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Spirituality, spiritual need, and spiritual care in aged care: What the literature says

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\textbf{ABSTRACT}

This article addressed the following questions: How are spirituality, spiritual need, and spiritual care in aged care defined? What constitutes spiritual care for older people in aged care? From an organisational perspective, what are barriers and enablers to providing spiritual care? Spirituality and spiritual care were defined in a variety of ways in the literature. The literature endorsed nurses and other aged care staff engaging in elements of spiritual care of older people as valuable. A whole-of-organisation approach is required rather than leaving it to the individual. New guidelines are being developed specifically for spiritual care in aged care.

\textbf{KEYWORDS}

Aged care; guidelines; organisational approach; spiritual care

\section*{Background}

Existential or spiritual concerns are of fundamental importance and are especially important for older people and those faced with their own mortality (Bruce, Schreiber, Petrovskaya, & Boston, 2011). Older people receiving aged care services in nursing homes or in the community may feel unable to express such existential or spiritual concerns during care, thereby creating a form of distress that can easily become a neglected component of their overall suffering and distress. For those providing care to older people, meeting spiritual needs can be considered lower priority than physical needs especially when health care resources are stretched or organisational demands are high.

Best practice increasingly identifies spiritual care as a component of care in general (International Council of Nurses, 2012; World Health Organization, 1998). However, up to now there has been little guidance on the provision of spiritual care with specific reference to aged care and no specific guidelines exist as yet for these care settings. In preparation for the development of Australian guidelines for use in aged care, we
reviewed the literature on spirituality, spiritual need and spiritual care for older people.

This article aimed to address the following questions through a descriptive and analytical summary of the literature:

1. How are spirituality, spiritual need, and spiritual care defined in the context of meeting the needs of older people receiving aged care?
2. What constitutes spiritual care and its elements for older people in aged care?
3. Within an organisational approach, what is needed in order to apply the elements of spiritual care?

**Method**

The literature on spirituality, spiritual need, and spiritual care covers a wide range of disciplines and approaches so in order to address the questions posed, a literature search strategy involved a number of steps and a wide range of databases including nursing, allied health, psychology, medical, business, and sociological data bases (see Figure 1). This approach yielded a large database of articles. After excluding papers not relevant to the research questions and duplications, a total of 335 relevant papers were selected for review and added to EndNote software. Searches were performed on keywords and research terms within EndNote to address the research questions and to create groups for the relevant sections of this review.

**Results**

The results of the literature search were categorised into descriptive definitions of key terms, and a more analytical review of the topics that addressed our second and third research questions. Each of these descriptive and analytical summaries are provided below.

**Definitions**

A significant gap was found in the literature for definitions of spirituality, spiritual need and spiritual care in the context of aged care. Nevertheless numerous definitions of these terms were found, and of those the following definitions appeared most relevant to aged care.

**Spirituality**

The following definition captures the main concepts used in the literature to define spirituality:
Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. (Puchalski, Vitillo, Hull, & Reller, 2014, p. 643)

Figure 1. Development of search strategy used to collect literature on spiritual care and spirituality in aged care.

Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred. (Puchalski, Vitillo, Hull, & Reller, 2014, p. 643)
Within various disciplines there was a documented lack of consistency of
definition of what was spirituality, what were the needs of various
groups, e.g., older people and people from different cultural back-
grounds, and what were the methods of providing spiritual assessments
and care (Timmins, Murphy, Neill, Begley, & Sheaf, 2015).

The following view of spirituality was offered by National Health Service
Scotland (2009):

Spirituality provides the higher level intelligence and wisdom which integrates
the emotional with the moral. It acts as a guide in integrating different aspects
of personality and ways of being and living. It is found in the integration of
several deep connections: the connection with one’s true and higher self; the
connection with society and especially with the poor, the deprived and under-
privileged; the connection with the world of nature and other life forms; and
for some, a connectedness with the transcendent. (p. 19)

**Spiritual need**

No papers were found that addressed a definition of spiritual need in older
people living in residential aged care or receiving home care.

Narayanasamy (1991) defined spiritual need in the following terms, which
seemed relevant to aged care settings:

- The need to give and receive love; the need to be understood; the need to
  be valued as a human being; the need for forgiveness, hope and trust; the
  need to explore beliefs and values; the need to express feelings honestly;
  the need to express faith or belief; the need to find meaning and purpose in
  life.

**Spiritual care**

Spiritual care occurs in a compassionate relationship and responds to a
person’s search for meaning, self-worth, and their need to express themselves
to a sensitive listener.

