

## Special Article

# The Evolution of Spirituality in the Nursing Literature

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### Abstract

This article reviews nursing literature published during the last 50 years with regard to the nursing profession's attitudes towards the religious and spiritual well-being of patients. The literature shows that early writers equated spirituality with religiosity and believed that it was a nurse's duty to intervene religiously in the Catholic faith with a patient to facilitate healing. Over time, the literature progressed to include other faiths. However, there were few guidelines for patients who considered themselves spiritual, but not religious. In the last quarter of the 20<sup>th</sup> century, a major shift took place in the literature. Spirituality was no longer equated with religiosity, but was seen as a critical component of a holistic approach to healing. The article reviews literature by nurses and others who have conducted spiritual research, developed spiritual assessment tools, and attempted to define spirituality.

**Key words:** spirituality; religion; meaning; caring; nursing

### The Evolution of Spirituality in the Nursing Literature

This paper will review numerous articles on religion and spirituality in nursing care that appeared in the literature from the 1950s through the first decade of the 21<sup>st</sup> century in an attempt to show when interest in the *religious* care of patients shifted to their *spiritual* care. Because there were copious definitions of spirituality as this shift was made, this paper will also compare the various definitions as well as the various assessment instruments that were developed or adapted to measure the spirituality of or the spiritual needs of the patient.

### Methodology

CINAHL and MEDLINE were used for years 1982 to 2009. In addition, the Nursing Cumulative Index was used for years 1950-1990. Original articles were retrieved from the Boston College Library. Subject headings used were "spirituality" and "religion." Topics in articles varied and included: "concept of spirituality,"

"spiritual care," "the Catholic nurse," "ministry of healing," "spiritual coping," "spiritual well-being," and "spiritual distress." Keywords used were: "spirituality," "religion," "meaning," "caring," and "nursing."

The term "spirituality" has appeared in the nursing literature for many decades. Looking under the subject headings of "religion" in the Nursing Cumulative Index, an interest in articles published in spirituality can be traced back to more than 50 years.

Most of the early articles were focused on the Christian nurse and most had a clear Roman Catholic slant. The nurse's spiritual role, while secondary to that of the Catholic Priest, was to provide spiritual intervention as well as physical care to the patient.

Ridgeway (1959) explained the meaning of practicing of practicing as a Catholic nurse. She wrote that it was the nurse's moral duty. . . "to endeavor to bring to those in darkness the light of Christ" (p. 59). To help fortify the nurse,

Ridgeway recommended that nurses pray each day and suggested that they use the following prayer by the then popular Jesuit priest, the Rev. Daniel A. Lord (1954):

Dearest Lord. May I see Thee today and everyday in the person of Thy sick and while nursing them minister unto thee. Though Thou hidest Thyself behind the unattractive disguise of the irritable, the exacting, the unreasonable, may I recognize Thee and say, Jesus, my Patient, how sweet it is to serve Thee. . . . (p. 60).

This excerpt from a much longer prayer clearly indicates that for a Christian nurse, caring for patients is the same as caring for Jesus. To reject a patient, no matter how difficult and demanding that patient might be, would be to reject Christ.

Most of the early writers considered spiritual intervention to be critical to patient health. Mother Virginia (1966) stated that in order for the nurse to perform a corporal work of mercy, she must also provide care for the soul. Her insight addressed the fact that the nurse cannot provide a diagnosis of a patient's spiritual connection. Nor can she prescribe any soul medication to be administered around the clock. However, she can observe the patient's reaction to her kindness, patience, sympathy, and her silent ways. The role of the nurse requires an intuitive skill to attain spiritual awareness for her patient. "That is why the Catholic nurse must first *herself* be filled with the charity of Christ. . . . It will be our Catholic nurse's Christlike attitude that will lessen the number of those patients who leave our American hospitals cured in body but still so depressed in spirit. Having contacted Divinity Itself in the humanity of our Catholic nurses, Patients will accept their discharge from the hospital with a renewed spiritual vigor as well as restored bodily health" (p. 51, 71, 72).

