SPIRITUAL CARE

Spiritual Care – how does it work?

Eckhard Frick sj
Psychiatrist and Psychoanalyst

Berne: European Conference on Religion, Spirituality and Health, May 17th 2012

www.spiritualcare.de

The matter of spiritual care of patients

WHEN I am dying — if it's in a hospital — I hope that all concerned are interested in more than my body. I hope the nurse is understanding and sympathetic; that she doesn't bother me too much but sees to it that a priest is there; that meanwhile she helps me make a short act of trust in God and resignation to His Will and sorrow for my sins, not indeed with lugubrious solemnity but sincerely, naturally, confidently. I hope the interns and residents will not lose interest in me as a human

Gerald H. FitzGibbon, S.J.

This article is an address substantially as given in April at the annual convention of the Mid-West Hospital Association in Kansas City, Mo.

4. There is such a thing as being a success in the eyes of men, but a failure in the business of life itself, that is, in getting to heaven.

5. The most important moment in life is the moment of death. If I am in God's friendship at that moment, all will be eternally well; if I have deliberately turned my back on God by going against my conscience in a serious matter, He my Creator can only wait until I His creature reverse my position and turn back to Him.

FitzGibbon s.j. GH (1951): The matter of spiritual care of patients. Health Prog 32:266-267

The hospitalized patient may be afraid...

- "that my every bodily need is cared for indeed, but nobody cares about me"...
- About the nurse: "where lack of knowledge or alertness in her part may mean the loss of a soul. If a nursing practice procedure is mishandled, the worst can happen is that the patient dies; if a spiritual care procedure is missed, it can mean the eternal death of the soul. Hence - neglect of thorough instruction of the nurse in spiritual care procedures by those in authority is no less than criminal".

- FitzGibbon s.j. GH (1951): The matter of spiritual care of patients. Health Prog 32:266-267.

LMU LUDWIG-MAXIMILIANS-UNIVERSITÄT MÜNCHEN

HOW TO SUPPLY STAFF MEMBERS WITH MEANS TO FURTHER THE ETERNAL INTERESTS OF THE SICK AND DYING

At each chart desk —

One. (posted permanently as standard procedure)
"Spiritual FIRST AID Procedures" — folder obtainable from The Queen's Work (St. Louis, Mo.)*

Two. (handy for reference)
"ROUTINE SIRIPTUAL CARE Procedures"— 24-page booklet (formely 8 pp. in mimeographed form) obtainable from The Catholic Hospital Association (St. Louis, Mo.)**

Three. (supply of)
"My Daily Prayer" — in card form, available in 22 languages and in Braille at any of the sources indicated below.***

Four. (supply of)
"Prayer for Use by Critically Ill Children" — in card form, obtainable from The Queen's Work.*

Nurses especially and all who come in contact with the patient, e.g., interns, doctors, aides —

One. Should be given copies of:
"Spiritual FIRST AID Procedures"
"ROUTINE SPIRITUAL CARE Procedures"
} **and be instructed in their contents**

Two. Should carry with them while on duty copies of:
"My Daily Prayer"
"Prayer for Use by Critically Ill Children"
} and understand their use and valuoe

In the Nursing Service Office, a never failing supply of —

One. "Spiritual FIRST AID Procedure" (folder)

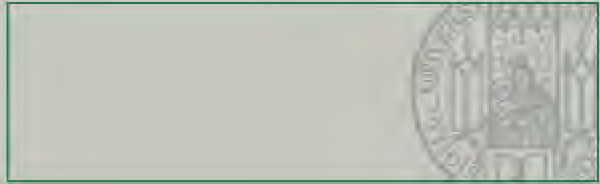
Two. "ROUTINE SPIRITUAL CARE Procedures" (booklet)

Three. "My Daily Prayer" (in card form) (including a complete set in foreign languages and in Braille)

Four. "Prayer for Use by Critically Ill Children" (in card form)

} with a published notice of their availablity on request.

The above suggestions are not mere theory. They serve as a checklist for examination (of conscience) on the means taken to save souls in the hospital. It is surprising how many souls will be saved by this simple means — what loss will result when it is nealected or even postponed.



