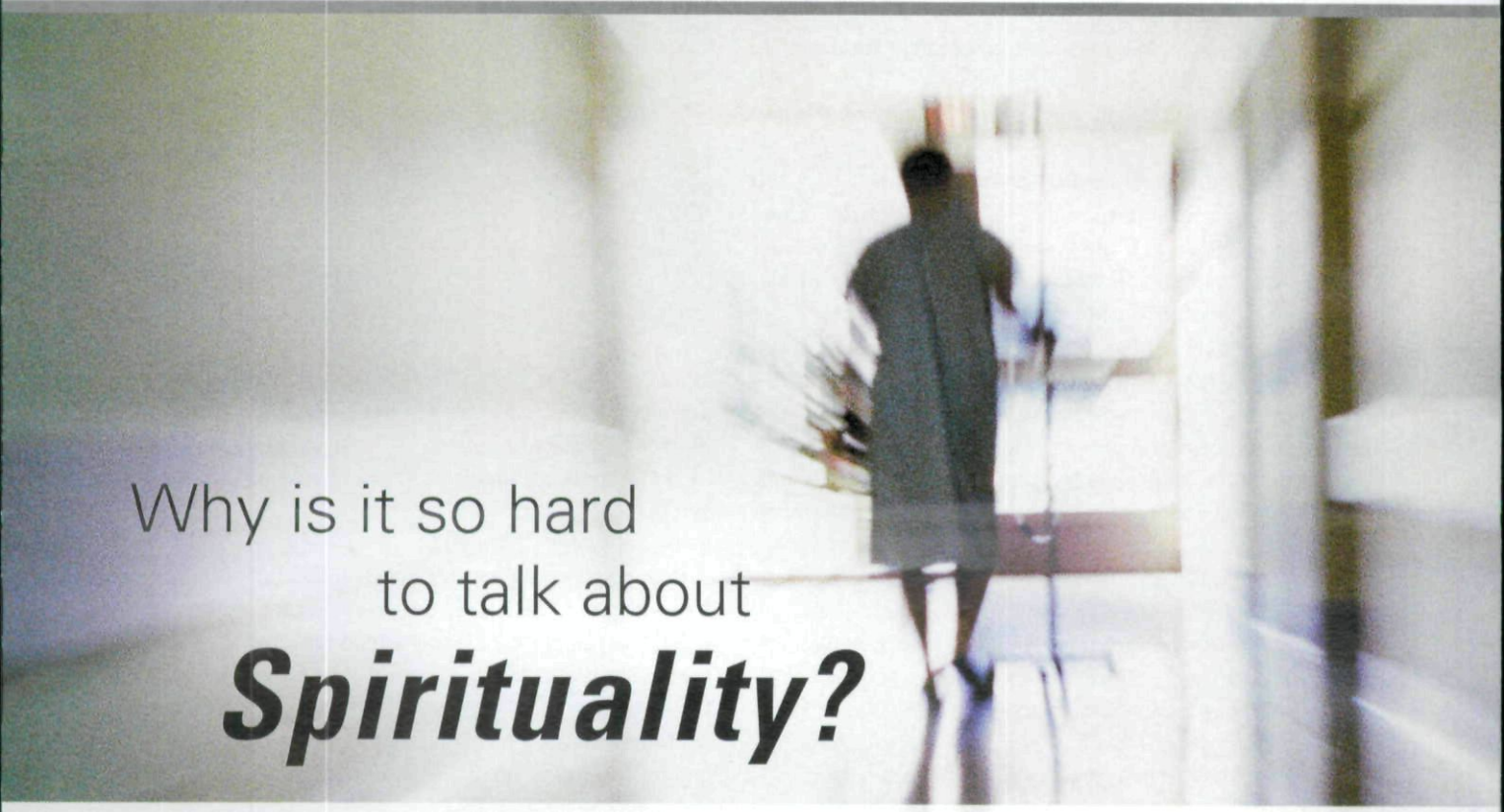
ANITA E. MOLZAHN, RN, PhD

LAURENE SHEILDS, RN, PhD



Why is it so hard to talk about *Spirituality?*

As nurses, we are in the privileged position of working closely with human beings and helping them to deal with many aspects of the human condition. We have access to the most intimate elements of human experience. We care for people when they are at their most vulnerable and talk with them about sensitive topics. However, many nurses have difficulty addressing spirituality with their clients.

