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A Literature Review: Current Trends in Spirituality in Holistic Nursing

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Abstract

There is scarcity of documentation that seeks to define spirituality relating to holistic nursing; consequently, a literature review was formulated to define spirituality and guide nursing practice towards recognizing the importance of and implementation of spiritual care. By researching the current trends in peer-reviewed journals from the past three years and analyzing associated articles, this paper addresses the need for a comprehensive definition of spirituality. Key concepts such as belief, values, interconnectedness with self, others and God, energy, hope and transcendence will be analyzed, and the accumulated data will be compiled into a framework that is easy for a nurse to understand and use. This thesis strives to validate the necessity of spiritual care through the mechanism of holistic nursing and equip nurses to assess and implement care for the ever-present spiritual needs of one's patients.

A Literature Review: Current Trends in Spirituality in Holistic Nursing

Literature Review

Current Increased Interest in Spirituality

An elevated interest of spirituality within the general public has catalyzed the publication of related literature. According to Muller et al. (2001; as cited in Miner-Williams 2006), surveys indicate that more than 90% of people believe in a higher being. In the research that Miner-Williams conducted, a study by King and Bushwick (1994) surveyed 203 patients, and among these patients 77% wanted their physicians to consider their spiritual needs, and 94% of patients thought that spiritual and physical health were equally important (2006). In times of great hardship, such as that of an illness or difficult life circumstances, patients have an innate tendency to reevaluate what in their life brings purpose and provokes a sense of importance, and often spiritual avenues provide a network of resources that produce resilience (Baldacchino, 2006). As a majority of the patient population is desiring and needing proper spiritual care, nurses need to understand the nature of, evaluate and provide spiritual care. However, the difficulty, as examined by Narayanasamy and Owens, lies the fact that nurses today are uninformed due to the vague nature of spirituality and lack of sufficient education and guidance in giving spiritual care (Grant, 2004). Thus as one ventures to understand how to provide this essential aspect of care—spiritual care, understanding the essence of spirituality is vital.

The spirit of a person can be their stamp of vitality—their life source. Although a concept like spirituality usually is understood in general conversation, to actually define the “spirit” or “spirituality” indeed requires contemplation and precise articulation, and to

some, the concept of “spirituality” is beyond words—ineffable. As the nature of spirituality is difficult to articulate, likewise, research on the subject is equally difficult to perform and interpret. Many researchers have sought to form a comprehensive definition, appropriate frameworks, and practical knowledge that seek to understand and to gain knowledge of the spirit. Despite the vagueness of the concept, holistic nursing has acknowledged its importance and has incorporated it as an essential component in its theory. As there is a lack of research on the subject of “spirituality” in the framework of holistic nursing, a literature review was performed to define spirituality (by elucidating common themes), present available theories, and to provide a practical guide for assessment, planning, intervention, and evaluation. This literature review has been compiled in hopes of enabling nurses to provide appropriate spiritual care in a manner that is effective, needed, and meaningful to patients to promote therapeutic healing.

Definitions of Holistic Nursing

The word *nurse* is derived from the Latin words *nutrire* which means “to nourish.” Holistic nursing embraces any practice that is purposed to heal the entirety of a person, and the schema of holistic nursing draws on nursing knowledge, theories, evidence-based practice, the expertise of seasoned nurses, and intuition. In this literature review, the focus centers on the concept of spirituality and this term’s implications in the life and the care of a nurse. The idea of holism is derived from the basic concept that the sum of the parts is greater than its entities. In the handbook, Holistic Nursing, by Dossey (1995) et al., holism is defined as all the intricate, integrated parts that fashion the whole person (i.e. physical, emotion, social, spiritual aspects). When these components

combine, they together have a synergy that is far superior to that of the individual parts. To better understand the concept of holistic nursing, different paradigms have been composed by a variety of theorists. While paradigms of holism have been reviewed for a basic comprehension of holism, the most applicable paradigm for all intensive purposes is the bio-psycho-social-spiritual model. In this model, all these components: biological, psychological, social, and spiritual are incorporated to understand a patient's symptoms and disease pathway that influence the variety of manifestations that occur in each patient. All four concepts are unique, yet interconnected, and all, regardless of the etiology of the disease, need to be involved for optimal healing (Dossey et al., 1995). As holistic nursing acknowledges the connectedness of mind, body, and spirit, modern-day holistic healthcare should be compelled to pay attention to the concerns and deficits of the spirit as well as to the medical needs of the mind and body (Clark et al., 2004). In fact, the human spirit can cross the chasm between death and life and conquer the barrier that separates sickness and health. The spirit can conquer the devastation of great injustices and can deliver hope as a towering source of strength. As the importance of spirituality has been established in the context of holistic nursing, one can recognize the importance of its role in therapeutic healing. Therefore, to understand the subject on a greater level, one needs to understand the prevalent themes in literature. As we begin to discuss spirituality and its implications in holistic nursing care, one must first distinguish the difference between the spiritual and the religious.

Difference between Spirituality and Religion

As Johnson (2004) states, “Although they are related, spirituality is different from religion. While religion is formal, communal, more visible, and often communicated through a process of socialization, spirituality is individual, subjective, less visible, and informal” (p. 79). Spirituality and religion are separate concepts; yet often, the terms are used synonymously. Religion can act as a mechanism that allows for the nurturing and fostering of one’s spirit. As Miner-Williams (2006) states, “the two constructs overlap for those people for whom religion is the means of expressing their spirituality” (p. 814). In contrast, a person can be religious yet lack spirituality. For example, religious persons could follow certain rituals and attend ceremonies yet could potentially neglect to connect with their spirit. In contrast, a person could be spiritual yet lack a religious affiliation. For instance, although an atheist professes that no deity exists, one continues to interact with the universal phenomenon of spirituality. Their personage still possesses a potential for interaction with their integrative energy although this manifestation does not involve religion (Miner-Williams, 2006).

Method

Procedure

Initially, research was performed to analyze the existing knowledge base regarding spirituality. Galek et al. (2005) performed a preliminary MEDLINE (National Library of Medicine) search to determine the time range in which published articles in relation to spirituality were prevalent. According to Galek’s (2005) statistical analysis, 88% of the articles were published after 1990. Since a majority of studies were published

after 1990, this study focused on more current literature and used searches from 2004-2008. Electronic databases CINAHL, OVID, and MEDLINE, were used to conduct research using the search terms of *spirituality, spirituality in holistic nursing, spiritual needs, spiritual assessment, spiritual interventions, and spiritual care*. With the consequent search results, article titles and abstracts were reviewed in relation to their relevance, and relevant articles were subsequently retrieved. The sample size consisted of 28 articles. The sample was limited to researched-based, peer-reviewed journal articles written in the English language. In addition, the articles that focused on a specific religion were excluded.

