



CRITICAL CARE NURSES' PERCEIVED NEED FOR GUIDANCE IN ADDRESSING SPIRITUALITY IN CRITICALLY ILL PATIENTS

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Background The term *spirituality* is highly subjective. No common or universally accepted definition for the term exists. Without a clear definition, each nurse must reconcile his or her own beliefs within a framework mutually suitable for both nurse and patient.

Objectives To examine individual critical care nurses' definition of spirituality, their comfort in providing spiritual care to patients, and their perceived need for education in providing this care.

Methods Individual interviews with 30 nurses who worked in a critical care unit at a large Midwestern teaching hospital.

Results Nurses generally feel comfortable providing spiritual care to critically ill patients but need further education about multicultural considerations. Nurses identified opportunities to address spiritual needs throughout a patient's stay but noted that these needs are usually not addressed until the end of life.

Conclusions A working definition for spirituality in health care was developed: That part of person that gives meaning and purpose to the person's life. Belief in a higher power that may inspire hope, seek resolution, and transcend physical and conscious constraints. (*American Journal of Critical Care*. 2016;25:206-211)

Although health care is grounded in the tradition of caring for the entire person, it can be argued that advances in technology and the emergence of new science have led to a disconnect between caring for the body and caring for the soul.¹ To provide holistic care, nurses must be prepared to address all dimensions, including spiritual dimensions. Research^{2,3} has indicated that nurses often feel unprepared to meet the spiritual needs of their patients. A review of definitions in the literature revealed no common or universally accepted definition for the term *spirituality*.⁴ Without a clear definition, each nurse must reconcile his or her own beliefs within a framework mutually suitable for both nurse and patient.

Literature Review

In 2001, the Institute of Medicine⁵ referred to health care in America as fragmented and impersonal. Since then, initiatives for an enhanced focus on patients' satisfaction have created an increased demand to return to patient-centered or person-centered holistic care.⁶⁻⁹ Person-centered care focuses the locus of decision making back on the person receiving care.⁶ Watson¹⁰ describes the transpersonal caring relationship as one that explains how a nurse considers a person's subjective meaning of the person's health care situation. The nurse's own caring consciousness lends connection and understanding of the other person's perspective. The person and the nurse are both unique but find mutuality upon which to connect. The person and the nurse embark on a mutual search for meaning and wholeness and perhaps for the spiritual transcendence of suffering.¹⁰ Nurses may embrace holistic person-centered approaches to care to help patients achieve a balanced relationship between 3 interrelated entities: mind, spirit, and body.¹¹

Spiritual needs must be addressed in all patients, no matter what religion the patient practices.⁹ Although the concepts are often considered interchangeable both in practice and in literature, religion and spirituality are not synonymous. For some persons, spirituality is grounded in religion, whereas others see spirituality on a metaphysical

or existential level. Narayanasamy and Owens¹¹ found that confusion exists over the meaning of spirituality and therefore over the role of nurses in providing spiritual care.

Patients place high importance on consideration of spiritual matters; attention to emotional needs was identified as the third top priority in the 2010 Press Ganey hospital pulse report.¹² Response to concerns or complaints and involvement in care were the top 2 priorities. A study of more than 4000 nurses revealed that 93% thought that attending to spiritual needs enhances the overall quality of nursing care. Kociszewski¹³ found that providing spiritual care has important meaning for nurses and enhances professional satisfaction. Spiritual care interventions by nurses promote a sense of well-being for the nurses and promote positive outcomes for patients.¹⁰

As nurses face increasing responsibilities and workloads, the quality of spiritual care they are able to offer may be in jeopardy.¹⁴ Balboni et al¹⁵ concluded that spiritual training for nurses is critical to meet national end-of-life care guidelines. Yet, little is known about what type of training is needed to enhance competence in addressing the spiritual needs of patients. In research^{2,11} on the extent to which nurses are prepared to meet the spiritual needs of hospitalized patients, 60% to 79% of nurses indicated a need for more guidance and educational preparation. Lack of preparation and comfort may lead to hesitance in investigating patients' spiritual needs.