Often, the people we care for want to discuss spiritual issues. In a study of 921 adults, McCord et al. (2004) found that 83 per cent of participants from four urban residency training sites and one private group practice in Ohio wanted physicians to ask them about their spiritual beliefs under certain circumstances: when faced with either life-threatening illnesses (77%) or serious medical conditions (74%) and when dealing with the loss of loved ones (70%). Most participants thought that offering information about their spiritual beliefs would affect their physician's ability to encourage realistic hope (67%), give medical advice (66%) and change treatment (62%). Because nurses are trusted (Leger Marketing, 2007), many people turn to them to talk about their spiritual beliefs (Taylor, 2003).

People coping with serious illnesses and loss report that spiritual and religious supports are important to them (Brady, Peterman, Fitchett, Mo, & Cella, 1999). Those faced with aging, chronic disease or serious illness often struggle with questions about mortality, suffering and the inevitability of death. These questions are fundamental to the human experience and touch upon spiritual understandings of life and death.

Several major scholars have addressed spirituality in their nursing theories (Martsolf & Mickley, 1998; Oldnall, 1996); the traditional biopsychosocial model of nursing has been expanded to include spirituality (Neuman, 1995; Watson, 1988); and there has been an interest in a unifying approach to caring for the whole ►

person (Newman, 1994; Parse, 1998). In a review of the work of 26 nurse theorists, Oldnall found that 12 suggested that nurses provide spiritual care; he concluded that Roy (Roy & Andrews, 1999), Neuman (1995) and Watson (1988) most clearly and specifically incorporated the spiritual dimension as a core element in their theories. It is evident that many nurses consider spirituality an important aspect of their practice and research. For example, the growing interest in parish nursing illustrates the focus on the spiritual needs of community members (Van Dover & Pfeiffer, 2007).

There is considerable research that links spirituality to health and well-being. For example, Loeb, Penrod, Falkenstern, Gueldner and Poon (2003) reported that relying on either spirituality or religion was an important strategy employed by the older adults who participated in a study on managing multiple chronic conditions. Brady et al. (1999) found that in people living with cancer, spirituality and physical well-being were associated with quality of life to the same degree.

Despite evidence of the positive effects of spirituality on well-being, nursing curricula provide few opportunities for discussions of spirituality, and nurse educators and nursing students report that spirituality is not discussed. Yet it is not clear why nurses are reticent to discuss spiritual issues with people for whom they provide care.

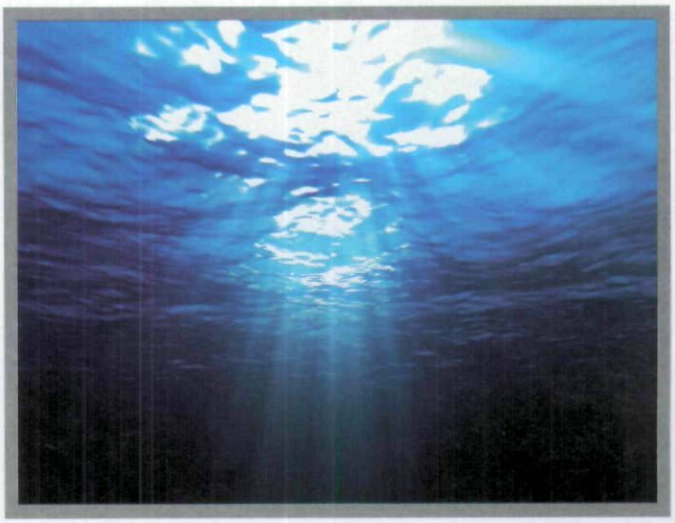
We don't know what spirituality is. In earlier literature, religion and spirituality were terms that were often used interchangeably. Today, there is greater understanding that the two concepts are quite different (see Table 1). Religion refers to a formalization and institutionalization of the spiritual, whereas spirituality is more often defined using the language of human experience. Several authors view spirituality as a harmonious interconnectedness (Burkhardt & Nagai-Jacobson, 2002; Macrae, 1995). The concepts of transcendence; unfolding mystery; connectedness; meaning and purpose in life; higher power; and relationships can be found in the definitions (Tanyi, 2002).

ABSTRACT

Although there is recognition of the importance of spirituality in the nursing literature and in nursing theory, many nurses find it difficult to talk about this sensitive area with people for whom they provide care. In this article, the authors discuss why spirituality is integral to nursing care and explore why nurses don't talk about spiritual concerns with their clients. The authors examine the meaning of spirituality and the factors that contribute to the reluctance of nurses to discuss spirituality with others: not having the right words, lack of education, a view that spiritual care is someone else's responsibility, influences of secularism and diversity in society, and the current health-care context. Openness to learning about the spiritual beliefs of individuals and attending to their nursing needs in a holistic way will enhance nursing care.