A content analysis was performed for each article. Initially, each article was read to receive a comprehensive understanding of the collective body of research. The purpose of the first reading was to gain an understanding of prevalent themes in research such as common definitions and concepts in regards to spirituality and spiritual assessment, intervention, and evaluation. The second reading added to the depth of the concept analysis by asking five key questions: what are the existing theories, what are the characteristics of the key concepts, what are the relationships between these key concepts, are there any short comings or inconsistencies in knowledge, and what evidence is lacking? The articles were analyzed, and major elements were recognized.

Results

The collective research body consisted of a sample size of n=28 articles. A majority (n= 17) of the articles were taken from nursing journals, and a majority of these articles were taken from *Holistic Nursing Practice Journal*. On the basis of providing

patients thorough-holistic care, articles were chosen, including 17 qualitative research articles and 7 quantitative research articles. In addition, a number of the articles focused on specific patient aggregate such as hospice patients, cancer patients, MI patients, pediatric patients and psychiatric patients. The study attempted to delineate the wide-ranging scope of the definitions of spirituality in a more concise, practical definition that can be easily internalized and therefore, used in practice. In addition, the study surveyed the common elements of spiritual assessment and intervention to establish effective and pragmatic ways of taking care of spiritual needs.

Discussion

The concept analysis examined each of the 28 articles for the underlying themes in spirituality. From the compilation of data, spirituality is represented by the five concepts of: meaning and purpose, interconnectedness, value and belief systems, energy and transcendence.

Definition of Spirituality

Originally, the word *spiritual* was derived from the late-Latin and middle-English word *spiritus*, which signifies ‘to breathe.’ Therefore, concisely and simply, spirituality is that which breathes life and vitality into a person (van Loon, 2004). Breathing is essential to each human. With each breathe, fresh oxygen flows through the blood and rejuvenates the cells in order that they can function and live. Without oxygen or breathing, cells are no longer able to function and eventually, due to lack of oxygen, die. The function of inspiration and the necessity of oxygen are analogous to the service of the spirit. As we become more connected with our spirit, humans are able to truly

breathe, which brings rejuvenation and life. Just as breathing is essential to sustain life, spirituality is essential for wholeness. Dossey et al. (1995) declares that “ultimately one’s soul is the essence of humanity, a link in humans that breaks through the bondage or our atomical structure, and begins to grasp transcendence, which leads to liberation from enslavement from the mortal and perishing to the eternal” (p. 42).

Furthermore, as defined by the current nursing literature, spirituality is a very personal, individualized concept. However, spirituality is universal. Every ethnic group, nation, and language can identify with their spirit, but their spirit pervades so many areas of life and the environment that each individual uniquely identifies with their own spirit. As Dossey (1995) et al. states, “‘Spirituality’ is a stamp of humanity that differentiates us as a species yet draws and connects our race with a distinct unity. Spirituality is directly related to an inner-knowing and the source of strength that is reflected in one’s being, knowing, and doing” (p. 42).

McSherry and Ross (2002) acknowledge that, “the word [spirituality] is not bound by a common set of defining characteristics” (p. 481). In fact, some (Moya and Brykezynska, 1992; as cited in Galek et al., 2005) deem that making generalizations about spirituality would be utterly impossible--futile. Despite the vacillating essence of spirituality from person to person and the term’s ambiguity, current trends in nursing literature have emerged that attempt to grasp the concept of spirituality. For example, Murray and Zenter (1985; as cited in Fawcett and Noble, 2004) incorporate many themes of spirituality. They express that ‘spirituality’ is:

A quality that goes beyond religious affiliation, that strives for inspirations,

reverence, awe, meaning and purpose, even in those who do not believe in any god. The spiritual dimension tries to be in harmony with the universe, and strives for answers about the infinite, and comes into focus when the person faces emotional stress, physical illness or death. (p. 137)

Spirituality transcends the tangible, yet creates authentic experiences that enrich one's purpose. This meaning can be derived by authentic experiences through intrapersonal (as a connectedness within oneself), interpersonal (in the context of others and the natural environment), and transpersonal relations (referring to a sense of relatedness to the unseen, God, or power greater than the self) (Miner-Williams, 2006). In correlation to the realm of relationships (intrapersonal, interpersonal, and transpersonal), these interactions catalyze and synergize the groundwork for establishing cognition, emotion, and consequent behavior that develop into personhood (O'Hara, 2002). Fawcett and Noble (2004) noted that the essential characteristics of spirituality derive a sense of meaning and purpose in life, trust and faith in someone outside the self, and love and relatedness in oneself, others, and the transpersonal, and also establish hope. Furthermore, Dossey (1995) et al. defines spirituality as a turning inward to the human traits of honesty, love, caring, wisdom, imagination, and compassion. In addition, spirituality is the acknowledgement of the existence of a quality of a higher authority. This guiding spirit is the dynamic balance that allows and creates healing of body-mind-spirit (Dossey et al., 1995). Van Loon (2004) cited Fowler (1981), who stated that "the spiritual dimension gives shape to a person's life, providing hope and helping the person to ascribe meaning and purpose to their life. This in turn shapes how they invest their

deepest love” (p. 266). The love that the spirit evokes is powerful and is able to overcome every type of adversity and infidelity. This loving power is stronger than any other (including death). In addition, Seaward (2004) theorizes that the “spirit” is housed in the soul of each human and is a gift of companionship that synergizes a person to have purpose and to possess innate acknowledgement of the transcendent (Miner-Williams, 2006).

Aspects of Spirituality

While these definitions may be helpful and profound, the depth and intricacy of spirituality may simply be beyond humans’ capacity of comprehension. Perhaps, the spirit cannot be defined by words and language which have limitations; however, because the spirit is the center of our nature, we strive, even to no avail, to understand its essence. According to Denise Miner-Williams to understand a concept like spirituality, one must understand the different aspects, and as each aspect becomes understandable, one can gain a greater understanding of the whole (2005). To illustrate this point, she uses the analogy of a puzzle. For example, to understand a puzzle, one must examine the different pieces and how they are incorporated. Once one has successfully made connections, the picture of the whole puzzle becomes comprehensible, and just like a puzzle, as one examines the different aspects of spirituality, one receives a greater grasp of the whole (Miner-Williams, 2005). In her research, Miner-Williams noted a study performed by Chiu et al. (2004). In this study, Chiu et al. (2004) reviewed 73 research articles that had been published from 1990 to 2000 on the concepts of spirituality, and upon analysis, the researchers found four general themes: existential experience, connectedness,

transcendence, and an inner energy or force (Miner-Williams, 2006). Like Chiu et al. (2004) by compiling comprehensive, qualitative research of the existing data (n=28) by searching out recurrent themes and integrating the meanings of these concepts, one can derive a better understanding of the whole.

