Assessing a Patient's Spiritual Needs

A Comprehensive Instrument

■ *Kathleen Galek, PhD* ■ *Kevin J. Flannelly, PhD* ■ *Adam Vane, MA* ■ *Rose M. Galek, MS, RN*

Seven major constructs—belonging, meaning, hope, the sacred, morality, beauty, and acceptance of dying—were revealed in an analysis of the literature pertaining to patient spiritual needs. The authors embedded these constructs within a 29-item survey designed to be inclusive of traditional religion, as well as non–institutional-based spirituality. This article describes the development of a multidimensional instrument designed to assess a patient's spiritual needs. This framework for understanding a patient's spiritual needs hopefully contributes to the growing body of literature, providing direction to healthcare professionals interested in a more holistic approach to patient well-being. **KEY WORDS:** *hospitalization*, *palliative care*, *patient care*, *spiritual assessment*, *spiritual needs*

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Although empirical research is just beginning to unveil the causal links among spirituality, religion, and health,[1,2] the importance of religion and spirituality in coping with loss, stress, and illness has long been recognized.[3–5] Many, such as Puchalski and Romer, have long believed that "patients learn to cope with and understand their suffering through their spiritual beliefs, or the spiritual dimension of their lives."[6(p129)] The intention of this study was to develop a comprehensive quantitative measure, inclusive of both traditional religion and noninstitutionally based spirituality, for evaluating the spiritual needs of hospitalized patients. The measure was designed in order to be brief enough to include in clinical or epidemiologic surveys, allowing for an extensive investigation of various indices.

Recognition of a patient's spiritual needs is now being formally expressed through the Joint Commission on Accreditation for Health Care Organizations (JCAHO) and the Commission on Accreditation of Rehabilitation Facilities (CARF) mandates to conduct spiritual assessment and make arrangements for meeting a patient's spiritual needs.[7,8] This is particularly important in hospice and palliative care settings, where the focus is on quality of life; controlling pain; and meeting a person's social, emotional, and spiritual needs.[9]

Handzo and Koenig[10] stated,

> there is little disagreement any more in the healthcare community about *whether* spiritual care should be part of the treatment process. In many forums, the question has shifted to *how* spiritual care is to be provided and, more specifically, *who* should provide it.

Although recognizing the importance of this line of inquiry, the authors of this study believe that the fundamental preceding question should be "*what* really are a patient's spiritual needs." Only through acquiring a better understanding of patients' spiritual needs will professionals be able to develop tailored and effective spiritual interventions.

Many theorists and researchers[11–14] have written about the inherent difficulties in attempting to encapsulate something as intangible and mystical as spirituality. For example, Moya and Brykczynska[15] write, "the human spirit is not easy to define and, perhaps, there is an argument that . . . the human spirit is indescribable." The question, therefore, becomes how to understand and investigate a phenomenon that is both transcendent and beyond the sphere of the finite mind.

From The HealthCare Chaplaincy, New York (Drs Galek and Flannelly); Paragon Global Consulting (Mr Vane); and the Community College of Rhode Island, Warwick (Ms Galek).

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Corresponding author: Kathleen Galek, PhD, The HealthCare Chaplaincy, 307 E 60th St, New York, NY 10022 (e-mail: kgalek@healthcarechaplaincy.org).

SPIRITUAL TYPOLOGIES

To discern essential aspects of patient spiritual needs, the authors reviewed several articles delineating typologies related to spirituality. The need to commune with something beyond the self or to connect with something transcendent or nonmaterial in nature is central to the spiritual domains presented in these articles. Leder,[16] for example, demarcated 3 distinct domains of spirituality: (1) the capacity to commune with the sacred; (2) the capacity to become absorbed by the aesthetic wonder of life; and (3) the capacity to give and receive compassion.

Additionally, Leder[16] observed that "to become aware of and to deepen" interconnections between oneself, others, and the divine is to "realize ontological relatedness." Ontology, the branch of metaphysics that deals with the nature of being and existence, examines the nature of spirituality and the sense of joining with the universe. A central theme of eastern ontology is that all phenomena are unique and yet interdependently related. This is the great mystery that keeps humankind in flux between a desire for separateness and a yearning for intimacy. Trying to meet our needs, we engender a sense of separateness and suffering in our attempts to control people and events. Consequently, interventions aimed at meeting the spiritual needs of patients can be more effective when we as caregivers recognize, acknowledge, and let go of our needs for control and allow for our innate knowledge and compassion to emerge.