Aims

The purpose of this study was to learn more about critical care nurses' self-described definition of spirituality in health care, to assess the nurses' comfort in providing spiritual care, and to determine their perceived need for guidance in providing

Nurses must be prepared to address all dimensions of care, including spirituality.

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Table 1
Characteristics of nurses in the study

Characteristic	%
Age, y	
20-29	56
30-39	27
40-59	17
Sex	
Female	93
Male	7
Ethnicity	
White	97
Hispanic	3
Highest educational level	
Bachelor of science in nursing	73
Associate degree	20
Nursing diploma	4
Master of science in nursing	3
Years of nursing experience	
1-2	30
3-4	34
5-6	17
7-12	6
12-24	13
Years of experience as critical care nurse	
1-2	40
3-4	30
5-6	14
7-12	16

Table 2
Interview questions

We are conducting a study about spirituality and would like to talk with nurses about their thoughts related to this topic. There is no clear definition of spirituality, particularly as it relates to nursing. Could you tell me about a time when you interacted with a patient who really needed some spiritual support or attention? (During dialogue: What motivated you?)

Please describe your personal definition of spirituality.

How do you see the connection between religion and spirituality? (Do you feel like you have to be religious to be spiritual?)

Could you talk to me about your own comfort providing spiritual care to critically ill patients?

spiritual care to critically ill patients. Additionally, we sought to create a working definition of spirituality in health care to guide nurses within their organizations. The focus for the study evolved from discussions with nurses and spiritual care staff in the medical intensive care unit at Cleveland Clinic in Ohio. Informal discussions suggested that many critical care nurses did not feel confident in addressing the spiritual needs of their patients and wished for more education and guidance in how to meet these needs.

Methods

The holistic and multiperspective nature of spiritual care experiences are best addressed by using qualitative research approaches.¹⁶ A literature search did not reveal a common or universally accepted definition for spirituality, and only a few investigations focused on nurses addressing spiritual needs of critically ill patients. The phenomenological approach of von Manen¹⁷ was considered the best one for eliciting the “lived experience” of how nurses addressed spiritual needs while caring for critically ill patients.

After approval by the appropriate institutional review board, a purposeful cross-section of nurses who worked full-time, part-time, or as needed as direct caregivers in the 25-bed medical intensive care unit were recruited to participate in individual interviews. Nurses were recruited to provide representation of the overall nursing staff on the unit in terms of sex, ethnicity, and chronological age (Table 1).

The research team was composed of a nurse manager, 2 assistant nurse managers, a clinical nurse specialist, 3 bedside nurses, and a senior nurse scientist who served as research mentor. In order to prevent hierarchical differences and promote truth and disclosure, interviews were conducted by 2 nurses who worked as bedside caregivers on the unit. The research team acknowledged challenges inherent to using peers to conduct qualitative research.¹⁸ The voluntary nature of participation in interviews was noted on the recruitment flyer along with assurance that all personal identifiers would be removed during transcription. The senior nurse scientist offered mentoring and behavioral coaching through role-playing to prepare the 2 nurses who conducted the peer interviews.

A total of 30 nurses participated in individual interviews conducted in a private conference room. The interviewers obtained written informed consent, which included consent to audio recording. A script of questions designed to elicit responses to meet the specific aims of the study was provided; however, interviewers were encouraged to ask additional open-ended questions to gain insight into the lived experiences of nurses in relation to the phenomenon of spirituality in the care of critically ill patients (Table 2). Interviews were transcribed by a member of the research team and then validated by the principal investigator.

Each member of the research team was provided with a deidentified copy of the transcribed interviews. An analysis of all responses to each interview question was conducted both independently and then collaboratively among members of the research team. Interpretive summaries were then developed. Data

were further analyzed to determine themes and phenomena that aligned with the specific aims of the study.