Piepgras (1968) encouraged nurses, especially religious nurses, not to turn away from patients who needed spiritual help. She described a patient, the mother of two small children, who was dying of kidney disease. The patient was terrified and in mental and spiritual anguish, which short visits from a local parish priest could not soothe. The patient died still pleading for help. Piepgras lamented that the priest, the nurses, and the doctor did not work together to

help this patient. She asked, "Why...is the important third aspect of patient care—the spiritual—so often neglected?" (p. 2610)

Piepgras believed the answer may lie in the fact that nurses are afraid of practicing outside the scope of physical nursing and that providing spiritual help is often threatening to a nurse. To overcome this, the nurse should be "self-confident about her own relationship with God" (p. 2613). She advised the nurse to be accepting of the patient's ideas and beliefs and be a compassionate, non-judgmental listener.

### Religious Interventions

In the late 1950s and early 1960s the literature began to reflect a new interest in the religious life of Jewish and Protestant patients as well as Roman Catholics. Phillips (1959) developed a checklist of religious rites for Jews and Protestants, discussing the proper rites and rituals for the occasions of birth, death, serious illness, major surgery, and extreme old age from the perspective of each of the three religions. Yet, no attempt was made to determine the level of a patient's faith or the type of rituals a patient might actually embrace. In other words, nurses were to provide a "cookie cutter" approach to religious intervention.

Spiro (1961), sensitive to the beliefs of the Jewish patients, explained many of the faith's rituals, for example, making sure that a circumcision was performed eight days after birth and why some Jewish mothers were hesitant to register their baby girl's names before the ceremony at the synagogue. Spiro also discussed dietary rules, explaining why most Jewish patients would refuse pork, might refuse food items which were not kosher, and could refuse to eat any leavened food during Passover.

In summary, the nursing literature of the 1950s and 1960s was concerned primarily with the religiosity of the Roman Catholic patient and later the Protestant and Jewish patient. The early writers had one commonality—they encouraged the nurse to intervene in a religious manner with the patient. However, there was little concern of the spirituality of patients who had not indicated their religious preference on their hospital intake forms.

## Research

It wasn't until the late 1960s that research regarding spirituality in patient care first surfaced in the literature. O'Brien (1968) sought to determine whether or not the administration of the Sacrament of the Sick to patients with a diagnosis of myocardial infarction was a cause of apprehension or comfort. Like Piepgras, O'Brien concluded that communication needed to be enhanced among patients, physicians, and nurses. Although O'Brien's study pioneered research on patient spirituality, the concentration was solely the religious aspects of spirituality by receiving the religious sacrament. Therefore, patients who might have been spiritual, but not traditionally religious, were overlooked.

It wasn't until eight years later that Simsen (1976) published a rudimentary assessment tool to help nurses determine all patients' spiritual needs. She wrote that nurses needed to assess for the following:

- The casual or even amusing mention of God or religion.
- Comments such as, "I don't understand why God lets me suffer like this."
- Reading scripture or using a rosary.

Simsen's approach to assessment called for excellent verbal and nonverbal communication between the nurse and the patient. Clearly, she also was a forerunner of the shift from religiosity to spirituality when she wrote, "Our plea is that we break the fetters of tradition of the religious concept and try to discover the true...spirituality of man" (p. 14).

### Transition from Religiosity to Spirituality

During the early 1980s, the focus of the nursing literature slowly shifted from a concentration on the religious aspects of spirituality to the quality-of-life aspects of spirituality (Ellis 1980, Penrose & Barrett 1982).

Shelly (1982) captured the relationship between spirituality and quality of life when she wrote, "Spiritual care assists a person in dealing with ultimate issues which give life meaning... Spiritual care creates a bond between the patient and the care-giver which communicates caring and love. It provides an atmosphere and motivation for recovery. It also draws on a power

greater than ourselves and provides hope" (p. 8). During the mid-1980s, Burkhardt and Nagai-Jacobson (1985) addressed the manner in which spiritual concerns affect the various dimensions of the person. They stressed that a person's spirituality can be expressed in ways that are different from the religious paradigm and suggested that a nurse engage in conversation with her patient and seek answers to the following questions:

1. What is sacred to this person? What gives life meaning?
2. For what/whom will this person make sacrifices?
3. How does this person see God acting toward him/her personally? Is God stern? capricious? angry? benevolent?
4. What is trustworthy? In what/whom does he/she place trust?
5. Is life for this person mostly gift or mostly demand?
6. Does the person have a sense of belonging--to a primary group? to the human family?
7. Is this life marked by playfulness? caution? grimness? creativity? fear? joy?
8. What brings joy? What brings satisfaction?
9. Does this person feel he/she makes a difference? Is there a sense of mission and purpose?
10. Does the person view himself/herself as a responsible agent in the situation or as a victim or martyr? Does the person see the potential for taking an active role in the situation? (p. 195)

Burkhardt (1989) continued to look at spirituality separate from religion. "Spirituality is of the essence of one's human nature, whether or not it is expressed through religious beliefs or practices" (p. 71). "Some consequences of healthy spirituality can include inner peace, joy, purposeful life, sense of fulfillment in life, making life-giving choices, drawing on inner strength, and health. . . ." (p. 74).

That same year, Nagai-Jacobson and Burkhardt (1989) wrote that spirituality "is a broader

concept than religion, involves a personal quest for meaning and purpose in life, relates to the inner essence of a person, is a sense of harmonious interconnectedness with self, others, nature, and an Ultimate Other, and is the integrating factor of the human person" (p. 19). Their article emphasized that the nurse needs to develop an awareness of what is sacred to the patient. This can be accomplished by the nurse listening and reflecting on what the patient is able to share. Examples include: What brings joy? What is sacred? What are the patient's fears?

Although a strong sense of God remained in the literature of spirituality in the 1980s, more authors emerged whose focus was clearly on spirituality, not religion. For example, Lane (1987) focused on spirituality as it applied to the individual, not to God. She purports that the "human spirit" makes us different from all other creatures in the world. This spirit expresses itself in four ways: "...transcending or going beyond the here and now...connecting or belonging... giving life, ... [and] being free" (p. 333).

In order to provide spiritual care effectively, Lane believed that the nurse must first engage in "inward turning or reflection" (p. 335). As the nurse's spirit grows and is healed, it would be better able to reach out to others and would allow the nurse to engage in active listening. The commonality of the nurse and patient both having suffered pain promotes a sense of connectedness.

Also, Lane called on nurses to develop a sense of "hospitality within the self" (p. 336). Such hospitality may be defined as a genuine warmth and sense of giving which causes the nurse to become vulnerable and open to the patient. The nurse should enable the patient to express the emotions of helplessness, hopelessness, pain, anger, suffering, and joy. He or she should not avoid, but should encourage these emotions to come up and as they do, offer compassion to the patient.

### **Assessment and Definition of Spirituality**

More spiritual assessment tools were developed and put into use throughout the decade (Treloar 1999, Govier, 2000, Maddox 2001). In addition, scores of definitions of spirituality emerged from the literature. Few of them showed commonalities (see Table 1). Emblen (1992)

described the various definitions of spirituality and religion and how they transformed over time in the nursing literature. She writes that in the 1960s, religion was defined as, "...the recognition of man's ultimate dependence upon a superior being." (Hubert 1963, p. 9). By the late 1980s it was defined as an "...organized body of thought and experience concerning the fundamental problems of existence. . . an organized system of faith" (Dombeck & Karl 1987, p. 183).

Similarly, Emblen also showed that the definition of spirituality evolved over the years. In the early 1970s she wrote that spirituality was defined as ". . . the quality of those forces which activate us, or. . . the essential principle influencing us. Spiritual. . . does not necessarily mean religious; it also includes the psychological. The spiritual is opposed to the biological and mechanical, whose laws it may modify." (Vaillot 1970, p. 30).

By 1988, the definition of spirituality had been expanded and transformed to "... an aspect of the total person that influences as well as acts in conjunction with other aspects of the person...is related to and integrated with the functioning and expression of all other aspects of the person; has a relational nature which is expressed through interpersonal relationships between persons and through a transcendent relationship with another realm; involves relationships and produces behaviors and feelings which demonstrate the existence of love, faith, hope and trust, therein providing meaning to life and a reason for being" (Labun 1988, pp. 314-315).

