional associations focusing on nurses also promote spiritual care in practice. The ICN, the CNA, and the ANA have been previously referenced in the discussion on codes of ethics in nursing. Other documents published by these bodies also advocate for spiritual care, such as *Vision for the Future of Nursing* (ICN, 2007); *The Position Statement: Spirituality, Health and Nursing Practice* (CNA, 2010); and the book, *Nursing’s Social Policy Statement: The Essence of the Profession* (ANA, 2003). The AHNA and parish nursing associations in both Canada and the United States also promote and educate about spiritual care in nursing. Some organizations, such as Nurses Christian Fellowship (an international organization), promote and educate nurses from a particular worldview, in their case: Christian.

As can be seen from these examples of professional mandates (and there are many more), spirituality is intended to be part of health care and nursing care. Because of such mandates, many agencies will have developed and/or adopted policies related to spiritual care for their particular agencies.

**Nursing Standards and Competencies**

Nursing education standards and competencies related to spiritual care have already been discussed. Nursing practice standards have implications for spiritual assessment and spiritual care (Lantz, 2007; McEwen, 2005; Pesut, 2009b): for example, the CNA's *Framework for the Practice of Registered Nurses in Canada* (CNA, 2015) and the ANA's *Nursing: Scope and Standards of Practice* (ANA, 2010). Specific groups within nursing also have standards relevant for spiritual assessment and care, for example, the Canadian Holistic Nursing Association (2009).

Competencies for spiritual care in nursing practice are discussed more thoroughly in Chapter 4. However, it should be noted here that both the United States and Canada have national nursing competencies focused on spiritual assessment and spiritual care of clients. The inclusion of a focus on the spiritual dimension of practice in both nursing standards and nursing competencies means that such a focus is not optional, or an “add-on” for nursing care, but such a focus needs to be integral to the practice of nursing.

**Summary of Rationale**

Overall, the discussion provides rationale for the inclusion of spirituality into nursing practice. There is ample guidance in the literature and in nurses’ clinical wisdom to support this inclusion. As Mattison (2006) asks, “What do health care providers have to lose by integrating the spiritual dimension into care delivery and accessing a powerful
intervention that can make a difference to patients” (p. 32)? To expand understanding and competency in articulating the rationale for the inclusion of spirituality into nursing practice, a thorough review of the resources identified for each rationale is recommended.

Reflection 3.7

Reflect on the many reasons for the inclusion of spirituality into nursing practice. Can you think of any additional reasons as to why spirituality should be included? How has your perspective been enriched by this discussion? Are you now more enthused and motivated to include the spiritual dimension in your own nursing practice?

CHALLENGES TO INCORPORATING SPIRITUAL CARE INTO NURSING PRACTICE, EDUCATION, AND RESEARCH

Although there is ample rationale for the inclusion of spirituality into nursing practice, education, and research, there are also challenges to such inclusion. Some would identify these challenges as “barriers,” but the word “challenges” seems to have more potential for positive action with respect to exploring each challenge and ways to overcome it. Table 3.1 summarizes many of the challenges identified by nurses as existing within themselves and within their work environment. The challenges are discussed in the nursing literature complete with examples of supporting documentation.

Each challenge needs to be addressed by nurses. But because many of the challenges lie within the overall health care system/environment itself, they also need to be addressed by other health care professionals, health care managers, and government officials. Some challenges can be addressed by education in the area of spirituality in nursing and by conducting and/or considering research that would refute a challenge. For example, with respect to the challenge of “lack of time,” in van Dover and Bacon’s study (2001), it was found that nurses were providing spiritual care within a few hours of meeting the client/family. This suggests that spiritual care does not always require an in-depth knowledge of the person or situation, nor a long-term nurse–client relationship. Furthermore, with respect to time management, spirituality is so intricately connected to health and well-being that it can consume more time to not address it. For example, a client might initially present with considerable emotional distress and multiple physical ailments and complaints. After several medical tests, which generated normal results, more in-depth assessment might reveal that the “root” of the symptoms is related to a spiritual issue arising from a loss of meaning and purpose in life or some significant life event, or even guilt over an adulterous affair. Time and resources might be expended in addressing the emotional and physical complaints (and rightly so, as these would be very real to the client). However, if the spiritual issues are not dealt with, in a timely fashion, then the client’s issues may never be fully addressed.
### Table 3.1 Challenges to Spiritual Care