Meaning of Life

Among the articles researched, the theme of “significance” emerged. In Miner-Williams article, she quotes Rolheiser (2001), who accurately describes one’s search for significance. Rolheiser (2001) defined meaning as:

The deepest root, each of us aches for significance, meaning, uniqueness, preciousness, immortality and to have in our lives a great love and great beauty.

This ache is congenital, incurable, and obsessive. We are, as Plato said, fired into life with this divine restlessness in us. (p. 131, cited in Miner-Williams, 2006, p. 815)

As a person acknowledges and understands one’s purpose, this new-found significance produces resilience during times of great suffering. Not only does meaning produce resilience, but it also brings clarity (McEwen, 2005). A person can understand what items in their life deserve prioritization and what areas are irrelevant. In fact, as one gains understanding of spirituality, one’s sense of meaning increases. For example, Burkhardt’s study (1994) found in his statistical analysis that a positive relationship exists between having a rich spirituality and identifying one’s purpose in life (Miner-Williams, 2006). In addition, Maeragvilia’s critical analysis (1999) was also consistent with Burkhardt’s results. Meragvilia’s analysis determined that meaning was an associated

outcome of spirituality (Miner-Williams, 2005). Spirituality enlightens a person to one's purpose and to why they desire to live another day.

Interconnectedness

Connectedness is a harmonious interdependence that springs from one's soul and is a component of spiritual well being (McEwen, 2005). To illustrate this concept, one's interpersonal relationships often reveal the status of one's spiritual health. Healthy, meaningful relationships are often indicative of a healthy spirit. On the contrary, burdensome relationships or lack of meaningful relationships are indicative of a broken or apathetic spirit. In much of the literature, connectedness is perceived as two levels: vertical and horizontal. The vertical level is one's perceived relationship to that which is not of this world. The vertical manifests in relationships to persons like God or the transcendent (which will be discussed in greater detail in a forth-coming section). Miner-Williams (2006) suggested that if one's supreme desire is to be a spiritual being by relating intimately with God (the vertical), then consequently, the connection and relatedness one feels with all else will stem from this vertical relationship. In fact, "Narayanasamy found that 'reaching out to God' or striving for a vertical relationship was the primary means of coping for chronically ill patients" (McEwen, 2005, p. 166). Certainly, as human beings, our nature, as observed, seems to long for something greater than oneself (Miner-Williams, 2006). Therefore, one's relationship with the vertical is satisfying and can give people a greater fulfillment in the horizontal relationships around them.

The horizontal level of relationships is one's perceived relations to the people whether these interactions involve oneself, others or nature. To be connected, one must engage in the present. Each word, action, and thought that is based on horizontal relationships is forming ties and networks with one's present surroundings. As one understands the spirit's connection with the world that is around it, one will understand how the spirit pervades its surrounding. The spirit's bounds are boundless. The human spirit endlessly relates, and the spirit relates to itself, the people around it, and the environment-- the spirit is always relating. Influence, whether positive or negative, will occur. If one is a courteous, attentive listener, a positive connection will most likely form. Consequently, this positive connection is the pathway to developing more links, which will eventually create a network, and as the network of information grows, one will be able to perceive the unique links that comprise the patient. A nurse can then identify the broken and weak links that need healing. Understanding these connections and their interrelations facilitate healing for the patient. With greater perception of this influence, one can understand the patient's involvement with the vertical and the horizontal levels, and can subsequently assist them to achieve a greater level of connectedness and ultimately, spirituality. Although throughout this discourse, the interconnection has been relayed in an insensitive tone, Galek et al. (2005) found that the recurring theme of connection was complemented by the emotions of love, respect, and kindness. In fact, Plato sought to seek after spiritual love above physical. Instead of desiring the temporary elation from physical love, Plato longed for a love that penetrated into all aspects of his life, and the spiritual love spurred on a striving for righteousness

and a possession of the self that came from an intimate connection with the spirit. In conclusion, as one increases the connection between the vertical and horizontal relationships, one's spirit will strengthen.

Values and Belief System

Another concept of spirituality is found in one's beliefs and values. Although one's intellect and logic guide belief, the roots of one's values and beliefs stem from resonance with one's soul. Bellingham et al. (1989) affirmed that one's beliefs need to be congruent to one's soul in order to maintain harmony and obtain an intimate connection as mentioned in the previous section (Miner-William, 2006). To describe the valuable concept of beliefs, the analogy of the relationship of a tree to its branches has been used. Just as branches stem from a tree, likewise, beliefs stem from one's soul, and as beliefs are consistent with the grains of the core (or the trunk, in this analogy), they produce a tightly, interwoven connection and therefore, harmony. The dense bark of harmony fortifies one's spirituality. The external bark of harmony holds together the older, solidified beliefs as well as fosters the growth of new ideologies and new intimate connections just as the bark of a tree supports the rings of both old and new growth and holds them together. As these truths are congruent with one's soul, these values and beliefs nurture and establish meaning, existence, behavior, and subsequent action. If one can take this analogy further, one can imagine the stems of belief branching further into consequent behaviors. For behavior is a consequence of belief. Thus, actions and feelings that are congruent with the soul are the logical byproducts of belief.

In addition, belief systems are mechanisms that enable people to understand their spirituality at a greater level. Often these belief systems establish a foundation that explains the fundamental problems of existence, the acknowledgement of a higher power, and naming life's purpose. A person's values are their standards that they uphold concerning truth, rationality, and allocation of worth to possessions, ideologies, and behaviors (McEwen, 2006).

Energy

While energy was not frequently mentioned in the literature, the concept is essential to understanding the current-day model of spirituality. The concept of energy stems from the word vitality. Miller and Thorensen (2003) described *energy* as, "the notion of being concerned with life's most animating and vital principle" (p. 27). In addition, Goddard (1995) defined spirituality as *integrative energy* (Miner-Williams, 2005). Her research suggested that the *integrative energy* is an integral and networking connection throughout, and these networks guide and direct the person (Miner-Williams, 2006). For those whose spirituality coincides with their relationship with God, God is the catalyst of their energy. God initiated their relationship. In fact to them, all human thoughts and actions are in response to an understanding or encounter of God's love. To them, it's God who loves, and the source of their energy is a response to his initial act of love. Therefore, as one forms connections with both the vertical and horizontal relationships, this energy has more sources to flow to and from, and the strength and value of each connection is a determinant of the power of the allocated energy.