KEYWORDS

holistic care, spirituality



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Bruce, McDonald and McIntyre (2005) argued that it may not be necessary to define the term and suggest that an openness to engage in spiritual care is more important. The degree to which a nurse is prepared to provide spiritual care may depend on a number of factors, including level of experience, practice setting and culture, and level of personal comfort. Nursing students and novice practitioners may find it difficult to provide care of a nature that is not clearly defined.

We don't have the right words. We are involved in a research interest group pertaining to spirituality and health. In an exercise, members of the group were asked to define spirituality and comment on its importance. Although we believe spirituality is an important dimension of human experience and nursing care, we found that we struggled with writing and talking about its meaning. Many in the group were concerned that aspects of spirituality were missing in what they wrote and suggested that they could not be articulated. Clearly, there is an "unspokenness" that pertains to the mystery and mysticism inherent in spirituality. Perhaps the lack of language simply represents the ultimate mysteries of human existence; we do not know why people are born, why suffering is a part of life, when we are going to die and what happens after. It is within these mysteries that discussions of spirituality must rest, and for many of us that is an uncomfortable place to be. We may not be able to use language to describe spiritual beliefs as fully as we might wish. Further, many cultures and religious traditions use language about spirituality in different and sometimes contradictory ways, adding to the complexity of respectfully entering into discussions with clients.

In earlier literature, religion and spirituality were terms that were often used interchangeably. Today, there is greater understanding that the two concepts are quite different.

We lack education. Oldnall (1996) made the observation that spirituality does not have a prominent position in nursing theories or curricula, although today there are more opportunities for nursing students and nurses to learn about spiritual care. In a Canadian study of nursing curricula (Olson et al., 2003), it was found that little content is offered in this area and that educators did not fully understand the terms. The reason for this gap is not clear; one of the faculty participants in this study noted, "I believe that there is some inconsistency in our faculty; we have the tendency to believe that spirituality is a private matter, yet we see its importance in a person's health."

It's someone else's responsibility. Making a referral to clergy should not replace having a discussion of spirituality with a client. In a study examining nursing and collaborative roles with other health professionals, Miller (2004) noted that only 3 per cent of diploma- and baccalaureate-prepared nurses and 6.9 per cent of master's- and doctoral-prepared nurses considered promoting spiritual well-being to be a nursing role; a large majority considered it a role to be shared with other professionals, and 21.3 per cent of diploma and baccalaureate graduates and 8.4 per cent of master's and doctoral graduates suggested it should be entirely within the domain of other health professionals. But if we consider the spiritual dimension to be beyond the boundaries of religious affiliation, then to whom do we refer our clients?

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Over the past century, there has been an increasing commitment to the provision of health care based on scientific evidence. Physicians and administrators — and, undoubtedly, some nurses — may consider spiritual ideas to be superfluous to the realities of modern health care. There may be a hesitance on the part of nurses to raise issues that pertain to the spiritual dimension in what is predominantly a science-based model of health care.

Societal influences. Our social, public education, legal and judicial systems — and to a great extent our health-care system — are espoused as secular and separate from religious traditions. However, many health-care institutions in Canada were founded on Judeo-Christian perspectives. Nurses may be ensconced in their own beliefs and unsure of how to communicate with others about spirituality. They may be concerned about using inappropriate language or may fear offending a client. It is not realistic to expect that nurses are knowledgeable about all of the ethnocultural and spiritual beliefs and traditions of Canada's highly multicultural society. Further, reported religious affiliations may not accurately represent personal belief systems (Molzahn, Starzomski, McDonald, & O'Loughlin, 2005). It is not uncommon for people to hold a variety of beliefs that are not consistent with the religious tradition that they ostensibly follow. For example, a documentary film about the pill (PBS, 2007) noted that more than 80 per cent of American Catholic women of reproductive age use birth control and do not support their church's position on contraception.

The fear of offending others likely contributes to our reluctance to open discussion of spiritual issues. One nurse participant in a study of spiritual caregiving (Kirkham, Pesut, Meyerhoff, & Sawatzky, 2004) said, "I'm so careful about not transgressing professional boundaries. Since she hadn't brought it up, I hadn't..... I've been too paralysed by these fears of imposing my religion... being so respectful that you avoid the subject" (p. 157). But when this nurse eventually brought up the topic, the client "opened like a flower; she wanted to talk about it." A rich spiritual relationship ensued (p. 158).