<table>
<thead>
<tr>
<th>Challenges</th>
<th>References</th>
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<tbody>
<tr>
<td>Lack of awareness, uncertainty, comfort about own spirituality, and unresolved spiritual pain</td>
<td>McEwen (2005); Ruder (2013); Sweat (2011)</td>
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<tr>
<td>Inadequate preparation to provide spiritual care; lack of knowledge about spiritual assessment/care</td>
<td>Carr (2010); Jackson (2011); Lemmer (2010); Miller (2013)</td>
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<td>Lack of confidence/comfort in spiritual assessment and providing spiritual care, including how to converse with clients about spirituality/religion; sense of/actual lack of competence</td>
<td>Jackson (2011); McEwen (2005); Miller (2013); Reimer-Kirkham, Pesut, Meyerhoff, &amp; Sawatzky (2004); Taylor (2002)</td>
</tr>
<tr>
<td>Lack of time due to staff shortages, never-ending tasks, and so forth</td>
<td>Biro (2012); Burkhart &amp; Hogan (2008); Swinton &amp; McSherry (2006)</td>
</tr>
<tr>
<td>Institutional/workplace factors such as lack of support, and nonconducive environment</td>
<td>Burkhart &amp; Hogan (2008); Carr (2008, 2010); McEwen (2005)</td>
</tr>
<tr>
<td>Confusion about concept of spirituality; spiritual needs versus psychosocial needs</td>
<td>Molzahn &amp; Shields (2008); Narayanasamy &amp; Owens (2001)</td>
</tr>
<tr>
<td>Confusion/uncertainty about role in spiritual assessment and care in relation to chaplain/pastoral care role</td>
<td>Carr (2010); McEwen (2005); Ruder (2013)</td>
</tr>
<tr>
<td>Health care system emphasis on physical/technical care/empirical science/economics</td>
<td>Carr (2008, 2010); Gilbert (2010); McSherry &amp; Jamieson (2011); Miller (2013)</td>
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<tr>
<td>Spirituality of clients in a pluralistic society</td>
<td>Cockwell &amp; McSherry (2012); Pesut (2009a, 2009b)</td>
</tr>
<tr>
<td>Differing spiritual beliefs/values of clients and nurses and appropriate action needed</td>
<td>Pesut (2009a, 2009c)</td>
</tr>
<tr>
<td>Ethical issues such as appropriateness of interventions, professional competency, boundaries</td>
<td>Pesut (2009a, 2009c)</td>
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(continued)
Other challenges to incorporating spiritual care into nursing practice can be addressed through reflection on practice and from clinical experiences. For example, in addressing some of the challenges to spiritual care, Creel (2007) posed some thought-provoking questions for reflection by nurses relating to spiritual care: “How much education would it take to treat a person like a human being and not just a medical diagnosis? How much time would it take to smile and touch a person’s hand while pushing the intravenous medicine? How much privacy would be needed to ask a person if they are afraid?” (p. 19).

### Table 3.1 Challenges to Spiritual Care (continued)

<table>
<thead>
<tr>
<th>Challenges</th>
<th>References</th>
</tr>
</thead>
<tbody>
<tr>
<td>Fear of being intrusive/proselytizing</td>
<td>McEwen (2005); Narayanasamy (2011); Pesut (2008)</td>
</tr>
<tr>
<td>Negative personal views of religion/religious people</td>
<td>National Health Service (NHS) Education for Scotland (2009)</td>
</tr>
<tr>
<td>Seeing spirituality/religion as “private” to client and therefore hesitant to explore same</td>
<td>Carson (1989)</td>
</tr>
<tr>
<td>Trend in society and health care toward secularism</td>
<td>Molzahn &amp; Shields (2008)</td>
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Other challenges to incorporating spiritual care into nursing practice can be addressed through reflection on practice and from clinical experiences. For example, in addressing some of the challenges to spiritual care, Creel (2007) posed some thought-provoking questions for reflection by nurses relating to spiritual care: “How much education would it take to treat a person like a human being and not just a medical diagnosis? How much time would it take to smile and touch a person’s hand while pushing the intravenous medicine? How much privacy would be needed to ask a person if they are afraid?” (p. 19).