Hope

The idea of hope has been conceptualized in a variety of ways in research. Hope has been defined as the ability to see beyond one's present circumstances and draw one's strength from belief (Galek et al., 2005). As beliefs are fortified and congruent with the soul, one can focus their attention and rationale in what they trust. Trust is the foundation to hope. Hope is the strength a person receives from placing confidence in truths that exist outside of oneself. As hope is a source of resilience based on trust, one could understand why the research confirms that there is a positive relationship between hope and the will to live. The will to live is strengthened as hope is enriched. In fact, hope not only provides resilience but healing. McEwen (2005) states, "Recent studies have linked hope—another commonly researched concept related to spirituality—with effective illness management in women with human immunodeficiency virus (p. 166). As these women gained hope from their strengthened spirituality, they received a physical healing, but an even better type of a healing emerged. Their once broken person was transformed into a new, whole person. Hope helps them see beyond their illness as well as discover healing in and through their illness.

Transcendence

According to Teixeira (2008) transcendence is parallel to spirituality in that it is also an inherent quality of every human. Transcendence helps the spirit because as a person transcends, one can adapt to the past, present, and future stresses. One rises above the claustrophobia of the parameters of time and daily life to the sphere of what is meaningful. Villagomez (2005) defined transcendence as, "an expansion of personal

boundaries beyond the immediate or constricted views of oneself and the world that results in self empowerment and the ability to cope with stressful situations” (p. 287). The fruits of self-transcendence allow a person to gain a greater awareness and often increase one’s altruistic efforts and decrease one’s vain pursuits (Teixeria, 2008). For example, Teixeria (2008) states that “the nurse’s inner striving for full awareness can then lose the self to experience the other. The nurse transcends self through self-sacrifice and awareness” (p. 27). As the concept of transcendence coincides with spirituality, a person will feel a greater connection to their *integrative energy* or God as this connection enables transcendence (Teixeria, 2008).

Discussion

Theoretical Framework

When these prevalent themes are understood, one can better reflect on the entire entity of spirituality; yet to achieve an even broader conceptualization, one must relate these prevalent themes and understand their connections. To preface this framework, the presupposition is that the spirit or spirituality is the raw substance of our being. Also, another presupposition is that spirituality produces health; yet, spiritual and physical health cannot be equated. As previously mentioned, the social, physical, psychological, and spiritual are integral parts to the whole. One cannot separate the body from the soul. For all intensive purposes of this framework, “Health is defined as wholeness, and unity and harmony of the body, mind, and spirit (Miner-Williams, 2006, p. 818). To demonstrate this, Mary Rockword, Ph.D., RN (2005) states that research has proved that spirituality can heal a person. By connecting a patient to their spirituality, a person is

able to engage the parasympathetic nervous system, which transitions a person from a state of stress to relaxation. As the body enters a state of relaxation, the parasympathetic nervous system slows the heartbeat down, transports blood to the intestines to facilitate digestion, drops the blood pressure, and decreases oxygen demand (Rockwood, 2005). In addition, as one pursues spirituality, these endeavors activate the hypothalamus, which initiates the response of the autonomic nervous system that maintains the equilibrium of one's heart rate and hormone levels. As Rockwood (2005) observed in recent studies that "...art in an intensive care unit relaxes patients; these patients use less pain medication and leave the hospital a day earlier than those who do not have art in their rooms" (p. 123), and in the last 20 years, nurses now realize the healing effects of spiritual tools, music, and art. These spiritual modulations are effective tools for healing.

As one considers these thoughts of health and these themes of spirituality, one must consider how the synergy of these elements adds to the health of a person. Each person is a unique combination of body, mind, and spirit. As human beings, we individually contain a different spirit or *integrative energy*. As development begins, one's spirit and values, which are influenced from one's surroundings, help bring understanding of one's existence, meaning, and purpose in life. As one establishes values and beliefs that authentically correspond with one's core and as they become interconnected with the vertical and horizontal relationships, the synergy of the elements will contribute to a greater sense of health. For example, some people have God or deity-based spiritualities, and they view their relationship with God, which is a relationship of love, as the primary catalyst towards their spirituality. From this relationship from God, which ignites their

integrative energy and facilitates meaning and purpose, the person will form intimate vertical and horizontal relationships. Consequently, as this interconnectedness between God, self, and others begins to strengthen, an authentic spirituality manifests in discernable products of love, hope, harmony, and peace. Therefore, these so-called fruits of the spirit contribute to a sense of overall health and formulate a resilience that enables one to withstand suffering. Likewise, those, who focus on the *integrative energy* within themselves, experience the same continuum to spiritual health.

As a theoretical framework has been established, the complexity of spirituality has been simplified in a manner that can be internalized and that can be applied in practical ways. As mentioned previously, spirituality is an integral, synergistic component of health. Thus, spirituality is relevant in the nursing field. However, although a greater understanding of spirituality has been obtained, the challenge is integrating spirituality in everyday nursing care. To integrate “spirituality” into the field of nursing one can as Miner-Williams (2006) states, “...both provide spiritual nursing care and can provide nursing care spiritually” (p. 818).

The Nurse as a Healer

To begin internalizing and applying the concept of spirituality, the nurse must, first and foremost, be comfortable with spirituality. According to Harrington (1995), if a nurse does not prioritize spirituality in his or her own life, one will consequently neglect to prioritize spiritual care in one’s patient’s life (Baldacchino, 2006). Often nurses experience anxiety and discomfort when discussing the topic of spirituality. Being an intimate and personal matter in the Western mindset, spirituality is not often associated

with medical care. However, through the theoretical framework, one can grasp the concept of spirituality and understand its relevance to the health continuum, yet as a nurse, one must begin to visualize oneself as a healer and must be reflective about one's own spiritual state. Jackson helps to clarify the concept of a nurse as a healer. The word *healer* implies an active role that catalyzes movement and change (2004). A healer, according to Keegan, is capable of foreseeing and enabling the spirit of another in the direction of wholeness and interrelatedness. In addition, in Jackson's (2004) review of literature, she quoted:

Dossey et al. describes healing as a blending of technology with care, love, and compassion; as learning to open that which has been closed in order to expand inner potentials; and as a lifelong journey where we seek healing for ourselves or help others to recover from illness or transition to a peaceful death. (p. 68)

However, to be effective healers, one needs to be self-aware. When self-aware, one can acknowledge the wounds and activities that deplete one's energy, yet one can also understand the people and actions that promote restoration. Along these lines, Conti-O'Hare states, "Without awareness, they (nurses) drain their healing energies, making themselves therapeutically ineffective and incapable of transcending their own wounding" (Jackson, 2004, p. 69). As nurses understand their integral spiritual, mental, and physical components, they are able to relate to their patient as a whole.