National Health Service Scotland (2009) offered the following definition of
spiritual care:

- … that care which recognises and responds to the needs of the human spirit when
  faced with trauma, ill health or sadness and can include the need for meaning, for
  self-worth, to express oneself, for faith support, perhaps for rites or prayer or
  sacrament, or simply for a sensitive listener. Spiritual care begins with encouraging
  human contact in compassionate relationship, and moves in whatever direction
  need requires. (p. 6)

The National Health Service Scotland (2002) differentiated between spiritual
care and religious care suggesting that “spiritual care is usually given in a one
to one relationship, is completely person-centred and makes no assumptions
about personal conviction or life orientation,” while in contrast, “religious care is given in the context of shared religious beliefs, values, liturgies and lifestyle of a faith community” (NHS Scotland, 2002, p. 6).

Spiritual care was not characterised in the literature as being just about religious beliefs and practices or about imposing one’s own beliefs and values on another, using one’s position to convert. Nor was spiritual care a specialist activity or the sole responsibility of the chaplain (Royal College of Nursing, 2011).

According to the National Health Service Scotland, spiritual care could be provided by all health care staff, by carers, families, and other patients.

**The elements of spiritual care in aged care**

In order to address the second research question, papers on spiritual care were categorised into the components or elements of spiritual care. In the literature a number of elements of spiritual care were described. The literature supported that it was important to provide an environment in which a person’s religious, spiritual, and cultural beliefs and values were safeguarded (Ramezani, Ahmadi, Mohammadi, & Kazemnejad, 2014).

**Spiritual assessment**

Assessment was a key element. The importance of spiritual assessment was widely affirmed in the literature (Baldacchino, 2010; Fitchett, 2012; MacKinlay, 2006). However, there was no agreement regarding definition, methodology, or domains to be assessed. One article identified six approaches to spiritual assessment (McSherry & Ross, 2010): direct method, indicator-based assessment, use of audit tools, value clarification, indirect methods, and acronym-based methods.

A number of tools for spiritual care assessment both for patients and families were identified (Oliver, Galiana, & Benito, 2015), including both quantitative and qualitative tools (Hodge & Horvath, 2011; Hodge, Horvath, Larkin, & Curl, 2012). There was general consensus that spiritual assessment should be carried out using a two-stage approach: initial spiritual screening and an in-depth spiritual assessment (Fitchett, 2012; MacKinlay, 2006; McSherry & Ross, 2013; Puchalski, 2012). The exploration of a person’s spirituality or their perspective would help to understand their sources of strength and hope and their spiritual needs (Ramezani et al., 2014).

**Trusting relationships**

In the literature a trusting relationship was considered to be another element of spiritual care. Such relationship develops slowly, taking months before
older persons would be ready to open up and talk about deeper issues present in their life (Wilkes, Cioffi, Fleming, & LeMiere, 2011). For older people, having someone other than a family member or a person living in the residential facility (perhaps a person in similar circumstances to themselves) was important to gain an outside perspective and to provide an outlet to share what was going on inside. In a trusting relationship an older person would be able to open-up and honestly disclose deeper thoughts and confide in the person providing spiritual care. From a practitioner’s point of view, each individual relationship would be built on the premise of being a companion on every step of a journey with an older person. It would incorporate spending time, being present, active listening, and passive responses and would see the practitioner contributing to the person’s life not only in conversation but in practical and in physical ways.

An example of a trusting relationship is found in an analysis of a chaplain’s journey with a terminally ill patient (Maddox, 2012). The chaplain sought to assess a person’s spiritual needs and over a period of time formed a relationship, built upon faithful companionship, that was essentially an intentional, authentic human relationship grounded in professional sacred intent (Schlauch, 1995).

From a nursing perspective, an important element of a trusting relationship is the concept of patient-centeredness. That is, seeing the person uniquely as an individual and having the ability to reflect upon this. Developing meaningful therapeutic relationships that instilled hope using spiritual, religious, and complementary therapies formed another attribute of a trusting relationship in spiritual care (Ramezani et al., 2014).

Other aspects of a relationship that is trusting included responding in a non-judgemental way and active listening (Ramezani et al., 2014).

**Support**

Support as an element of spiritual care could be on an individual or group basis. One paper that described supportive-affective group experiences for older persons with life-threatening illness focussed on spiritual and religious aspects of the illness experience and tested a psycho-sociospiritual intervention (Miller, Chibnall, Videen, & Duckro, 2005). Small groups of people with life-threatening illness met for 75 minutes monthly for 12 months and were facilitated by one or two staff with enabling, mediating, and motivating skills. Groups discussed immediate challenges, emotions, and spiritually challenging aspects of life-threatening illness. Therapy was more concerned with the process than about the content, offering people a chance to connect with self, others, and the transcendent. The study showed that supportive therapy
reduced depression symptoms, increased spiritual well-being, and reduced feelings of meaninglessness.