Basic and specialised competencies

KEYWORDS

1. Definition
2. The secular age of authenticity
3. Spiritual plurality
4. Struggle
5. spiritus contra spiritum
6. purposelessness
7. Beyond aims
8. Context
9. Providers
10. The European situation
11. Evidence Based Medicine
12. Discernment

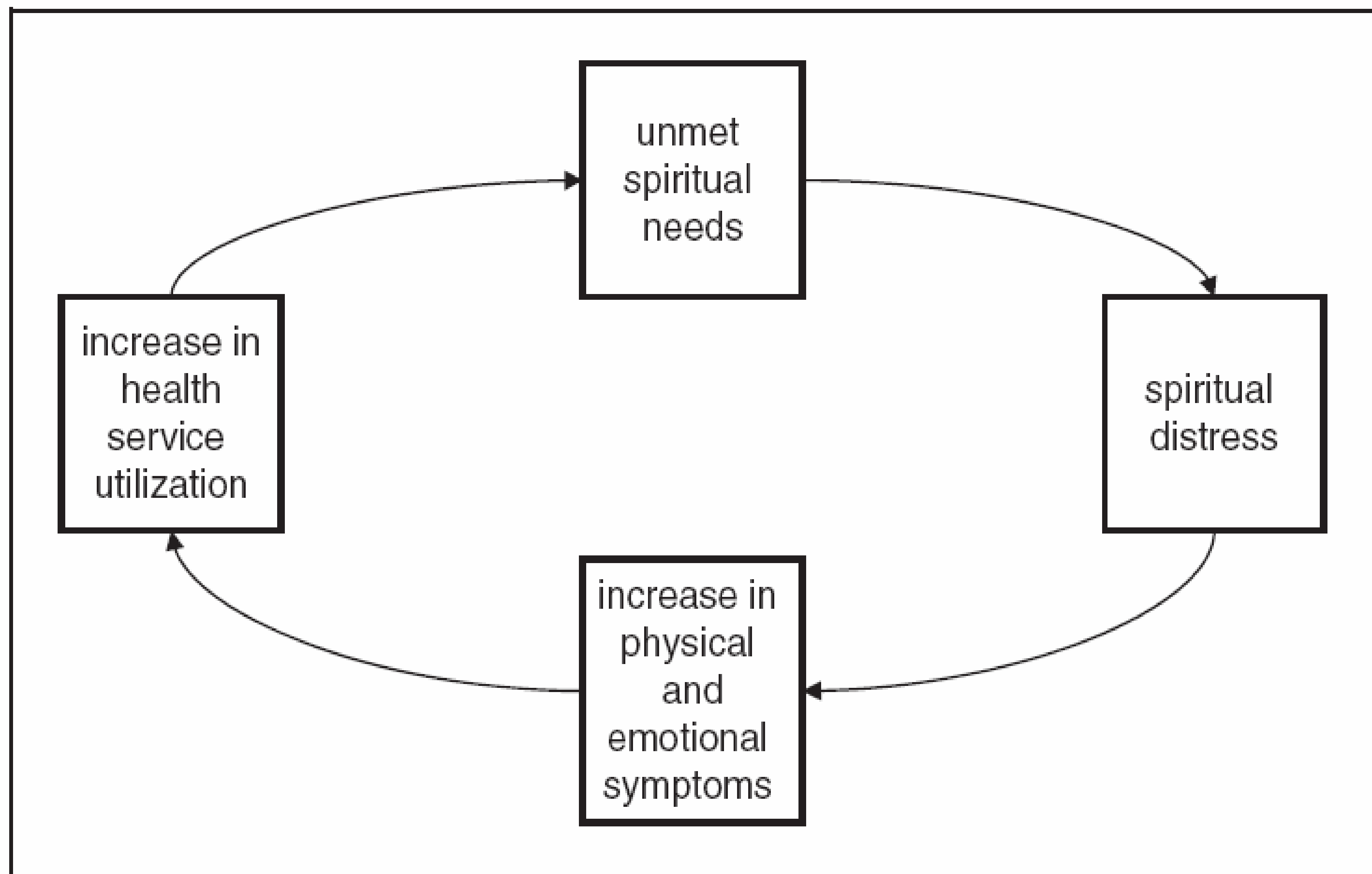


Figure 4. Possible effects of unmet spiritual needs. (Adapted from Grant et al.[49]).

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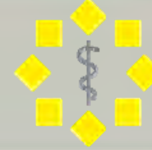

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„Geist“

“It indicates passion, fire, etc. It is related to the Germanic word ‘us-gaisjan’, to induce an emotional condition, to get someone out of himself. As we say in Swiss German ‘ ‘s isch zum Ufgeischte’, meaning that a situation or person has become intolerable. This corresponds to the English word aghast”

(Jung 1940: 93).

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Jung to to William Griffith Wilson (January 30th 1961)

- “You see, "alcohol" in Latin is "spiritus" and you use the same word for the highest religious experience as well as for the most depraving poison. The helpful formula therefore is: *spiritus contra spiritum*”.