Consequently, nurses will be confident in caring—finding security in themselves and their spirit. Thus, the wholeness of others and their specific needs become increasingly apparent. In spite of both the patient and the nurse having different expectations, socio-

cultural backgrounds, ideologies, and environments, they enter into a partnership of the nurse-patient relationship. In moments of the nurse-patient relationship, opportunities arise to deliver love and energy that catalyze healing on all holistic levels. As nurses know and understand their patient's needs, they will conduct accurate spiritual assessments and facilitate appropriate spiritual interventions.

Spiritual Assessment

According to Florence Nightingale, "Spirituality is intrinsic to human nature and is our deepest and most potent resource for healing" (Jackson, 2004, p. 79). Even in today's nursing profession, the Joint Commission on Accreditation for Health Care Organizations (JCAHO) formally recognizes the need to meet a patient's spiritual needs. Angst and inadequacy for nurses are often byproducts from lack of assessment skills for observing spiritual distress and lack of education, training, and skill in providing spiritual care (Villagomez, 2005). Physical assessments note observable manifestations and internal cues (such as lab values); however, spiritual assessments are far more difficult. The difficulty arises as spiritual distress deviates from the usual tangible manifestations (Baldacchino, 2006). Although occasionally, spiritual concerns can be translated into verbal and non-verbal cues, a spiritual assessment requires a greater depth of insight into the core of a person.

Although the need for providing spiritual care has been noted, the question must be asked as to what spiritual needs the patient has and how as nurses are we able to assess spiritual deficit or distress. Throughout the reviewing of the current trends of spirituality, Taylor, in a qualitative research study that involved cancer patients and their family

members, devised a comprehensive collection of seven spiritual needs (Villangomez, 2005). Taylor's (as cited in Villangomez (2005)) seven spiritual needs are as follows:

- (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. (p. 287)

Without these spiritual needs met, a person will exhibit spiritual distress.

Districu and *distringere* are the Latin derivatives for the word distress, which are defined as “to draw apart or hinder,” and are related to the current terms of stress and strain, which are associated with the symptomatology of misery, pain and suffering (Villangomez, 2005). Ridner (2004) and Armstrong (2003), from their research on psychological distress, defined distress as, “a non-specific, biological, or emotional response to a demand or stressor that is harmful to the individual” (Villangomez, 2005, p. 287). Usually the word distress is associated with concrete, physical strain. The concept is tangible. However, when the concept of distress merges with the idea of spirituality to *spiritual distress*, it loses its tangibility and transitions to the abstract.

Spiritual distress is the dissonance and disharmony between the previously mentioned concepts of spirituality: connectedness, one's value and belief system, energy, hope, and transcendence. As termed by North American Nursing Diagnosis Association (NANDA), spiritual distress is “the disruption in the life principle that pervades a person's entire being that integrates and transcends one's biological and psychological nature” (Villangomez, 2005, p. 288). Spiritual Distress is a diagnosis by NANDA that

is evidenced by a gamut of emotions: crying, being withdrawn, worrying, difficulty concentrating, hostility, apathy, feeling of pointlessness and hopelessness. Spiritual distress manifests itself in various ways depending on the attribute of spirituality that is impaired (Villangomez, 2005).

If a person has an impaired sense of connection with oneself, others, or God/transcendent power, a patient will manifest a desire for alienation, frequent self-blame, difficulty accepting themselves, separation from normal support systems and separation from the source of inner strength. They demonstrate a disinterest in the environment and nature, and feel disconnected from God or a transcendent being (Villangomez, 2005).

If a person is experiencing dissonance from their beliefs and values, often they will manifest distress by stating a lack of faith. In addition, the patient will notify the nurse about inner-turmoil, feeling abandoned or expressing anger towards God or a transcendent being. They will question if this life circumstance is a punishment from God, or they will ask and seek answers for the *why* questions (Villangomez, 2005).

Furthermore, physical illness can initiate a person to question their sense of purpose and meaning in life, which can manifest as questioning the reasons for their suffering. They will display a difficulty implementing their purpose in life amidst their current circumstances. In addition, when vitality in a patient's life diminishes, a patient loses the ability to think positively, complains of tiredness, withdraws away from people, turns inward, and feels "broken-hearted."

Lastly, as a person loses their sense of transcendence, they often lack the inability

to think introspectively and lose their inability to forgive and reconcile with others. They lose their feelings of relatedness with anything or anyone outside themselves (Villangomza, 2005). While these are general guidelines in identifying a spiritually distressed patient, currently a standardized assessment tool for spiritually distressed patients does not exist, although spiritual assessment tools are mentioned in literature. Dossey's Spiritual Assessment Tool utilizes questions that assist with assessing, evaluating, and initiating introspection in the concepts of purpose and meaning, resilience, and interconnections (McEwen, 2005). In addition, the HOPE model of taking a spiritual history and the FICA manipulate acronyms to structure questions for easy memory (McEwen, 2005). For instance, FICA stands for the categories: Faith and belief, Importance (determining the importance that faith has in your life), Community (support systems such as churches, mosques, and interests groups), and Address in care (allowing the patient to have autonomy) (Elkwin and Cavendish, 2004). However, despite the fact that no universal standard exists, as a nurse understands the concept of spiritual distress, one can begin to assess according to this level of holism. According to Villangomza, assessment does not necessarily involve direct patient questioning that is guided by set list of questions, rather by casually observing stories and developing a therapeutic relationship, these skills often reveal more about a patient's spiritual needs (2005).

More research is needed to determine effective procedures that identify spiritual distress in the health care setting. Again, while published assessment tools exist, analysis needs to be done to understand which tool performs the most accurate assessment. In addition, although there are six common underlying concepts that aid in assessing a

spiritually distressed patient, more research needs to be done to distinguish the difference between the symptomatology and etiology of depression and spiritual distress. As one takes into account the areas still in need of research, one can still assess a patient with spiritual distress. Once one identifies spiritual distress, appropriate interventions need to be provided.