Reed (1992) addressed the paradigm shift in spirituality and its evolution into a broader view of the wholeness of the person and his or her connections to others. She believed that although there were assessment instruments on spirituality such as Paloutzian and Ellison's Spiritual Well-Being Scale, spirituality was still hard to quantify. As Reed stated, "...spirituality is a broad concept useful for conceptualizing the person as having the capacity for health through transcendence of ordinary boundaries in a variety of understandable ways. A key point is that spirituality per se is not measurable any more than would be such concepts as *physicality, emotionality, or wholeness*" (p. 351).

Reed's focus on the spiritual importance of a connection to others was echoed when Burkhardt (1993) investigated how rural Appalachian women felt about spirituality in their lives. Results showed that it was relationship—relationship with others, self, environment, and God or a Higher Power—that emerged as the common and most important theme of the study. The author stated that for these women it is through “the context of these relationships [that] one finds meaning and purpose in life and the strength for living” (p. 16).

Walton (1996) turned not only to the nursing literature, but to leading psychologists—Elkins, Hundleman, and Erickson—to understand and explain spirituality. Walton borrowed from these psychologists when she wrote, “religion may or may not play a role in individual spirituality and is quite distinctive from spirituality” (p. 238). In her conclusion, Walton purported that all relationships have the potential to be spiritual and, like Lane, called on holistic nurses to develop their own personal and professional spiritual relationships on and off the wards.

**Table 1: Common Definitions of Spirituality from the Nursing Literature**

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Spirituality is . . .

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“the quality of those forces which activate us, or are the essential principles influencing us. Spiritual . . . does not necessarily mean religious; it also includes the psychological. The spiritual is opposed to the biological and mechanical, whose laws it may modify” (Vaillot 1970, p. 30).

“a quality of having a dynamic and personal relationship with God” (Ellis 1980, p. 42).

“is that which inspires in one the desire to transcend the realm of the material” (O'Brien 1982, p. 88).

“defined in terms of personal views and behaviors that express a sense of relatedness to a transcendent dimension or to something greater than the self” (Reed 1987, p. 336).

“of the essence of one's human nature, whether or not it is expressed through religious beliefs or practices” (Burkhardt 1989, p. 71).

“expressed and experienced in the context of caring connections with oneself, others, nature, and God/life force” (Burkhardt & Nagai-Jacobson 1994, p. 10).

“an approach to life, which is made manifest in ordinary, or in extraordinary, circumstances it is a pervasive force operating through commonplace, or quotidian, events” (Goddard 1995, p. 809).

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### **Spirituality in the New Millennium**

In the first decade of the new century, the quantity of literature on spirituality continued to grow. Articles expanded into enormous subsets of their own including: spiritual distress, spiritual meaning, spiritual coping and spiritual care (Humphreys 2000, Tongprateep 2000, Walton 2002, Narayanasamy 2002). All authors concluded that spiritual care is an essential component of the well-being of the patient.

An assortment of tools for assessing and measuring spirituality continued to be used and new ones developed (Ai et al. 2005, Hermann 2006, Mackenzie et al. 2006, Piedmont 2007.) Some tools focused on spiritual needs (Hermann 2006, Cole et al. 2008).

Meraviglia (2006) focused on spiritual meaning and used the Life Attitude Profile-Revised (LAP-R), the Adapted Prayer Scale (APS), and the Symptom Distress Scale (SDS) to assess certain

responses to breast cancer. Still other researchers focused on stress reduction (Kreitzer et al. 2009). While all the researchers used or developed different tools, they all had one belief in common: that the spirituality of the patient could be evaluated and to some degree measured.

The spiritual well-being of patients with many different diseases and treatments continues to be a thrust of the nursing literature. These include: cardiac disease, HIV, and cancer (Highfield 2000, Koenig 2002, Råholm 2002, Walton 2002, Walton & Sullivan 2004, Arnold et al. 2006, Tuck & Thinganjana 2007). In addition, newer groups such as caregivers and geriatric patients were more prominent (Koenig, Thomas & Cohen, 2006).