**Rituals**

Rituals are another element of spiritual care that could be beneficial for older people living with cognitive impairment or with dementia (Carr, Hicks-Moore, & Montgomery, 2011). MacKinlay and Trevitt (2010) discussed the importance of rituals in providing cues to older people and people living with dementia. Rituals provided patterns and symbols and could be as simple as familiar sights, or spaces (e.g., a church interior and/or the smell of wine or bread). For older people of a particular faith or community, the particular order of service and the materials used (e.g., silverware, candle lighting, order of prayer, and reading of scripture) hold significant importance, drawing them into a sacred space and immersing them in the deeper meaning of their faith and spirituality. To be effective, the ritual must be linked closely to the person’s own religious and or spiritual beliefs and needs.

**Compassion**

For some aged care staff another aspect of spiritual care involved engaging in deeply respectful, compassionate care that went beyond physical care alone and involved an intentional connection with the other person (Pfeiffer, Gober, & Taylor, 2014). In this study nurses were guided by four principles: (1) awaiting invitation to discuss spiritual matters; (2) giving care with a spiritual part of oneself that provided a spiritual connection with the other person; (3) being attentive in care; and (4) allowing reciprocity in the relationship.

**Prayer**

Prayer is an obvious element of spiritual care. To connect with faith and faith in God during spiritual care, prayer (e.g., group prayer, intercessory prayer) has been found to offer a sense of strength and comfort for older people living with dementia (Carr et al., 2011; MacKinlay & Trevitt, 2010). Evidence for the impact of spiritual prayer-based interventions is inconclusive, but some practitioners and patients believed that prayer-based interventions by nurses may produce benefits for both nurses and those being cared for (Narayanasamy & Narayanasamy, 2008). The literature suggested that for practitioners—other than those religious and spiritual care professionals—engaging in prayer may appear to have use in a health paradigm that incorporated religious and spiritual care (Christiansen, 2008). Caution was emphasised in interpreting the results of numerous articles and studies that suggested that prayer had an impact on health.
Reading scripture

Another element of spiritual care identified was reading scripture. Through reading scripture and the Bible (or equivalent), some older people remain connected to their faith and faith in God and are given strength and comfort (Carr et al., 2011). For example, some older African American Christians found guidance in how to respond to stressful life events (such as serious illness, death of loved ones, and mental illness) through reading the scriptures contained in The Bible (Hamilton, Moore, Johnson, & Koenig, 2013). Allowing aged care residents access to the scriptures or providing meaningful passages of scripture in older persons’ rooms could assist in managing anxiety, depression, stressful situations, and crisis situations and contribute to spiritual care. Prayer forms an important intervention for the chaplain and knowing when and how to pray with a person was considered in the literature to often be more important than just engaging in prayer as a routine (Maddox, 2012).

Reminiscence

Spiritual reminiscence was also considered an element of spiritual care and an important component of seeking meaning in later life and in navigating the latter stages of life’s journey (MacKinlay & Trevitt, 2010). Reminiscence was considered to contribute to developing a greater sense of meaning in older age and a sense of resilience rather than fear. Reminiscence could be incorporated as part of a group experience in an aged care facility (other than attending church) or could become part of an individual’s later life journey through self-directed or facilitated exploration. Allowing people time to access and recount their narrative has potential to assist people toward finding meaning in their lives. Adding a period of reminiscence to group meetings could provide avenues for group members to examine meaning in their life and to discuss spiritual growth, strategies for spiritual growth, and to facilitate spiritual growth.

Story telling

Telling stories and the use of narrative was considered a possible element of spiritual care in the literature to have the potential to affect individuals’ well-being and their ability to navigate change in their lives. In contrast to the act of making statements containing facts about one’s condition, the act of telling one’s story or replying to a question with a narrative has the ability to allow the storyteller to impart a great deal of meaning and express fears in a safe way. The use of narrative was contingent upon the listener allowing time and being intentional and present during the telling. Through the story, both the narrator and the listener could potentially gain a greater understanding of the issues or situation surrounding the storyteller (Southall, 2011).
**Connectedness**

Making connections with older people was considered in the literature to be another component of spiritual care, by getting to know them, being present with them, understanding what was sacred to them, and helping them to connect with what was sacred to them or important in terms their faith or religion (Carr et al., 2011).