Spiritual Intervention

Once a nurse can recognize spiritual distress, one must perform the necessary spiritual interventions. In analyzing the current literature trends, a wide range of interventions were narrowed down to six main categories: establishing a trusting relationship, providing a supportive spiritual environment, responding sensitively to a patient's belief system, acknowledging the importance of *presence*, demonstrating actions, affections, and words with care, and integrating spirituality into one's scheduled care.

Establishing a Trusting Relationship

Clark et al. states that when a nurse has the opportunity to show one's patient empathetic care, these moments help establish a trusting relationship (2004). Even from a person's birth, developing a relationship of love and trust is essential to a human's survival. For a baby, developing a love-trust relationship with their parents and minimizing their separation is the baby's greatest spiritual need (Elkins and Cavendish, 2004). In addition, at the beginning stages of life, a nurse needs to provide continuity of care to fortify a trusting relationship. Developing a trusting relationship feeds a baby's spirit, and without a loving and trusting relationship, babies will physically die as

evidenced in their failure to thrive. To nurture and enhance a nurse-patient relationship, some specialized medical wards have developed a long-term patient allocation method. This method allows the patient to be assigned to the same nurse through the duration of their stay. Because the patient has continuity of care, a stronger therapeutic relationship can facilitate healing (Clark et al., 2004).

Providing a Supportive, Spiritual Environment

As a nurse, one will need to act as the facilitator of the spiritual environment. For example, if a person performs certain spiritual routines at a specific time of day, a nurse can plan care to avoid interruptions around this time and to promote a patient's sense of peace. In addition, a sense of privacy needs to be provided. Often patient's will look to nurses for help, and in their time of need nurses need to instinctively provide comfort measures, psychological support, and spiritual guidance (Clark et al., 2004).

Sensitively Respond to the Patient's Belief System

Just as providing a spiritual environment allows for spiritual strengthening, having respect and enabling patients to continue their own spiritual practices maintains and fosters the growth of their spirit. First of all, part of a therapeutic relationship is to establish a bond of trust. If nurses do not respect their patient's thoughts and beliefs, a patient will not trust in the nurses' care. To respect another's beliefs requires nurses to evaluate if they are judging a person's spirituality by their own standard. However, there exist transpiritual truths, ethics and key concepts of spirituality (belief, meaning, transcendence, etc.) that can guide the practice of spiritual care. In addition, nurses can acknowledge the differences in beliefs and try to understand how a person arrived at that

belief. Although nurses might appreciate the difference in the patient's belief, they are not mandated to be involved directly. While observing the patient's rituals and practices might be informative, nurses are not required to accept a belief that is contrary to their own. For example, a nurse, Sonia, who is an expert in the field of cross-cultural nursing, states her experience among a people group that had a different spiritual belief than her own. Arlene Miller (1999) in her book, Called to Care: A Christian Theology of Nursing, noted Sonia's care for a dying Hindu patient:

I (Arlene) asked her what she would do if a dying Hindu patient wanted her to chant prayers to Shiva, a common Hindu practice with dying patients. She replied that she could not do that, but she often asked for permission to pray to her God until the Hindu priest arrived. Patients rarely refused. She would send for the patient's religious leader if she was requested to do so. She prays for wisdom in her nursing interventions [guided by her own faith]. (p.113)

Acceptable tolerance will help nurses in spite of major differences in beliefs and values to love their patients despite initial apathy, annoyance or offense behaviors. However, acceptable tolerance does not signify believing that every belief coincides with absolute truth. In fact, if a nurse feels a patient's belief system inhibits spiritual healing, a patient has the right to know this practice is holistically unhealthy, and he or she needs to communicate the rationale why this practice is potentially harmful. This should be said with an informative and non-offensive tone only out of love to the nurse's patient.

Acknowledging One's Presence

The word “presence” often has implications of *being, existence, actuality, and essence*. As a nurse, one can be present in different manners. Being physically present, a nurse completes needed tasks of meeting the patient’s physical need (Dossey et al., 1995). Being psychologically present, a nurse considers her presence important because *being with one’s patient* works as a therapeutic tool that assists in meeting the client’s needs for help, comfort, and support (Dossey et al., 1995). In addition, being therapeutically present, the nurse is attending the patient as a whole person and enabling the patient to use the depth of their own inner resources: mind, body, relationships, and soul to promote healing on all levels (Dossey et al., 1995).

To demonstrate the importance of nurse presence, a two-year piloting study was completed to identify the effects of “in-the-moment, relationship-centered whole person care” by The New England School of Whole Health (Donadio, 2005). This qualitative study was based out of Union Hospital in the Cardiac Rehabilitation Department. Each nurse educator followed a specific curriculum based on “Maslow’s Hierarchy of Human Needs,” which enforced teachings that assisted nurses from moving beyond tasked-based care to care that takes into account the human experience (Donadio, 2005).

Consequently, because of the nurse’s additional training, each patient valued the time they spent with their nurse and indicated that they were able to understand their illness and felt the confidence that they would be able to overcome the expected trials (Donadio, 2005). In conclusion, when nurses have presence, they can understand more than just the pathological condition of the patient. When nurses relate to their patient’s illness, their

presence enables greater healing.

Demonstrating Actions, Affection, and Words with Care

In addition to *being* with the patient, others suggest that an excellent way to intervene spiritually is caring through a nurse's actions and words (Fawcett and Noble, 2004). Active listening to a patient in a sensitive manner and with responsive feedback allows the nurse to understand the turmoil in which the patient is going through. Listening also allows for time for the patient to express the most relevant, pressing spiritual concerns. With this knowledge, the nurse can continue to guide his or her care in a way that is therapeutic to that specific patient. Moreover, touch has been used for centuries to promote healing. In current nursing practice, physical touch has been acknowledged in encompassing care in 5 areas: physical comfort, emotional support, psychological comfort, social interactions, and spiritual sharing (O'Brien, 2003). As one acts, speaks and listen with care, nurses are required to invest their time and themselves, which helps develop a stronger therapeutic relationship. Investing one's time and fortifying relationships are essential for establishing trust, which are needed grounds for laying a foundation for providing spiritual care (Fawcett and Noble, 2004).