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H.G. Koenig 2008: 172-173

"Even if religious involvement were completely unrelated to physical health and medical outcomes, however, integrating spirituality into patient care should still be a priority. Because so many medical patients have spiritual needs, spiritual conflicts, or derive comfort from religious beliefs and traditions, this makes a strong argument for training health professionals to assess, respect, and make accommodations for patients' spiritual beliefs and practices. It also emphasizes the importance of having strong Pastoral Care Departments in hospitals to ensure that someone meets the spiritual needs of patients in a way that is sensitive and culturally appropriate".

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Koenig *J Rel Health* 2012

"If people use religion for the primary purpose of achieving certain health goals, then this is a misuse of religion for non-religious goals and could ultimately lead to disillusionment and the abandonment of religion".

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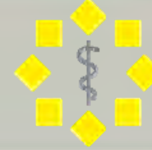
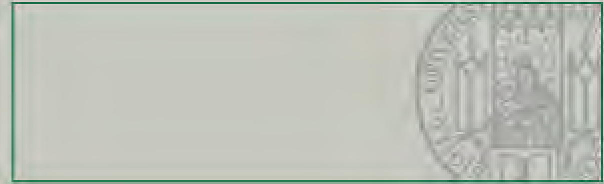
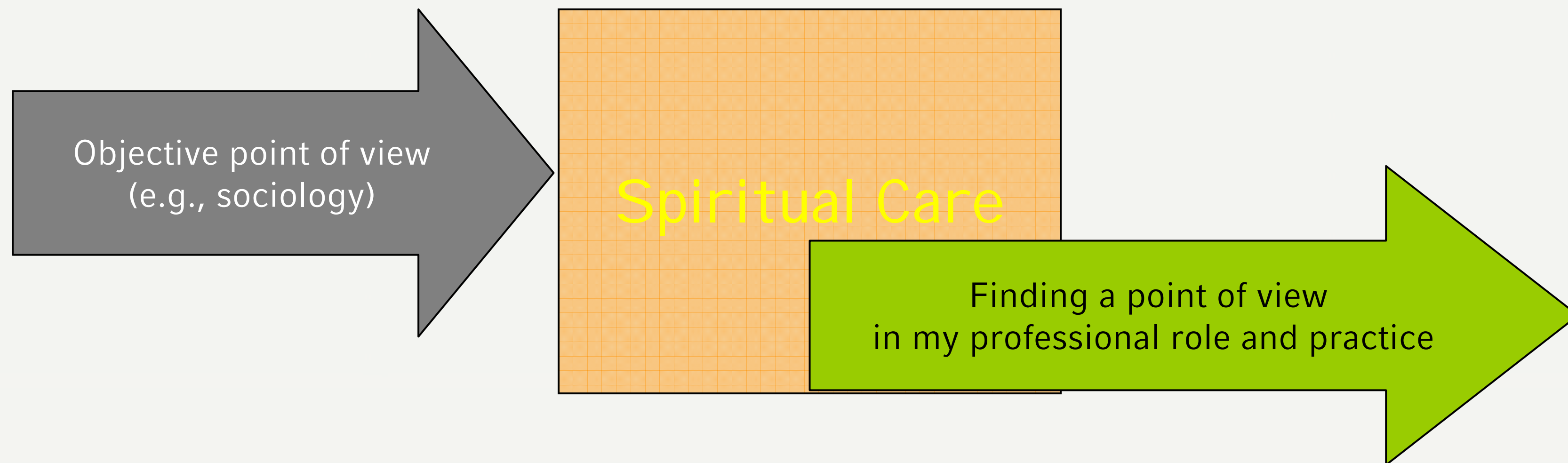





Objective point of view
(e.g., sociology)
Spiritual Care
Finding a point of view
in my professional role and practice

Monod et al. BMC Geriatrics 2010, 10:88
http://www.biomedcentral.com/1471-2318/10/88

BMC Geriatrics

RESEARCH ARTICLE Open Access

The spiritual distress assessment tool: an instrument to assess spiritual distress in hospitalised elderly persons

Stefanie M Monod[1*], Etienne Rochat[1,2], Christophe J Büla[1], Guy Jobin[3], Estelle Martin[1], Brenda Spencer[4]