Peterson and Seligman[17] delineated a series of character strengths associated with the capacity to forge a connection with the transcendent. They suggested that individuals who notice and appreciate beauty and excellence in the various domains of life possess the character strength of awe that connects them to something larger than themselves "whether it is beautiful art or music or the majesty of nature." William James (1902–1999) described the appreciation of beauty as a mystical experience. In addition, the appreciation and cultivation of humor is a character strength related to experiencing the transcendent. *Humor* is defined as the capacity to laugh; the skill of bringing smiles to the faces of others; the ability to see the lighter side of serious subjects; and the talent for making, but not necessarily telling, jokes.

Nursing was one of the first healthcare professions to address the spiritual needs of patients and to recognize spiritual distress as a diagnosis,[18–20] and the current nursing literature has some respectable scholars on spirituality. For example, through qualitative interviews with cancer patients, Taylor identified 7 spiritual need categories: (1) the need to relate to an Ultimate Other; (2) the need for positivity, hope, and gratitude; (3) the need to give and receive love; (4) the need to review beliefs; (5) the need to have meaning; (6) the need for religiosity; and (7) the need to prepare for death.[21] Taylor found that family caregivers also experienced significant spiritual needs similar to the needs of those in their care. Patients typically turn to family members for support before turning to healthcare professionals. To ensure total holistic care, it is important for nurses to attend to the spiritual needs of family caregivers in addition to the needs of their patients.

Emblen and Halstead[22] compared the narrative responses of nurses, chaplains, and patients regarding the nature of spiritual needs. The 6 category typology that emerged from their phenomenological analysis included (1) religious aspects, such as prayer and transcendence; (2) referring to experiences that are beyond earthly existence; (3) affective feeling, including peace, comfort, and happiness; (4) values, such as health, faith, and hope; (5) communication, including talking, listening, and touching; and (6) an "other" category, referring to such items as questions with death and voids. Emblen and Halstead[22] concluded that the provision of compassionate spiritual care can "create optimal potential for healing in biological, psychological, and social dimensions."

SPIRITUALITY IN RELATION TO TRADITIONAL RELIGION

A number of writers have explored spirituality within the Judeo-Christian traditions. Although the term *spirituality* does not occur in Hebrew or Christian scriptures, there are various approaches to understanding the concept. While some authors such as Jones[23] believe that contemporary spirituality "avoids the disciplined practices necessary for engagement with God," many others align with Apostle Paul, who affirmed notions of the transcendent being present in all people (Romans 1:18–21). For example, Bash,[24] in his exploration of spirituality within the Judeo-Christian tradition, writes, "spiritual experience is what each person says it is, and the task of nurses is to identify and respect

that person's expression of their spiritual experience and to offer them support."

Western ontology, drawing more on a Cartesian understanding of mind-body dualism, is based on a long philosophic and theologic tradition in which spiritual experience is thought to be divorced from the bodily sphere. In interviews, Fagerström et al[25] found that certain patient spiritual needs were expressed through caring for their bodily needs. One patient, for example, commented that having one's hygiene needs met allows a sense of cleanliness "which can be experienced as confirmation of their human dignity."

Pargament and colleagues[26] present an interesting model of spiritual struggle that embraces Judeo-Christian themes as well as those from other religious traditions, such as Buddhism. The authors highlight the many obstacles faced on the spiritual journey, which they classify into 3 dimensions. (1) *interpersonal struggle*, as reflected in mythic stories such as Moses' struggle for freedom against a powerful authority (the Pharaoh), (2) *intrapsychic struggle*, as illustrated by Siddhartha Gautama's struggle with his own inner demons before becoming the enlightened Buddha, and (3) *struggle with the divine*, as reflected in Christians who seek to embody the Holy Spirit in their daily actions.

Florence Nightingale, the founder of modern nursing, considered spirituality to be an intrinsic part of human experience and treasured the spiritual teachings of eastern texts, such as the Bhagavad Gita.[12] Because we did not find contemporary pieces that explored a patient's spiritual needs from an eastern perspective, we searched contemporary Buddhist writings for a comprehensive model of spirituality. Our adapted model, *The Eight Gates of Zen*,[27] provides a comprehensive system for actualizing spirituality as a modern, practical expression of Buddha's Eightfold Path. Entering and dwelling within the gates or paths expressed within the model makes possible a life of clarity and compassion.