Integrating Spiritual Practices in One's Care Plan

The actions of a nurse foster holistic care, and moreover, the spiritual practices that a person might know to be effective should be encouraged and made available. Of spiritual practices, prayer is one the most frequently associated interventions of spiritual care. Over the last couple of years, research on the subjects of healing and prayer have been prevalent. DiJospheh (2005) et al., noted that:

A recent Centers for Disease Control and Prevention (CDC) Nation Center for Health Statistic survey indicates that more than 33% of Americans used CAM in 2002 than in the prior years. Prayer was the most widely used therapy; 43% of Americans pray for their health, 24% pray for the health of others, and 10% participate in prayer groups for their health. (p. 148)

According to DiJoseph, prayer is one of the most commonly preformed spiritual practices, and is defined as one's personal connection with a form of deity or higher power that is associated with one's belief system (2005). In addition, she mentions that prayer is manifested in many different forms with many different practices: formal or informal, silent or verbal, or even with rituals or at spontaneous occasions: "Prayer, one of the oldest methods used to achieve peace, has been associated with feelings of calmness, relief, rest and well-being, healing, and recovery" (DiJoseph, 2005, p. 152). As each patient is different, they each have different ways to express themselves in prayer. As a nurse, one needs to assess and be attentive to the specific spiritual needs of the patient. In regards to prayer, certain patients might customarily burn incense, pray through the rosary, or pray in a certain posture, and some of these practices can still be practiced in the hospital (DiJoseph, 2005). According to Roger, prayer is interrelated with a person's energy and the environmental fields of energy, and when one prays, one is in communion with these energy fields that can potentially bring about positive change (DiJoseph, 2005). To make prayer possible, hospitals should designate rooms that facilitate the patient's ability to maintain their personal prayer practices. DiJoseph wisely suggests, "To preserve patient's autonomy and to provide a safe and comfortable

environment for the expression of individual beliefs, the nurse can support the patient's choice of a particular form of prayer by providing space, privacy, and respect for sacred objects" (2005, p. 150).

Although prayer is used frequently, other spiritual practices can also be implemented. If a patient enjoys reading and meditating on certain religious texts, a nurse could make those texts available (such as the Bible, Torah, The Book of Mormon, or the Holy Qu'ran). In addition, the nurse has the opportunity to respect the patient's specific rituals. For instance, Orthodox Jews maintain certain dietary restrictions, and as these restrictions establish a healthy lifestyle, a hospital can accommodate to these restrictions. Also, fundamental Muslims participate in a ceremonial washing and prayer five times a day that takes about 15 minutes. Nurses need to respect the rituals and spiritual practices that are involved in a patient's care as long as they are feasible. Yet sometimes, nurses may feel inadequate to meet the spiritual needs of their patient. When nurses recognize that the spiritual needs of their patients are beyond the scope of their practice, nurses can refer these patients to a spiritual counselor. Although, a nurse should have a basic comprehension of the basic religious and spiritual counselors available so that he or she may refer a specific patient to the appropriate spiritual leader.

Difficulties in Providing Care

Despite the provision of practical interventions that a nurse can perform to provide spiritual care, nurses have legitimate barriers to overcome. These barriers include but are not limited to: lack of one's own spirituality, insufficient knowledge of spiritual interventions, fear of offending a person, trepidation of imposing one's own

spirituality on vulnerable patients, and lack of time (Clark et al., 2004). As Elkins and Cavendish (2004) observed, accommodations, in nursing care, have been necessary due to the hospital shifting from organization to corporation. These changes manifest in nursing care being directed toward task-based care, in contrast to, patient-centered care.

Although a person's spirit is an integral aspect of the whole person, spiritual concerns are often neglected because these concerns are phenomenological in nature. Aspects of care that are phenomenological in nature are difficult to research because in contrast to biological studies, which are validated by quantitative studies, spirituality simply cannot be proved by concrete data (Villagonmeza, 2005). Because of this paradigm shift, patients' biological needs are the primary focus; however, this focus diminishes the nurse's ability to take care of a patient holistically (Villagonmeza, 2005). In addition to the recent paradigm shift, the anxiety that many nurses feel is associated with their lack of knowledge about spirituality. Nurses perceive that they have inadequate education or lack the appropriate skills to assist patients with their spiritual needs (Villagonmeza, 2005). Moreover, many nurses omit spiritual care due to the discomfort of discussing a line of care that is too personal.

Case Study

In applying this knowledge, a case study was found to illustrate how the theory of spirituality can be translated to actual practice. A case study was obtained from the research journal of Mary O'Brien (2003), author of Spirituality in Nursing. She helped manage a five-year study of the nursing needs of persons living with HIV. In her journal she describes a particular event in the ICU where spiritual interventions were needed (the

following is paraphrased).

Mary set down the phone and peered out of the car window. “What a melancholy day!” she thought. The fall wind was blowing the remaining leaves off the trees while the sky had the coloring of a stagnant river: grey with a vague hint of green. She was on her way to work when she received the call from Luke, a friend of Jonathan. Jonathan was one of her patient’s with AIDS. Luke had apologized for calling so early but the desperation was apparent in his voice as he spoke, “Jonathan asked that I get in touch with you. He was admitted to the ICU during the night and they’re putting him on a ventilator; it does not look good.”

As she continued to drive to the hospital that dreary day, Mary remembered the first time she had taken care of Jonathan. About five years prior, she had been searching for persons living with HIV to participate in a five-year study to investigate coping strategies. “How his enthusiasm for the study was equal to his enthusiasm for life! It was contagious and touched everyone he was around,” she thought. During the months and years that followed, their relationship deepened through laughter, doubts, fears, and tears that the human immunodeficiency virus introduced into his life. However, through all the adversities, Mary was still amazed at the tenacity of his sincere joy. As Mary’s thoughts wandered from the hopeful land of the past to the ominous future, she could not help fearing for her patient’s and now dear friend’s prognosis.

When Mary arrived to the ICU, Jonathan had already been placed on a ventilator and was barely conscious. Luke was standing by the bedside. He was an aeronautical engineer who was detail-orientated and very intellectual. After he relayed the events of

the last couple of hours, he paused, and as if he gained reassurance, he petitioned, “Mary Elizabeth, would you do something for Jonathan?”

“Of course!” She responded without hesitation.

Again a pause, “Religion is not something that is very big with me; as a scientist I have difficulty with the mystery, but for Jonathan it’s important. He didn’t go to church a lot, but faith in God was a real part of his life. Would you say a prayer for him?”

Initially, Mary was filled with panic. She thought as a nurse she was not qualified to pray. She was wishing the chaplain would be present for a time like this. However, almost instantaneously, she realized that since she, the nurse, had been requested to pray, surely God would compensate for her perceived weakness—especially in regards to prayer. Although to this day Mary does not remember her prayer, she remembers Jonathan, Luke and her all holding each others’ hands and forming their own joined circle--a community of worship. When she finished, she glanced at Luke, and his eyes were streaming with tears of gratitude as he gently whispered, “Thank You.” For Mary, she gave thanks to the God of love who cares for us when we feel the most inadequate.