Abstract

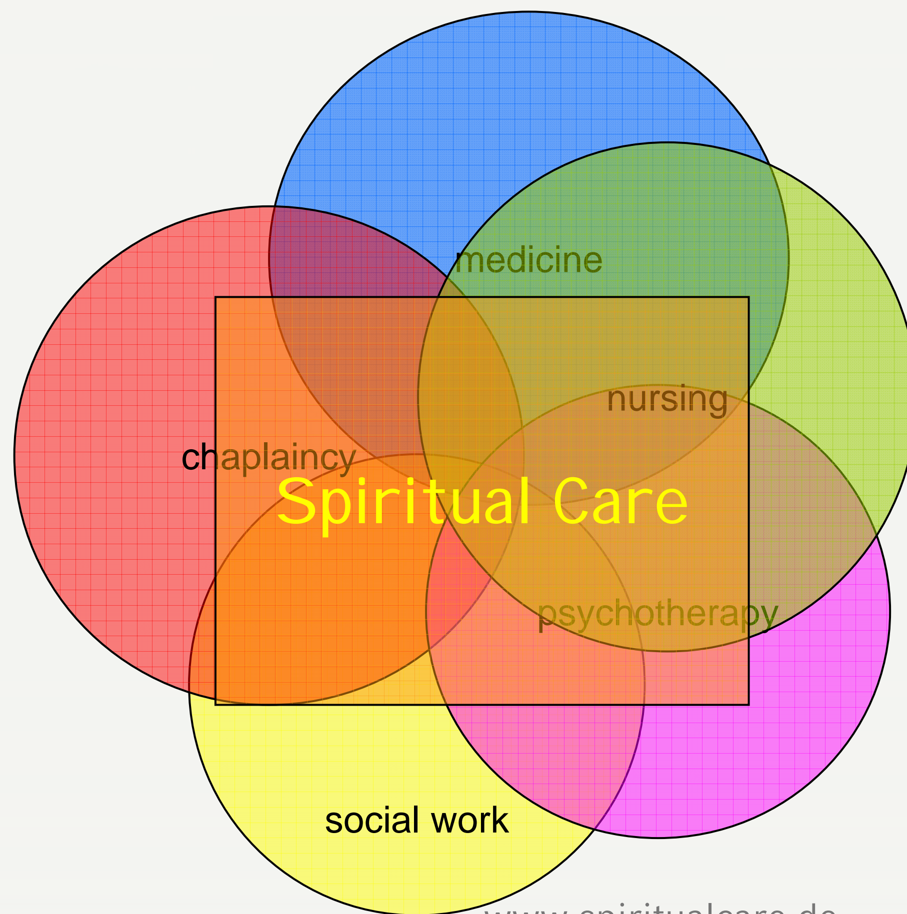
Background: Although spirituality is usually considered a positive resource for coping with illness, spiritual distress may have a negative influence on health outcomes. Tools are needed to identify spiritual distress in clinical practice and subsequently address identified needs. This study describes the first steps in the development of a clinically acceptable instrument to assess spiritual distress in hospitalized elderly patients.

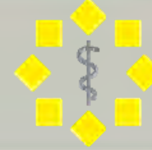
Methods: A three-step process was used to develop the Spiritual Distress Assessment Tool (SDAT): 1) Conceptualisation by a multidisciplinary group of a model (Spiritual Needs Model) to define the different dimensions characterizing a patient's spirituality and their corresponding needs; 2) Operationalisation of the Spiritual Needs Model within geriatric hospital care leading to a set of questions (SDAT) investigating needs related to each of the defined dimensions; 3) Qualitative assessment of the instrument's acceptability and face validity in hospital chaplains.

Results: Four dimensions of spirituality (Meaning, Transcendence, Values, and Psychosocial Identity) and their corresponding needs were defined. A formalised assessment procedure to both identify and subsequently score unmet spiritual needs and spiritual distress was developed. Face validity and acceptability in clinical practice were confirmed by chaplains involved in the focus groups.