The first path is *zazen*, which involves seated meditation as a means for inquiring deeper into the nature of the self. Zazen allows for a quiet space to meditate, helps maintain a positive outlook, and engenders a feeling of peace and contentment. Long periods of meditative practice can result in a sense of gratitude for all things, even those things that appear negative. The second path requires *study with a teacher* to help navigate the difficulties of daily life. In Zen practice, this usually includes face-to-face encounters with a sensei, or teacher, to examine and resolve deep questions that arise from meditation and daily practice; certain patients may seek similar spiritual guidance when speaking with a chaplain.

To better understand historical, philosophic, and psychologic foundations of Buddhist tradition, the path of *academic study* requires time spent engaging Buddhist texts and commentaries. The Zen practice of *liturgy* is thought to "make visible the invisible, bringing into awareness the shared experience of a group."[28] Engaging in liturgy also addresses spiritual needs through awakening compassion for, and a sense of intimacy with, one's self and all living things. The Zen path of *right action* involves studying and practicing Buddhist moral and ethical teachings as a means for living more harmoniously in a world of perceived differences. The Zen path of *art practice* explores the link between creativity and spirituality, with the recognition that both arise from the same source.

The path of *body practice* is based on the idea that mind and body are intimately connected, each filling and penetrating the other. A body practice, such as Yoga, Pilates, Tai Chi, or even aerobic exercise, can reduce stress, help maintain a positive outlook, and provide respectful care for our own bodily needs. On a personal level, body practice can be viewed as a gift from the mind to the body; a form of self-compassion and a means to feeling more deeply connected with the world. Finally, *work practice* path involves merging sacred activity with the mundane acts of daily living. All Zen paths are interrelated; together, they provide a more balanced, spiritual life.

METHODS

Electronic database searches were conducted on PsycINFO (American Psychological Association) and MEDLINE (National Library of Medicine), using the search term *spiritual needs*. Because a preliminary MEDLINE search (range, 1965–2004) indicated that 88% of spiritual needs articles were published after 1990, this study used searches conducted from 1990 to 2004, inclusively. Article titles and abstracts were reviewed to evaluate their relevance, and articles that appeared relevant were retrieved from libraries and electronic sources. The sample articles included were restricted to research and theoretic articles in English-language journals that examine patient spiritual needs. The sample was further restricted to those studies in which religion/spirituality was the

major focus of the research. Literature reviews were excluded from the sample.

Content analysis was conducted on each article to discern the overarching constructs pertinent to patient spiritual needs.[29] In the first step of thematic analysis, we identified (in tables, figures, and text of the selected articles) words and phrases that described spiritual needs, which were then entered into a spreadsheet. The constant comparison method[30] reduced the number of descriptive phrases to their basic elements, rewording the phrases as necessary to eliminate trivial differences between descriptors. To facilitate this process, the spreadsheet was periodically sorted. Then, 2 study authors independently classified the descriptors into higher order categories.

After the categories were established, 2 study authors independently selected the descriptors that they thought best reflected the essential aspects of each category or construct. The kappa coefficient was calculated to assess agreement between the authors regarding selection of descriptors representing the constructs.[31] Kappa values (0.84–0.86) indicated that the observed agreement between the 2 judges selecting the descriptors ranged from 84% to 86% for each construct. The final selection of the spiritual needs scale descriptors was achieved by consensus among the 4 study authors.

RESULTS

Article evaluation, by electronic search, yielded 22 relevant empiric and theoretic articles that enumerated the specific needs of hospitalized patients, including 12 qualitative studies, 7 quantitative studies, and 3 theoretic articles. More than 75% (17 of 22) were published in nursing journals, with the remainder published in medical journals. Seven articles were published in nursing specialty journals, with categories that included cancer,[21,32,33] critical care,[34] operating room,[35] orthopedic,[14] and psychiatric nursing.[36] The largest number of articles in our sample came from the *Journal of Advanced Nursing*,[13,37–39] followed by the *Journal of Clinical Nursing*.[40,41] The remainder appeared in the *British Journal of Nursing Practice*,[4] *Clinical Nurse Specialist*,[22] the *Journal of Holistic Nursing*,[5] and the *International Journal of Nursing Practice*.[25]

The studies delineated an extensive list of needs, classified into 3 to 8 dimensions or constructs. The most common construct was *love and belonging*, followed by *religious needs*. In all, the 22 articles contained a total of 339 descriptors of patients' spiritual needs. The analysis of these 339 descriptors yielded 9 broad categories (Table 1) that were independently derived by content analysis regardless of how they had been categorized in the original studies. The "control" and "other" categories shown in Table 1 were subsequently eliminated because they did not capture a spiritual dimension. The 7 remaining constructs each contained between 2 and 5 items (Table 2). The final version of the scale is presented in Table 3.