Upon reflection of the event, Mary wrote in her research journal:

The experience with Jonathan and Luke taught me that we, as nurses, are indeed called to lived reality of God’s love which may be manifested in terms of spiritual care, as well as physical and emotional support. I recognized the importance of allowing myself to be used as God’s instrument in the midst of feelings of personal inadequacy. Although I did not feel competent to minister spiritually,

through prayer, at the time, the Spirit provided the courage and the words. Luke told me several days later, after Jonathan's death, that he felt peace after we prayed together; that this was a turning point, and that he had now begun to think about his spiritual life and how he might understand God. I believe that not only the praying together, but also our joining hands, as a worshiping community, was an important dimension of our liturgy. Through the intimate touch of palm against palm, we became aware of our connectedness both as a human family and as a spiritual family of God. We were thus able to support and strengthen each other, even as we sought the support and strength of the Creator. (p. 164)

In this case study, one can note several correlations to the literature review. First of all, although Mary had established a therapeutic relationship with her patient as his nurse, she felt inadequate to prayer with and for him. As evidenced in literature, a majority of nurses are anxious in giving spiritual care. Because Mary had connectedness with her vertical relationship (in her case—the Judeo-Christian God), she was able to understand her role in connecting with the horizontal relationships as she sought to care for Jonathan. In addition, Mary transcended above her own fear and feelings of inadequacy to a desire to love for her patient and now dear friend.

For those nurses who claim a belief in the Judeo-Christian God, the essential question is not if a person can be spiritual without a belief in God; however, the more appropriate question is if a person can be a complete spiritual person without a relationship with God. Fawcett and Noble claim (2004):

If a nurse's aim is to aid a patient's restoration to full spiritual health, it becomes

of fundamental importance whether or not God is required for this end. The existence or not of a universal truth becomes a matter of utmost consequence, for only in the absence of a universal truth is the 'tolerance and tapestry' approach to spiritual care valid or ethical. (p. 140)

If, on the contrary, this absolute truth exists, then one must learn about it, in order that as a nurse, one can deliver complete, encompassing spiritual care. If the nurse, despite her belief, can practice with individuality and wholeness, then the nurse may feel permitted to share with the patient his or her whole self, including his or her relationship with God. However, this must be done with the utmost sensitivity and respect (Fawcett and Noble, 2004).

If we accept the tolerance of different forms of spirituality to adequately satisfy a person's spiritual need, then each person's journey to spirituality needs to be respected and encouraged. However, just in other areas of holistic nursing, guidelines are established to enable patients to heal properly. Nurses know that certain truths guide their practice. Although the following analogy is faulty on several levels, it sufficiently helps demonstrate the necessity of guidelines that facilitate holistic spiritual care. For example, when a patient with diabetes insists on eating ice cream every day to help maintain appropriate blood sugar levels, the nurse knows this information is incorrect if not harmful. In the example, one knows, physiologically, that if a patient consumes foods that are purely sugar, while initially rising blood sugar levels, their blood sugar levels will just as quickly fall. If a patient made this assertion, a nurse would need to ensure that proper education would be given to the patient to manage their diabetes. The same is true

with spirituality.

Guidelines are required to receive spiritual healing. Shelly and Fish (1988) claim that having a relationship with God is a guideline that promotes healing. A person's wholeness, their physical emotional, social and spiritual integration can only become a reality through a dynamic and personal relationship with God (Fawcett and Noble, 2004). In addition, "Kumar (2000) asserts that the reason that people need God and are incomplete without Him, is that God created them to be in relationship with Him, and this relationship is the sole purpose of human life" (Fawcett and Noble, 2004, p. 139). As Fawcett and Noble (2004) state, if these claims are in fact truth, then their implications indicate that a person's spiritual needs can only be fulfilled with God through a personal love-initiated relationship with Christ. To paraphrase Shelly and Fish (1988), our job as nurses would be offering meaning and purpose, love and relatedness, and forgiveness through Jesus Christ and his reconciliation. Understanding that this relationship is the source of fulfillment is essential to caring for patients as whole entities. However, nurses have the duty to assist patients to worship and practice their beliefs, faith, and spirituality despite their beliefs of these practices.

Discussion

While spirituality is an essential aspect of holistic nursing care, the current literature is often theoretical in nature and neglects to correlate theory to practical application by getting lost in vague, ambiguous language. In literature, there is a paucity in establishing guides for assist nurses to practice competent spiritual care. This literature review identified the key concepts of spirituality: purpose, interconnectedness (with

vertical and horizontal relationships), belief, integrative energy, transcendence and hope. Once the key concepts were identified, the relationships between these key elements were analyzed to comprehend a greater picture of the whole concept of spirituality. As a person develops, they formulate thoughts and perceptions of the world around them. These beliefs are often influenced or initiated by one's relationships either vertical or horizontal in response to love and trust, and from trusting people and forming beliefs, a person can experience hope and the ability to see beyond oneself to the needs of others. As these elements start to interact and the network of their entities strengthens, a person acquires purpose, which catalyzes an excitement and energy to live life. These concepts and their correlations were obtained from common themes in literature. However, the majority of articles are often based on a specific aggregate like oncology, MI, dialysis, or terminally ill patients. In addition, based on this literature review, serious gaps in research still need to be addressed. The lack of spiritual care is rooted in nurses' knowledge base; thus, nurses' education and their spiritual awareness manifest in a decreased aptitude in assessing and providing a patient spiritual care. For this reason, research needs to investigate effective methods of educating nurses in the realm of spirituality. In addition, there is a need for proper assessment guidelines. Spiritual distress manifests when one or more of the key concepts of spirituality are impaired, and spiritual distress most often has the signs and symptoms of withdrawing from relationships, crying, worrying, having a difficulty concentrating, exhibiting an increased hostility or apathy towards others and experiencing a sense of hopelessness. These are general guidelines, but there remains a need for a more standardized tool for assessing

spiritual needs. In addition, although interventions have been listed, there exists a scarcity of in the area of evaluating the appropriateness of interventions based on the time of delivery and specific patient. Moreover, research also needs to discuss not only the specific type of delivery of spiritual care but also to determine how the quality of delivery impacts care. Overall, as nurses begin to internalize the importance of spiritual care, recognition, restoration, and revitalization of the spirit will occur, and perhaps for the first time, a patient can experience a sincere love, hope, and purpose.

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