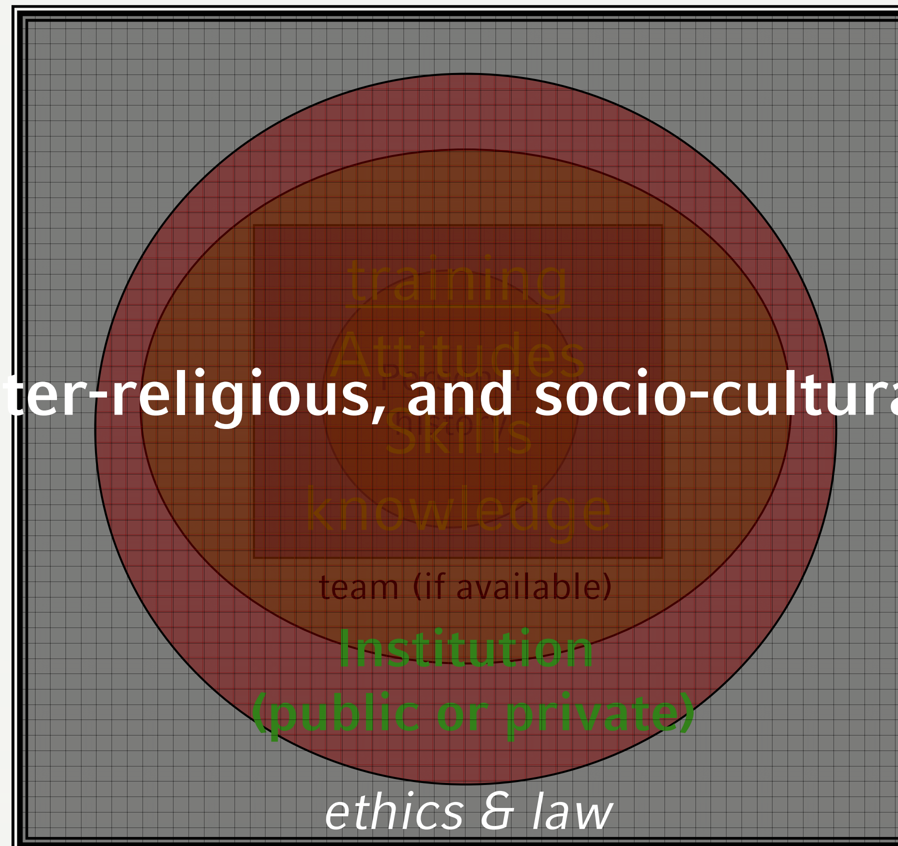
Conclusions: The SDAT appears to be a clinically acceptable instrument to assess spiritual distress in elderly hospitalised persons. Studies are ongoing to investigate the psychometric properties of the instrument and to assess its potential to serve as a basis for integrating the spiritual dimension in the patient's plan of care.

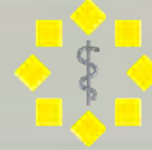
Spiritual Care is an overlap of health-care professions...





... and of several contexts:





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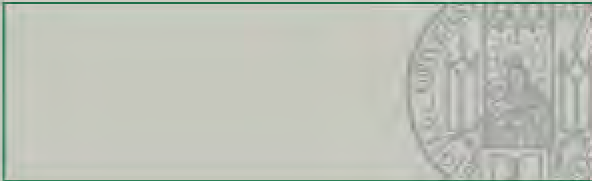
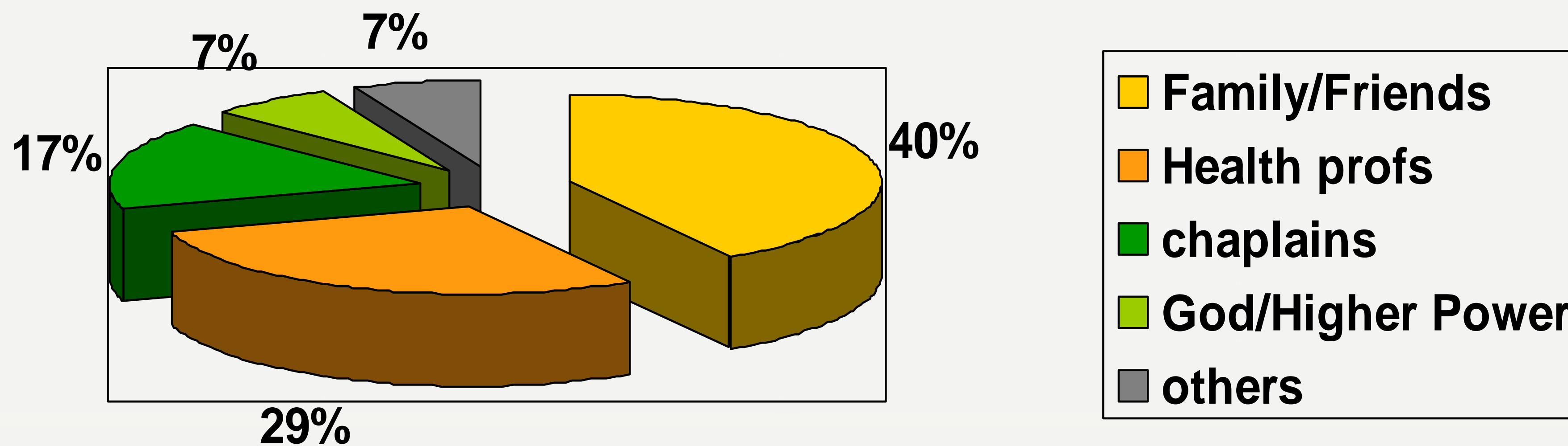


Hanson et al.: Providers and types of spiritual care during serious illness (*J Pall Med* 2008)



tion coefficients to examine bivariate associations between satisfaction and perceived value of spiritual care, and the characteristics of the spiritual care providers and types of spiritual care. All analyses were conducted using SPSS software, Version 15 (SPSS Inc., Chicago, IL).