DISCUSSION

Our thematic analysis of the empirical and theoretical literature revealed 339 initial items reflecting patient concerns relating to spirituality. From these initial items, we designed a 29-item quantitative survey with 7 representative constructs: Love/belonging/respect; Divine; Positivity/gratitude/hope/peace; Meaning and purpose; Morality and ethics; Appreciation of beauty; and Resolution/death.

TABLE 1. Construct definitions for spiritual need survey

Construct	Description
Love/belonging/respect	Feeling unconditionally accepted; connecting to self and others; giving and receiving respect and love
Divine	Prayer; religious rituals; being part of a community; connecting with the divine
Positivity/gratitude/hope/peace	Peace; calm; sensing enjoyment in life; having hope; expressing humor and laughter
Meaning and purpose	Finding one's reason for living; finding meaning in one's personal history
Morality and ethics	Needing to live an ethical and responsible life
Appreciation of beauty	Connecting with beauty, nature, art, music, and the creative process
Resolution/death	Addressing concerns about life after death; gaining a deeper understanding of death and dying; coming to resolution about letting go; putting closure on life; offering forgiveness
Control	Having the right to make decisions about one's own life; staying as independent as possible; desiring things to stay the same
Other	Needing comfort; needing to cope with physical pain

TABLE 2. Constructs and their corresponding items

Construct	Item
Love/belonging/respect	To be accepted as a person
	To give/receive love
	To feel a sense of connection with the world
	For companionship
	For compassion and kindness
	For respectful care of your bodily needs
Divine	To participate in religious or spiritual services
	To have someone pray with or for you
	To perform religious or spiritual rituals
	To read spiritual or religious material
	For guidance from a higher power
Positivity/gratitude/hope/peace	To feel hopeful
	To feel a sense of peace and contentment
	To keep a positive outlook
	To have a quiet space to meditate or reflect
	To be thankful or grateful
	To experience laughter and a sense of humor
Meaning and purpose	To find meaning in suffering
	To find meaning and purpose in life
	To understand why you have a medical problem
Morality and ethics	To live an ethical and moral life
Appreciation of beauty	To experience or appreciate beauty
	To experience or appreciate music
	To experience or appreciate nature
Resolution/death	To address unmet issues before death
	To address concerns about life after death
	To have a deeper understanding of death and dying
	To forgive yourself and others
	To review your life

Love/belonging/respect

Love, belonging, and respect comprised the largest category identified in the literature. Many patients, for example, expressed the following needs: not to be abandoned by their pastor, rabbi, or spiritual advisor[36]; to give and receive love[39]; and to experience the committed presence of others.[5,13,34,37,42] Sherwood[5] writes that through the "harmony of human-to-human connection [patients] can be healed." Our survey quantifies these numinous experiences through assessing a patient's need (1) to be accepted as a person; (2) for compassion and kindness; and (3) to feel a sense of connection to the world (4) for companionship and (5) for respectful care of bodily functions.

The divine

The second largest category involved expression of spirituality through traditional religious rites and practices, which our survey called "the Divine." Many spiritual practices, rituals, or services are designed to facilitate interconnection with the divine or sacred. Through these experiences of communion, one often realizes a relationship with the transcendent, whether called God, Mohammed, Krishna, Suchness, Tao, or any of an infinite list of names. The practices leading to this experience can be diverse, such as having someone pray with or for you, performing rituals, attending services, or reading spiritual or religious material.

Positivity/gratitude/hope/peace

Another theme that emerged from the literature was the power of hope and gratitude to nourish patients and replenish their spirit. Although hope was conceptualized in various ways, many authors emphasized the capacity of hope to connect with the possibilities and realities beyond the self.[3] Ross found a relationship between hope and the will to live.[39] Items in our survey reflecting this domain include the need to feel hopeful, to feel a sense of peace and contentment, to keep a positive outlook, to have a quiet space to meditate or reflect, to be thankful or grateful, and to experience a sense of laughter and humor.