### Reflection 3.8

Reflect on the challenges to spiritual care as outlined in Table 3.1:

- Would you add any challenges to this list that you have encountered or that arise from your reflection?
- Which of these challenges have you encountered in your own nursing practice? How have you dealt with these challenges? Or, how might you deal with them?

This chapter has provided rationale for the inclusion of spirituality/religion into nursing practice. Such rationale can engender confidence in nurses as they endeavor to incorporate the spiritual dimension into their nursing practice. It can also provide the basis for advocacy for such inclusion in settings in which nurses practice.
The Bottom Line

- There is ample rationale for the inclusion of spirituality and spiritual care into nursing practice, education, and research.
- Being familiar with the rationale can facilitate personal inclusion of spirituality into one's nursing practice.
- The rationale for the inclusion of spirituality into nursing practice can be used to advocate for more attention to the spiritual dimension of nursing practice.
- Awareness of the challenges to spiritual care in nursing practice is one of the first steps in promoting spiritual care in one's own practice and also in advocating for spiritual care to be incorporated as an essential aspect of nursing practice in general.
- Challenges to incorporating spiritual care into nursing practice need to be seen as opportunities for growth in this area of practice as opposed to barriers that cannot be removed.

Taking It Further

1. Conduct a review of the nursing literature to examine for yourself the extent of articles and books on the spiritual dimension of nursing practice. You can use such search words as “spiritual,” “spirituality,” “religion,” “spiritual care,” “religious care,” “spiritual assessment,” and “spirit.” Make a plan to read a number of the references each week to further your knowledge in this area of nursing care.

2. Create a “Movie Spirituality” group to search for and view movies that focus on some aspect of spirituality in the lives of the people featured in the movie. Watch a movie each week or month. Following the movie, discuss:
   a. Aspects of the movie that relate to spirituality
   b. Views of spirituality portrayed in the movie and how they are similar to or different from those of the people in the group who watch the movie
   c. The possible implications for nurses responding to any societal interest in spirituality as portrayed in the movies

3. Write your own ideas about the nature, values, and goals of nursing. How many of your ideas are related to some aspect of spirituality as discussed in this book? What are the implications for your nursing practice?

4. Review the literature related to the “art of nursing.” What aspects of the discussion about this aspect of the nature of nursing relate to the provision of spiritual care? Compare and contrast the provision of spiritual care within a technological view of nursing and also within a view of nursing that sees it as a
healing art. Toward which view of nursing do you more heavily lean? How might viewing the nature of nursing as both a “science” and an “art” open up advanced possibilities with respect to attending to the spiritual dimension in nursing practice?

5. In your clinical practice, identify clients who you consider to be resilient. Have a conversation with them about the place of spirituality/religion in their lives. If it is important to the clients, then discuss with them how they perceive spirituality/religion to be of assistance to them in fostering resilience.

6. In a group setting, discuss each of the challenges to incorporating spirituality into nursing practice. Discuss how, or if, you would refute the challenge—as well as how you might address it. Who else, besides nursing, needs to be involved in addressing certain challenges and how might they be involved?

7. What personal characteristics do you possess that might impact on how you would converse with clients or colleagues about why spirituality is important to nursing practice? Which characteristics would be facilitative to such conversations, and which would be restricting? How can you address the characteristics that would restrict such conversations?

8. Research standards of practice for registered nurses in your own jurisdiction. Identify those that refer directly or indirectly to the spiritual and religious care of clients.

9. Research the practice specialty of parish nursing. Interview and spend some time with a parish nurse to broaden your perspective on the spiritual dimension of nursing practice in that context. How have these two activities broadened your perspective on this aspect of nursing care?

10. Interview a number of people in management positions in health care agencies. Inquire with respect to identifying agency policies that are related to the provision of spiritual care within their agency. What conclusions can you draw from this exercise?