RESULTS

We identified 125 potentially eligible patients or family recipients of spiritual care. Of these, 103 (82%) agreed to participate, including 38 seriously ill patients and 65 family caregivers for seriously ill patients. (Table 1). Recipients' ages ranged from 34–98, and patients were significantly older than family caregivers (72.9 versus 61.1 years, $p < 0.001$). They had relatively high educational attainment with 45% achieving college graduation. One in five recipients screened positive for depression. Religious affiliation, when present, was predominantly Protestant (69%), and 14% of recipients described themselves as having no religious affiliation. One third of recipients described themselves as very religious, and 41% described themselves as very spiritual. All reported they had received some form of spiritual care, and half of these reported three or more people who provided them with spiritual care.

Table 2. Spiritual Care Providers

Characteristic	n = *237 (%)*
Age	
18–24	1 (0.4)
25–40	45 (19.7)
41–55	98 (43.0)
56–70	53 (23.2)
71–85	16 (7.0)
Not applicable ("God/higher power")	15 (6.6)
Race	
African American/Black	38 (18.4)
Non-Hispanic White	159 (77.2)
Other	9 (4.3)
Female	121 (52.0)
Shares your faith tradition	135 (62.8)
How often visit/talk	
Less than once a month or less	23 (10.8)
At least once monthly	11 (5.2)
At least once weekly	73 (34.4)
At least once a day or more	105 (49.5)
Relationship to patient	
Family or friends	95 (41.2)
Clergy	38 (16.6)
Health care provider	66 (28.8)
God/higher power	15 (6.6)
Other	15 (6.6)

Actual sample size ranges between 236 and 206 due to missing data and the exclusion "God/higher power" from age, race, and gender categories.

Undergraduate teaching in spirituality

Wasner M et al (2008) Dt Ärztbl 105(13), A674-5

- Students in LMU medical school, compulsory seminar ‚Introduction to Palliative Care – Psychosocial Aspects, Spirituality, Grief‘ (6 hrs.)
- n=845
- Evaluation before and after the course, and 1.5 years later

- Significant improvement in all aspects, especially *skills* and *attitude* ($p < 0.001$)

spirituality

Wasner M et al (2008) Dt Ärztbl 105(13), A674-5

Edwards et al. *Pall Med* 2010: The understanding of spirituality and the potential role of spiritual care in end-of-life and palliative cre: a meta-study of qualitative research

- 11 patient (N=178) & 8 healthcare providers (N=116) studies
- Oncology
- Relational spirituality
- ‚spirit-to-spirit' framework
- The way physical care is given → presence, journeying together, reciprocal sharing...
- Family caregivers
- Barriers & facilitators

Edwards et al. 2010: Facilitators / barriers to spiritual care

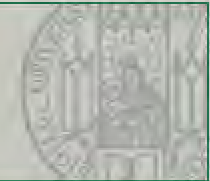
- Time and timing
- Friendly spiritual environment
- Reflection, education, training, willingness
- Vocation, calling, experience
- Awareness of one‘s own spirituality / reciprocal sharing
- Team support
- Assessment / documentation

Vermandere et al. *Br J Gen Practice* 2011

- Research questions:

(a) What are the barriers and the facilitating factors that GPs experience in assessing the need for spiritual care and in providing spiritual care?

(b) What are the views of GPs about their role in spiritual care?



Vermandere et al. *Br J Gen Practice* 2011

- Research questions:

(a) What are the barriers and the facilitating factors that GPs experience in assessing the need for spiritual care and in providing spiritual care?

(b) What are the views of GPs about their role in spiritual care?

Vermandere et al. *Br J Gen Practice* 2011: facilitating factors

Physician factors	Patient factors	Contextual factors
• Communicating a willingness to engage in (and have time for) spiritual discussions • Good communication techniques (such as friendly body language) • Assuring patients that spiritual confidences will be received in a non-judgemental fashion • Patient-centred approach • Taking care not to abuse their position • A diplomatic approach when the spiritual beliefs of the physician and patient differ • Physicians being more spiritually inclined	• Patient being 'the right sort of person' • Patients visiting the physician frequently • High degree of physician–patient cultural concordance	• Visiting patients at the bedside or at home • Co-workers reinforcing the GP's role as a spiritual care giver

Vermandere et al. *Br J Gen Practice* 2011

assessment

Barriers	Physician factors	Patient factors	Contextual factors
	• Feeling uncertain initiating spiritual discussions • Fear that patients will misinterpret spiritual discussions as pushing religion • Concern about invasion of patients' privacy • Fear of causing discomfort • Struggle with the spiritual language • Thinking that spiritual issues have lower priority than other medical concerns • Belief that spiritual discussions will not influence patients' lives • Lack of physician spiritual awareness • Different belief systems between physician and patient	• Patient being the 'wrong sort of person' • Time as a limiting factor • Setting (for example, the examination room) • Lack of discussion of the role of spirituality among care providers • Lack of continuity of managed care	• Lack of formal training and appropriate strategies