Current health-care context. Spiritual assessment and care take time that nurses may not have — or may feel they don't have. In institutions, spiritual concerns can become irrelevant because of the pressures of fiscal and time constraints. Perhaps it is not surprising that spiritual care is pushed to the sidelines. However, ►

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it may also be that nurses are using "lack of time" as a reason to avoid discussing topics with which they are not be comfortable. Although the health-care context does create barriers to addressing spiritual matters, we encourage nurses to reflect on other factors that may be interfering with the provision of spiritual care.

It may not matter that, as a profession, we do not have a clear definition or understanding of the concept of spirituality. It may not be possible to develop a single definition that adequately addresses the concept from a variety of different perspectives and religious affiliations. However, if we are open to the needs of people, we are able to offer spiritual care. A deep understanding of religious beliefs, theology and cultural beliefs is not necessary. First we need to engage with people as unique human beings who bring their own values, beliefs and experiences — and we must be willing to hear and learn about those experiences.

Recent research suggests that clients and families see spiritual care as a way of being rather than as specific interventions (Sellers, 2001). In a study of adults with cancer and their family caregivers, Taylor (2003) found that many were eager for spiritual care, which they suggested included kindness and respect; talking and listening; prayer; connecting with symmetry (i.e., working together), authenticity and physical presence; quality temporal nursing care; and mobilizing religious or spiritual resources. In fact, what they described are, for the most part, aspects of good nursing care; developing a connection by listening carefully, acknowledging concerns, exploring emotions and collaborating on common goals are all part of providing spiritual care. Similarly, a nurse participant in Kirkham et al.'s study (2004) said:

> I didn't provide spiritual care because we didn't talk about God, read any Bible verses, and I didn't even pray with him. So how did I provide spiritual care? Well, I was aware of his spirituality. I was present for him. (p. 158)

Educating practitioners, nursing faculty and students will raise awareness of the need for care that includes the spiritual dimension. Professional development activities could start with exercises that encourage nurses to reflect on their own spirituality and their understanding of the meaning of illness, suffering and

TABLE 1: DEFINING SPIRITUALITY AND RELIGION

SPIRITUALITY	RELIGION
• "Spirituality is an inherent component of being human and is subjective, intangible and multidimensional" (Tanyi, 2002, p. 500) • Sense of purpose and direction in life (Taylor & Ferszt, 1990) • "By virtue of being human, all people are spiritual regardless of whether or how they participate in religious observation" (Burkhardt & Nagai-Jacobson, 2002, p. xiii) • "...the animating energy that forms the core of all human beings; the real person; the active, living and continually unfolding core of the individual; the part that does not die, that provides meaning and purpose in life, that transcends, permeates, and influences all other human dimensions" (Olson et al., 2003, p. 97) • Reflects themes such as existential reality, transcendence, connectedness and power/force/energy (Chiu, Emblen, Van Hofwegen, Sawatzky, & Meyerhoff, 2004)	• Rational belief system with certain worship practices (Emblen, 1992) • "Human recognition of superhuman controlling power and especially of a personal God entitled to obedience" *(Concise Oxford English Dictionary,* 1990) • "Religion originates in an attempt to represent and order beliefs, feelings, imaginings and actions that arise in response to direct experience of the sacred and the spiritual....it becomes a process that creates meaning for itself on a sustaining basis, in terms of both its originating experiences and its own continuing responses." (Connelly, 1996)

death. The emphasis of such activities should be on exploring the possibilities rather than on finding the answers. The next step would be to teach communication strategies that open discussion and provide opportunities for clients to raise concerns of a spiritual or existential nature.

Spiritual care is integral to nursing practice, and nurses must be open to talking about spirituality within the context of their everyday work. We need further research that explores ways in which nurses can most effectively provide spiritual care and support and that examines the effectiveness of assessment processes or interventions relating to the spiritual dimension of care. The existing research, much of which is empirical and quantitative, does not capture the complexity and ephemeral aspects of spiritual care. Similarly, the qualitative research relating to clients' experiences is limited by the difficulty people have in finding the language to describe the essence of spirituality.

We believe it is important that all of us think about how we can remove the largest barriers to discussing spirituality: We must ensure that we are open to listening to our clients and learning about their beliefs, and we must model that openness for our colleagues. ■

ANITA MOLZAHN, RN, PhD, IS A PROFESSOR, SCHOOL OF NURSING, UNIVERSITY OF VICTORIA, VICTORIA, BRITISH COLUMBIA.

LAURENE SHEILDS, RN, PhD, IS AN ASSOCIATE PROFESSOR, SCHOOL OF NURSING, AND ASSOCIATE DEAN, FACULTY OF HUMAN AND SOCIAL DEVELOPMENT, UNIVERSITY OF VICTORIA.

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