11. Research the major nursing theories/models/frameworks presented in this chapter (see section on Nursing and Related Theorists). What specific aspects of these are related directly or indirectly to seeing clients and nursing as involving spiritual matters? What spiritual care nursing actions might be suggested in each theory/model/framework? Which are most helpful in terms of guidance for attending to the spiritual dimension of clients?

12. Review the two worldviews that Faucett (1993, 1995, as discussed in Martsolf & Mickley, 1998) discusses as being reflected in nursing theories and models, namely the reciprocal interaction worldview and the simultaneous action worldview. Identify how spirituality is reflected in each worldview. What are the implications for nursing practice?

13. Review the discussion of spirituality as a central concept in the theories/models of Neuman, Newman, Parse, and Watson in Martsolf and Mickley (1998). For each theory/model, develop case studies based on your area of nursing in which
some aspects of spirituality or religion are relevant for the client. Discuss these case studies with colleagues, including what spiritual care actions might be warranted and what might be the possible benefit of these actions.

14. Pesut (2013) has reflected on her experience as a scholar writing on the area of spirituality in nursing. She identifies three challenges within nursing that spirituality has attempted to address:

   a. To connect across differences in a globalized world
   b. To be “good” (p. 7) in a world of uncertain morality
   c. To find meaning in a disenchanted world

Read Pesut’s description of each of these challenges. What is your response to her ponderings? What are the implications for nursing as a profession?

15. Review the article by Pesut (2009a), which focuses on ontologies of nursing in an age of spiritual pluralism. Reflect on and discuss the following ideas present by Pesut as they pertain to nursing and to spiritual care in nursing:

   a. The secularization and sacralization within society
   b. The issue of ontological unity or diversity within nursing
   c. Ontology from the naturalistic/reductive and the holistic/unitary perspectives
   d. The issue of common ontology versus common ethics


   a. Identify phrases in each element of the code that relate directly or indirectly to spiritual or religious care.
   b. Study the standards of conduct that relate directly or indirectly to spiritual care under each of the elements in the code.
   c. Reflect on/discuss what each of these standards means to you personally.
   d. Reflect on/discuss how the standards can be applied to nursing practice so as to provide ethical spiritual care.
   e. Reflect on/discuss examples from nursing practice to identify ethical dilemmas and standards of conduct related to spiritual/religious care of clients. How might such dilemmas be resolved?
   f. Reflect on/discuss how nurses and nurse leaders can ensure that standards of conduct related to spiritual and religious care are translated into action? (Adapted from ICN, 2012, p. 6)

17. Review the code of ethics for nurses for nurses in your jurisdiction. Identify phrases and clauses that may be relevant to the spiritual/religious care of clients.

18. Review various professional mandates related to health, as referenced in the discussion in this chapter (see section on Professional Mandates). Identify material that may be relevant for spiritual and religious care of clients in these mandates.
19. Review the article by Cockell and McSherry (2012) in which they state: “Much has been learned about spiritual care over the last few years through a variety of research across contexts and countries. While there is much still to learn, enough is known to provide a solid evidence base [for including spiritual care in nursing practice]” (p. 966). Reflect on/discuss the following questions:

a. How can evidence-based information regarding spiritual care and nursing enable best practices to be developed?

b. How can the evidence regarding spiritual care and nursing address poor care delivery, the nurse’s motivation to provide spiritual care, and the need for a nonmedicalized approach to care?

c. Which research tools might be appropriate to educate nurses about spiritual care and the delivery of spiritual care in your area of nursing practice?

d. What can be learned about spiritual care in oncology/palliative care that can be applied to your own practice setting?

e. How can clients be kept at the center of spiritual care so that spiritual care is relevant to them?

f. How can spiritual care departments/chaplains be of assistance in promoting and providing spiritual care and spiritual care education of nurses in your area of practice?

g. How can the seven activities for nurse managers who want to respond to the research on spiritual care in nursing (Cockell & McSherry, p. 966) be of assistance to you in your own nursing practice?

REFERENCES


CHAPTER 3  Rationale and Challenges for Spirituality in Nursing