Slort et al. *Pall Med* 2011: Perceived barriers and facilitators for gp-patient communication in palliative care: A systematic review

- 15 qualitative, 7 quantitative studies
- Barriers: GPs‘ lack of availability; pts‘ & GPs‘ ambivalence to discuss ‚bad prognosis‘
- Facilitators: GPs being available, initiating discussion about several EoL issues, anticipating various scenarios

Slort et al. *Pall Med* 2011: Perceived barriers and facilitators for gp-patient communication in palliative care: A systematic review

At patient level, process barriers & facilitator related to various topics:

- Barriers: unwillingness to talk about spiritual issues or about euthanasia.
- the only facilitator related to topics was a patient's belief in the afterlife.

Slort et al. *Pall Med* 2011: Perceived barriers and facilitators for gp-patient communication in palliative care: A systematic review

At GP level, process barriers & facilitators related to various topics

- barriers: some GPs did not discuss their own mistakes (e.g. delay in diagnosis or referral), the spiritual concerns of their patients and euthanasia.
- facilitators: willingness to talk about diagnosis and prognosis, preparation for death, the patient's emotional, social and spiritual issues and the patient's end-of-life preferences.

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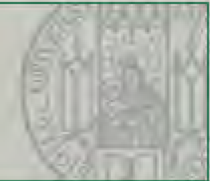
NICE Guidance for supportive care for adult cancer patients (2004 UK) – spiritual care ch.7

- All patients / carers receive support they desire within an integrated care approach
- All health & social care professionals acknowledge issues of spiritual significance and respond in flexible, non-judgemental way
- Spiritual needs of staff are recognised in palliative care



Spiritual care

- Proactive
- Neutral
- Benevolant
- Non-intrusive
- respectful

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Huguelet et al. (2011): A randomized trial of spiritual assessment of outpatients with schizophrenia: patients' and clinicians' experience. Psychiatric Services 62:79-86

- RCT: proactively taking a spiritual history vs. reacting to the patient‘s desire
- Prospective longitudinal design (2 measures)
- Assessment training for psychiatrists

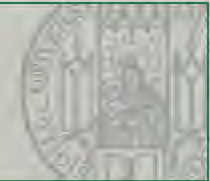
Do the patients whish to speak with their psychiatrist about religion and spirituality?

Table 2

Patients' responses at two time points to a question about whether they wished to speak with their psychiatrist about religion and spirituality, by treatment group[a]

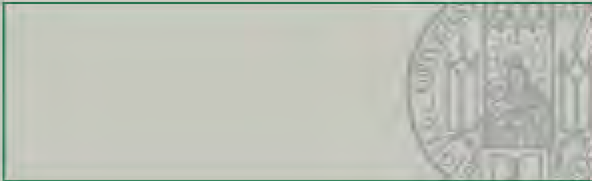
Time point and response	Spiritual assessment group (N=40)		Control group (N=38)	
	N	%	N	%
At baseline				
Not at all or a little	19	48	20	54
Average	10	26	6	16
A lot or totally	10	26	11	30
At 3-month follow-up[b]				
Not at all or a little	20	51	26	70
Average	7	18	7	19
A lot or totally	12	31	4	11*

[a] Data were missing for one person in each group.
[b] Wilcoxon rank test=–1.96, $p<.05$, for the difference between treatment groups
*$p<.02$, Wilcoxon paired-rank test=–2.41



Balboni, Balboni et al.: *Cancer* 2011: Support of cancer patients' spiritual needs and associations with medical care costs at the end of life

- 339 Pat. suffering from advanced cancer
- prospective, multi-centre study
- Patients satisfied with spiritual care vs. not satisfied patients
- Comparison of costs for ICU,ventilation, etc.