Other 21<sup>st</sup> century researchers turned to the use of formal surveys such as the Medical Outcomes Study's Short-Form Health Survey, the Index of Well-Being Measures of Quality of Life, the Spiritual Well-Being Scale, and the Relative Importance Scale—all in an attempt to determine the spiritual needs and well-being status of patients (Beery et al. 2002) (See Table 2).

### **Spiritual Care**

Although spirituality is now accepted as a standard concept in nursing care, there is still concern that nurses have yet to engage their patients spiritually. For example, Praill (1995) argued that “spiritual care has as much to do with the state of being of the carers as of the patient. If this is so, then spiritual care has to begin with the conscious effort of carers to cultivate their own spiritual journey, to struggle with their own eventual death and to learn how to tell their own story” (p. 56)

Praill echoed Peterson (1985) who ten years earlier tried to explain why nurses avoided discussing spiritual issues with their patients. “Another reason for avoidance of the spiritual concerns of clients is that it often poses very difficult questions for us to deal with. We are forced to grapple with questions about our own

source of meaning and purpose in life, of love and readiness, and for forgiveness. To the degree that those are unanswered questions in our own lives, we may find it is extremely difficult to support someone else while they attempt to find answers. Consequently, we avoid spiritual issues” (p. 26).

McSherry (2006) also believed spiritual care was not working. As a result, he formulated a model to investigate the restraints in the advancement of spiritual care in nursing and the health care system. McSherry's model provided an avenue in which nurses and other health care professionals could attempt to overcome some of the obstacles involved in dealing with spiritual dimension in patients.

### **Conclusion**

In conclusion, spirituality in the nursing literature has evolved considerably over the past five decades. In the beginning, the nurse was expected to intervene religiously with the Roman Catholic patient. During the 1980s and early 1990s a paradigm shift took place in nursing in which the focus was no longer on the patient's religiosity, but on spirituality. This might or might not have included a reference to or belief in God. As spirituality grew in the literature, it shifted into a variety of foci that included spiritual meaning, spiritual care, spiritual distress, and spiritual coping and spurred the development and use of psychosomatic and assessment tools.

Although the nursing profession has made great strides in expanding its understanding of spirituality as it relates to healing and patient well-being, nurses have not come to a full agreement on the definition of spirituality as it would apply to nursing. It is the author's belief that it is unrealistic to have a universal definition of spirituality because it is personal for that individual. However, the nursing profession can continue to expand by increasing qualitative studies in this area to discover more knowledge of spirituality from the patient's perspective.

**Table 2: Typical Assessment Tools Developed to Measure Spiritual Well-Being**

Assessment Tool	Author	Description
Patient Spiritual Coping Interview	McCorkle & Benoliel 1981	Composed of 30 questions-open-ended to reveal the spiritual essence of spiritual coping strategies related to a higher power or God
Spiritual Well-Being Scale	Paloutzian & Ellison 1982	Self-administered scale comprised of 20 items designed to analyze spiritual well-being as it relates to the religious (RWB) and existential (EWB) senses
Hess' Spiritual Needs Survey	Hess 1983	Patient survey comprised of four questions to identify a spiritual need, the capability to explain it; identifying the other person for the discussion; and whether or not the need was accomplished or not accomplished.
Moberg's Indexes of Spiritual Well-Being Scale	Moberg 1984	This seven-index scale investigates Christian beliefs, contentment with self, and holiness;
Spiritual Perspective Scale (SPS)	Reed 1986	Scale of 10 items analyzes the individual's thoughts on how spirituality affects their lives and the scope of interactions spiritually based.
Support Team Assessment Schedule (STAS)	Higginson 1992	Questionnaire consists of 17 items for patients and personnel which attests to palliative care outcomes in regards to physically, emotionally, socially, and spiritually aspects.
HOPE Questions	Anandarajah & Hight 2001	The HOPE questions measure: H“pertains to a patient's basic spiritual sources...O“...areas of inquiry about the importance of religion...Ppersonal spirituality and practices...” Epertains to the effects of a patient's spirituality and beliefs on medical care and end-of-life issues” (p. 86).
Spirituality Index of Well-Being	Daaleman & Frey 2004	This 12-item self-administered scale is “designed to measure the effect of spirituality on subjective well-being” (p. 499).

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