**Generating a sense of hope**

Generating a “sense of hope” was another element of spiritual care. Chaplains engage in a process of being accepted by individuals to accompany them through illness and at the end of life, becoming a companion prepared to stay with the person, sharing their experience and giving them strength and hope through their presence (Nolan, 2011). In this way, by being with people the potential exists for people to generate a sense of hope in not what would be their future but hope in the present and in their connectedness with others. In spiritual care, a hopeful presence can assist those in grief or in illness or at the end of life to move from what might be a loss of hope, or a redundant hope and to reconfigure their hope. Stuart (2010) suggested that as a caregiver, holding another person’s hope in one’s hands during times when the person was unwell or in difficulty and unable to find hope was an essential ingredient of caring for a person spiritually and assisting them toward recovery.

**Mindfulness and meditation**

Mindfulness training with a skilled practitioner has been considered in the literature to have the potential to enhance the experience of old age (Nilsson, 2014). Engaging in mindfulness techniques, e.g., physical mindfulness (yoga, Tai Chi), mental mindfulness (meditation), existential mindfulness (resilience) and social mindfulness (cultivating empathy and compassion) has the potential to transform the experience of the older person from an illness experience to a wellness experience. Aligned with Buddhist philosophy, the practice of mindfulness techniques over the lifespan has been shown to have beneficial health-giving effects (Gregory, 2012; Nilsson, 2014). For example, mindfulness meditation as part of a multicomponent spiritual care intervention has been shown to contribute to improved outcomes for community-dwelling adults with cardiac disease (Delaney, Barrere, & Helming, 2011). Mindfulness techniques mentored by a skilled practitioner are well within the reach and scope of learning for older people living in residential aged care facilities and in the community.

Meditation was considered to be an element of spiritual care in some papers. Two randomised controlled trials on adults with terminal disease studied the effects of meditation delivered by a qualified instructor and defined as involving an induced state of consciousness and delving into
self-realisation or meaning (Candy et al., 2012). The results found that meditation alone had no effect on well-being or quality of life. However, when combined with massage, reduced quality of life was prevented (Morgan, 2015).

A spirituality-based intervention piloted a combination of meditation techniques (Mindfulness/Self-Discovery Meditation, Relationship Meditation and Eco-Awareness Meditation) and led to a significant improvement on quality of life (Delaney et al., 2011).

**Applying spiritual care and its elements in holistic aged care nursing**

Considering the body of literature collected here, articles on spiritual care in aged care often focussed specifically on the need for nurses to incorporate spirituality and spiritual care into their practice, more-so than was found in other professions (apart from pastoral care specialists). The literature highlighted the need for spiritual care to be led by the staff member in a “person-centred” way emphasising the need to find the right balance in spiritual care between the “art” (self-awareness, sensitivity, communication, and person-centred) and the “science” (work in process, evidence, indicators, and outcomes; McSherry & Ross, 2010). A swing too far in favour of the “art” would likely lack rigour; and if the balance swayed too far in favour of “science,” it would potentially lack humanity.

**Enablers and barriers to applying spiritual care in aged care**

An earlier review sought to understand the enablers and barriers for incorporating spirituality into nursing practice in general and this review seemed particularly relevant to aged care (Tiew & Creedy, 2010). The results demonstrated five recurring themes affecting nurses’ delivery of spiritual care: (1) organisational and cultural factors; (2) lack of emphasis on spirituality in nursing education; (3) nurses understanding of spirituality; (4) attitudes; and (5) individuality.

Nursing literature also highlighted the impact that organisational cutbacks had created on nurses’ ability to provide spiritual care, including in aged care. As a result of nursing professional practice being embedded within a prevalent reductionist paradigm, nurses contended that they are faced with increasingly intensive and complex patient care situations and with significant workload increases (Carr, 2010). There is a large amount of literature on the impact of workload on burnout, compassion fatigue, and nursing which is relevant to the provision of complex spiritual care by aged care staff (Sanso et al., 2015).

The literature suggested that increased workloads lead to an inability to complete set tasks, leaving staff feeling that they are unable to meet the needs of their patients, therefore contributing to a sense of moral failure (Sanso et al., 2015). In a time-driven arena where staff are often faced with working
overtime to meet expectations, there is little or no time to meet the spiritual or existential needs of the very sick older person experiencing loneliness, anxiety, or distress. Other factors that directly impacted staff ability to participate in spiritual care include growing expectations to do more within the time available.