Results

Researchers asked each participant to describe a time when the participant interacted with a patient who really needed some spiritual support or attention. Three patient-centered themes emerged: end-of-life issues, resolutions associated with guilt and hope, and increased need for attention. The overarching response was offering. Offering was defined as personal presence, praying, touching, holding a hand, or listening. Nurses who were unsure about how to respond to patients offered to contact pastoral care for support of the patient or the patient's family. One nurse observed, "The doctors don't stay there and talk to [the patient] for an extensive amount of time. They quickly just have the [end-of-life] discussion and leave. So, that's what you are there for, . . . [to] provide additional support." Regarding nurses' presence, other nurses found that patients needing spiritual support might "require more attention than others. . . . They need a little more love than somebody else."

Nurses made statements about a sense that something more than the technical aspect of their job was needed. When discussing a situation about a critical care patient, a nurse noted the following:

I feel like all of the end-of-life cases need some sort of spiritual being, . . . finally people come to that fact that they are mortal and that they are going to die and they feel like at some point then they need to make peace with a higher being of some religion or whatever even if they're not, quote unquote spiritual people. So, they end up in, you know, they are searching, I guess, for some sort of an answer as to what's gonna happen to either themselves or a loved one, um, when in fact, they do die.

When the interviewer asked, "So, as a nurse, how do you address that?" the nurse responded by saying the following:

Uh, open conversation I feel like is beneficial. To just to ask them how they are feeling, what's going on, um, how they're coping. I mean, we are lucky to have consults with spiritual priest or whatever you want to call them to come up and talk to families, but, I found that just being a presence, um, and giving them open opportunity to talk is the best way that I found to help them cope through a situation like that.

When discussing situations in which spiritual support was needed, several nurses spoke about experiences when their patients were seeking resolution at the end of life. Interfamily conflict over end-of-life decisions emerged as a common theme, with nurses sharing stories about patients who had made decisions to pursue comfort over aggressive treatment. One nurse shared an experience of a patient who felt he was ready to decline further aggressive intervention and move on to comfort care.

His mother disagreed with his decision and caused him so much guilt and he was unable to take the steps he desired.

When nurses were asked to describe their personal definition of spirituality, 47% described a belief in a higher power, higher being, or God. Specifically, a nurse stated, "I believe that spirituality is just your relationship with a higher being; whatever it may be." Another said, "I feel spirituality is your relationship with God, . . . being able to talk to God, however you pray or however you do it."

Several nurses thought that spirituality was an extremely personal matter. One remarked, "I kind of think of it like pain. It's like whatever somebody says it is." Although some nurses did not make references to a higher being or God, many mentioned a higher power. One nurse stated, "I think it's your connection to your purpose and to whatever you feel is driving you for existence." Another nurse stated:

I think sometimes religious people are more spiritual. It seems like they just are more in touch with things but, I'm not religious, . . . when things are going bad I look to somebody to help me. Whether it be, like, God or, you know, my deceased relatives or something. Just somebody, like, give me strength to get me through something.

Interestingly, when speaking about the ambiguity of spirituality, a nurse stated, "I think everyone's definition would be completely different . . . I don't know. Like a background that no one can really explain."

Nurses were then asked the following question, How do you see the connection between religion and spirituality or do you feel like you have to be religious to be spiritual? All stated that they did not feel a person had to be religious to be spiritual; however, the majority of the nurses then referenced religion as a means to express spirituality. When discussing religion as it relates to spirituality, a nurse noted, "You know, it's more just a connection with people, and . . . making their experience better."

Interfamily conflict over end-of-life decisions emerged as a common theme.

Another nurse commented, "Religion . . . is more of a belief. Whereas, spirituality . . . is more of a feeling." Still another nurse stated, "I feel like religion is more of a set, a creed and structure and also a feeling of belonging to a people of the similar belief system and spirituality is your own internal connection."

When nurses were asked about their comfort level with providing spiritual care to critically ill patients, 75% expressed some degree of comfort. Nurses are ready to offer direct spiritual support if they sense it is needed but hesitate to initiate such support for fear that the offer will be interpreted as proselytizing and offensive to the patient or the patient's family. One nurse shared the following:

I'm not super comfortable just because everybody has their own beliefs and their own definition of spirituality and . . . it can encompass such a broad range of beliefs that it's hard to know what to say, or how to relate to the patient. . . . I don't want to say anything to offend anybody or make them feel uncomfortable.