Meaning and purpose

The need to find meaning and purpose is also a salient dimension throughout the literature; several authors emphasized that physical illness often acts as a trigger, leading one on an inward journey to consider questions of life and death,[14,40] as well as to reorder priorities related to physical, psychologic, social, and spiritual realms.[43] Narayanasamy[4] points out that illness can also challenge one's existing personal meaning system, intensifying the need to make sense of human existence; by seeing meaning in existence, one can find peace no matter how severe the illness is.[44] Our survey captures this area through identifying the need to find meaning in suffering, the need to find

TABLE 3. Spiritual needs survey

At any time while you were in the hospital did you have a need:	Yes	No	How important was it to you? Slightly	Moderately	Very	Extremely
1. To review your life?	☐	☐	☐	☐	☐	☐
2. To be accepted as a person?	☐	☐	☐	☐	☐	☐
3. To participate in religious or spiritual services?	☐	☐	☐	☐	☐	☐
4. To feel hopeful?	☐	☐	☐	☐	☐	☐
5. To find meaning in the suffering?	☐	☐	☐	☐	☐	☐
6. To feel a sense of connection with the world?	☐	☐	☐	☐	☐	☐
7. To be thankful or grateful?	☐	☐	☐	☐	☐	☐
8. To address unmet issues before death?	☐	☐	☐	☐	☐	☐
9. For companionship?	☐	☐	☐	☐	☐	☐
10. To have someone pray with or for you?	☐	☐	☐	☐	☐	☐
11. For peace and contentment?	☐	☐	☐	☐	☐	☐
12. To experience or appreciate beauty?	☐	☐	☐	☐	☐	☐
13. To find meaning and purpose in life?	☐	☐	☐	☐	☐	☐
14. For guidance from a power outside yourself?	☐	☐	☐	☐	☐	☐
15. To live a moral and ethical life?	☐	☐	☐	☐	☐	☐
16. To experience or appreciate music?	☐	☐	☐	☐	☐	☐
17. To address concerns about life after death?	☐	☐	☐	☐	☐	☐
18. To give or receive love?	☐	☐	☐	☐	☐	☐
19. To perform religious or spiritual rituals?	☐	☐	☐	☐	☐	☐
20. To keep a positive outlook?	☐	☐	☐	☐	☐	☐
21. To read spiritual or religious material?	☐	☐	☐	☐	☐	☐
22. To talk with someone about death and dying?	☐	☐	☐	☐	☐	☐
23. For compassion and kindness?	☐	☐	☐	☐	☐	☐
24. To have a quiet space to meditate or reflect?	☐	☐	☐	☐	☐	☐
25. For respectful care to your bodily needs?	☐	☐	☐	☐	☐	☐
26. To experience or appreciate nature?	☐	☐	☐	☐	☐	☐
27. To forgive yourself and others?	☐	☐	☐	☐	☐	☐
28. To understand why this medical problem occurred?	☐	☐	☐	☐	☐	☐
29. To experience a sense of laughter and humor?	☐	☐	☐	☐	☐	☐

meaning and purpose in life, and the need to understand why this medical problem occurred.

Morality and ethics

Morality and ethics are commonly found in the research on patient spiritual needs. In the face of everyday challenges and struggles, one often needs guidance and support in maintaining a commitment to principles that create the foundation of a spiritual life. Kellehear[9] states that, at times, pastoral care workers and other healthcare professionals can be "assistant ethicists," helping patients fulfill their moral responsibilities. We include this realm in our survey through assessing a patient's need to live an ethical and moral life.

Appreciation of beauty

Spirituality can also be cultivated through an aesthetic sensitivity to the beauty around us; for example, Stoll writes that spirituality can be expressed through an appreciation of "God, other people, a sunset, a symphony, and spring."[45] Hermann's qualitative research provides many examples of individuals who report feeling closer to God in nature than in any other place; in their view, nature represents the spirit of God.[32] The dimension of beauty, music, and nature appreciation was incorporated into our survey.

Resolution/death

Several writers explored how a comfortable sense of invulnerability and immortality can be shattered when physical illness is diagnosed, creating new awareness of life's finality.[4] Many patients need to verbalize their thoughts about dying and death[22,41] and to review their lives.[21] This field of inquiry was included in our study through questions assessing the need to address unmet issues before death, to address concerns about life after death, and to have a deeper understanding of death and dying. We included the need to forgive not only yourself but also others. Exploring the need for

reconciliation, Kellehear writes, "the need to put things right and to forgive and be forgiven is about the need for closure and transcendence."[9]

CONCLUSION

Our analysis of the relevant literature provides a working framework for the exploration of a patient's spiritual needs. The final measure, designed for religiously heterogeneous populations, was created to be inclusive of both traditional religion and noninstitutionally based spirituality. Within this overall framework, the emerging themes of belonging, meaning, hope, the sacred, morality, beauty, resolution, and a deeper acceptance of dying provide direction for healthcare professionals interested in a more holistic approach to patient well-being.

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