Other issues affecting staff ability to contribute to spiritual care included negative attitudes of peers toward spiritual care, suboptimal support from colleagues and executive officers, a lack of equipoise between effort and reward, limited access and support for professional development, increased job-related stress and strain, workplace abuse, and a general lack of respect within the health care system (Carr, 2010).

One review highlighted that it was essential for care-providers to attend to their own health and well-being and their own spiritual health (Tiew & Creedy, 2010). The literature identified a strong relationship between staff’s own spirituality, spiritual well-being, and sense of self and their ability to understand, practice, and provide effective sensitive spiritual care for others (Chang & Johnson, 2008). For example, nurses that either followed a particular religion or those with no religious affiliation but who engaged in prayer, meditation, or who read religious materials were more likely to have positive attitudes toward spiritual care (Tiew & Creedy, 2010).

Numerous studies on nurses’ attitudes toward spirituality have revealed a positive relationship between spiritual education and nurses’ spiritual awareness and spiritual care practice (Tiew & Creedy, 2010). However, evidence suggested that nursing textbooks and undergraduate nursing education did not provide adequate guidance in this field (McSherry, 2006a).

Four internal barriers to the provision of spiritual care have been identified: (1) the inability to communicate due to sensory loss, language problems, or cognitive impairments in patients; (2) lack of knowledge in assessing spiritual needs; (3) pluralism amongst nursing home staff, i.e., aligning spirituality with religiosity, resulting in reduced involvement or engagement; (4) emotional demand, particularly when staff repeatedly faced bereavement of residents (McSherry, 2006b). The provision of appropriate education for staff to encourage and raise spiritual awareness and confidence in discussing spiritual matters could overcome many of these barriers.

From this same perspective, external or organisational barriers to the provision of spiritual care were identified, which are particularly pertinent to aged care (McSherry, 2006b). The first barrier was the attitude of management and the organisation itself to spiritual care. It is very hard for staff who want to participate in and provide spiritual care when this is not supported by the organisation. The second external barrier identified was environmental distractions resulting in loss of privacy. This is particularly the case with shared rooms. The third constraint was the economics of staff time. When
there is a great deal of pressure to complete tasks within their shift, staff are reluctant to spend time with one resident because they are conscious of other residents wanting attention, and conscious of meeting task performance expectations. The fourth external barrier was the lack of recognition of spiritual issues in vocational and tertiary education. In nursing, emphasis on the scientific and technical would need to shift to a more holistic model of care. The fifth external barrier related to acute hospital episodes. Residents admitted to hospital for illness or surgery could potentially have increased thoughts or concerns about spirituality and want to talk to someone when returning home or to care but there is not capacity to do so among staff.

**Discussion**

We collected and reviewed the literature on definitions of spirituality, spiritual need, and spiritual care in aged care settings, what elements can be identified, and what organisational or external barriers mitigate against spiritual care in aged care. We found many definitions of spiritual care and spirituality in the literature, but none specifically for aged care. The topics of spirituality and spiritual care cross a number of disciplines and we found a diverse collection of literature. However, a large body of literature focused on how nurses can help with spiritual care. The results showed that much of the literature did not follow a standard scientific paradigm, but included both “art” and “science” perspectives. The literature summarised here indicates that although individual staff, including nurses, are responsible for incorporating spiritual care in their practice, a whole-of-organisation approach may be required to support and maintain good practice rather than expecting individual staff to bear responsibility for incorporating spiritual care.

Although the need for effective spiritual support is recognised amongst many providers of residential and home care services, strategic implementation has remained elusive to date, suggesting that the aged care industry needs more guidance on how to provide spiritual support. Numerous studies have identified a lack of confidence in providing spiritual care within the workforce (Baldacchino, 2008; Fenwick & Brayne, 2011). From these findings, we aim to fill a gap in practical guidance about spiritual care by developing guidelines specifically designed for these settings.

Looking forward, an organisational approach may need to be adopted to meet older people’s need for spiritual support in aged care. Spiritual care can be provided well by team members with varying backgrounds (Daalman, Usher, Williams, Rawlings, & Hanson, 2008). In terms of a whole of organisation approach, Hudson and Richmond (2000) considered that the entire team had a role in the spiritual care of residents, and argued that leaving spirituality to the chaplain (or the nurse) was not caring for the whole person.
Spirituality may arise initially from experience then move on to cognitive or more analytical thoughts although it is outside the scope of this literature review to expand on the origins of spirituality. Future guidelines for the provision of spiritual care in aged care will assist aged care communities to attend to and explore their spirituality. It will require a holistic, organisational approach that can support the needs of individuals receiving care as well as facilitating spiritual awareness among health professionals.

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**References**