Not knowing a patient's beliefs leads to discomfort. Nurses relied heavily on sensing cues from the patient or the patient's family and appeared to be

most comfortable with offering spiritual care when a patient or the patient's family asked for such care. If nurses did not sense the need for or the patient did not request spiritual care, they were hesitant to offer anything directly. Some nurses described providing spiritual care as being supportive through offering their

presence: holding a hand, listening, offering a hug. Nurses viewed the heavy demands of providing physical care as a barrier to taking time to provide spiritual care.

When asked what kind of education would be beneficial in improving their comfort with providing spiritual care to patients, some nurses mentioned formal classes in different religions, cultures, or spiritual values. Others suggested a reference guide on the unit that they could consult as needed, another example of the perception that religion is a means to expressing spirituality. Other nurses thought that formal class work might not be helpful because they would forget the details if they did not have a patient of a particular religion or culture until a much later date. Nurses described a need for learning how to start a conversation about spirituality, as well as knowing what the "rules" were so far as what was acceptable to initiate with the patients.

Of note, a few nurses were averse to spiritual education. One said, "Even if . . . I was educated on it, I still . . . wouldn't . . . I would just rather not, not be involved with it. . . . I'd feel more comfortable that way." Interestingly, this same nurse remarked, "I'm just a caring person. I'll care, but, I don't really like getting involved. . . . I'm not a religious person." This reply illustrates not only the need for education but also the need for defining spirituality as the term pertains to health care. Most likely, defining spirituality would be the first step in developing a framework for confident practice among nurses who are struggling to recognize their own spiritual competence. Nurses who are confident providing spiritual care recognize the need for education and support from more experienced mentors. A nurse who had practiced for 24 years stated, "I just think the nurses need to know it's OK . . . if the family is praying, you can stand there quietly and offer, show your support, you know, you don't have . . . to be afraid to let them know that . . . you do believe in something and . . . you're not just about the technical stuff."

Discussion

In this qualitative study, we explored critical care nurses' perceived needs in addressing spirituality in patients. The nurses in our sample identified the concept of spirituality with belief in a higher power. Although religion is not necessarily tied to spirituality, nurses noted that religion is often a means to express one's spirituality. Nurses respond to a patient's needs by offering themselves to provide direct support or by reaching out to others when they think they are not equipped to address the patient's needs. Our findings support existing evidence that nurses do not feel completely prepared or comfortable in attending to the spiritual aspect of patient care.^{2,11} The nurses in our study perceived a need for further education or readily available resources to assist them in providing culturally competent spiritual care.

Limitations of this study include the setting and demographics. The research was conducted in a single site at a large teaching hospital among nurses who provided care to patients with pulmonary, renal, or liver disease. Replicating this study in a surgical, cardiac, or neurological intensive care unit might not produce the same results.

Nurses were recruited from a purposeful cross-section of direct caregivers on the designated unit. Variability in ethnic background, sex, and nursing experience among the sample was limited. Therefore, our results may not be generalizable to the overall population of critical care nurses.

Nurses do not feel completely prepared or comfortable with the spiritual aspect of patient care.

Conclusion

Developing a definition of spirituality pertinent to health care is imperative to empower nurses who seek to give whole-person care to their patients. Governing agencies mandate spiritual assessment and interventions by health care providers; however, no accompanying framework to guide this practice is available.¹⁹ After interviews with the 30 intensive care nurses in our study, the following definition of spirituality was developed: That part of a person that gives meaning and purpose to the person's life. Belief in a higher power that may inspire hope, seek resolution, and transcend physical and conscious constraints.

Our findings from this phenomenological study provide a framework for creation of resources to support critical care nurses as they deliver care at the bedside. Additionally, the results provide the foundation for further research related to strategies for addressing spiritual needs of critically ill patients.

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FINANCIAL DISCLOSURES

None reported.

eLetters

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