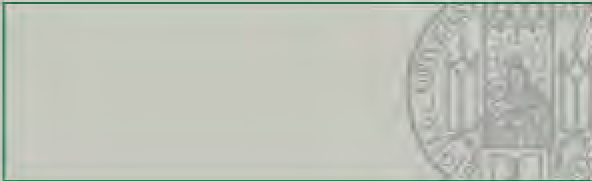


Balboni, Balboni et al.: *Cancer* 2011

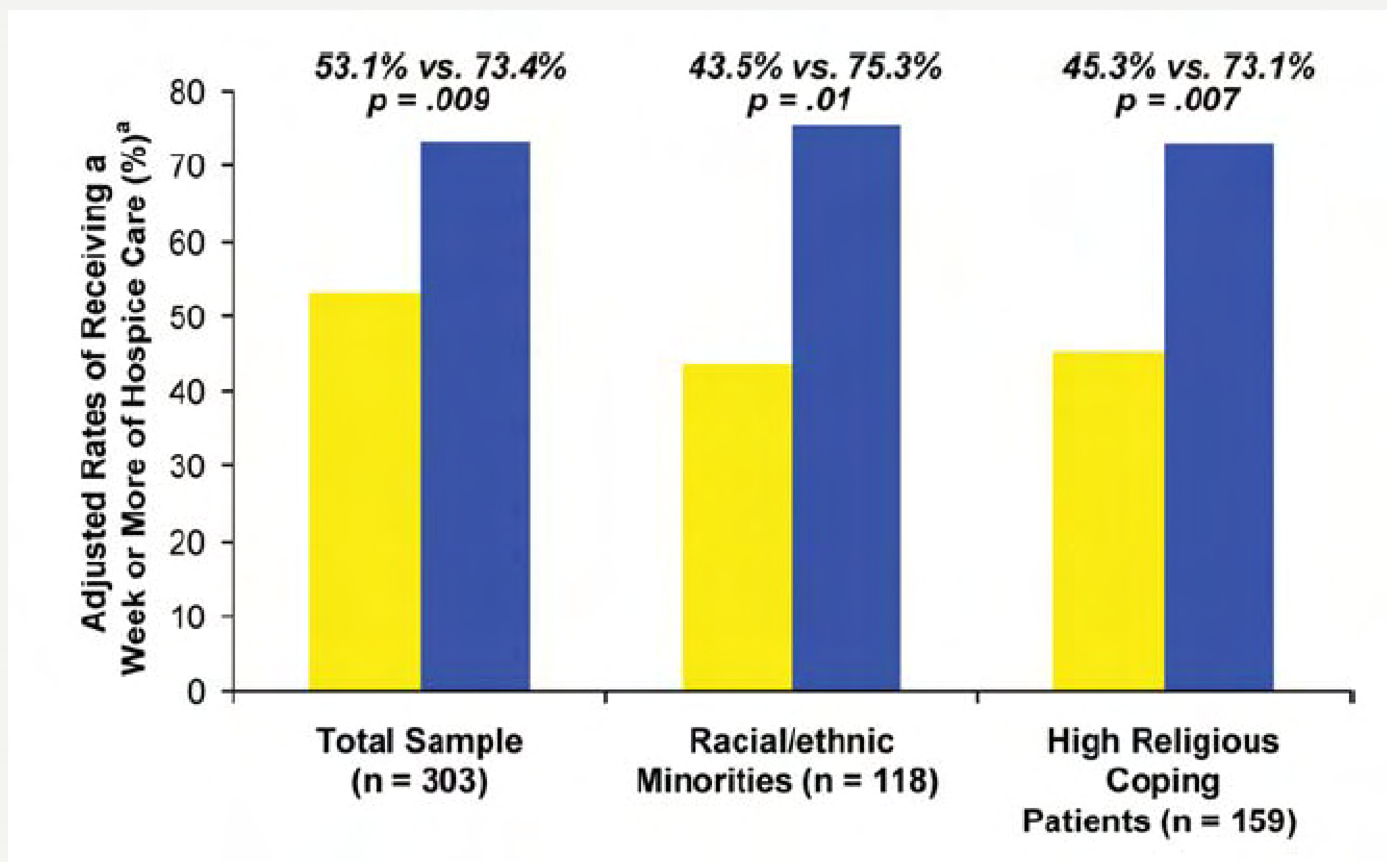
Adjusted Rates of EOL Care (%)[a]

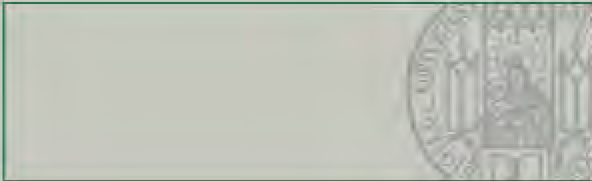
Low Spiritual Support
High Spiritual Support

	Total Sample (n = 303)		Racial/ethnic Minorities (n = 118)		High Religious Coping Patients (n = 159)	
	ICU Admission	ICU Death	ICU Admission	ICU Death	ICU Admission	ICU Death
	8.7 vs. 3.6%, p = .11	*5.1% vs. 1.0%, p = .03*	*11.3% vs. 1.2%, p = .03*	*11.2% vs. 1.2%, p = .03*	*13.1% vs. 1.6% p = .02*	*7.7% vs. 0.6%, p = .009*

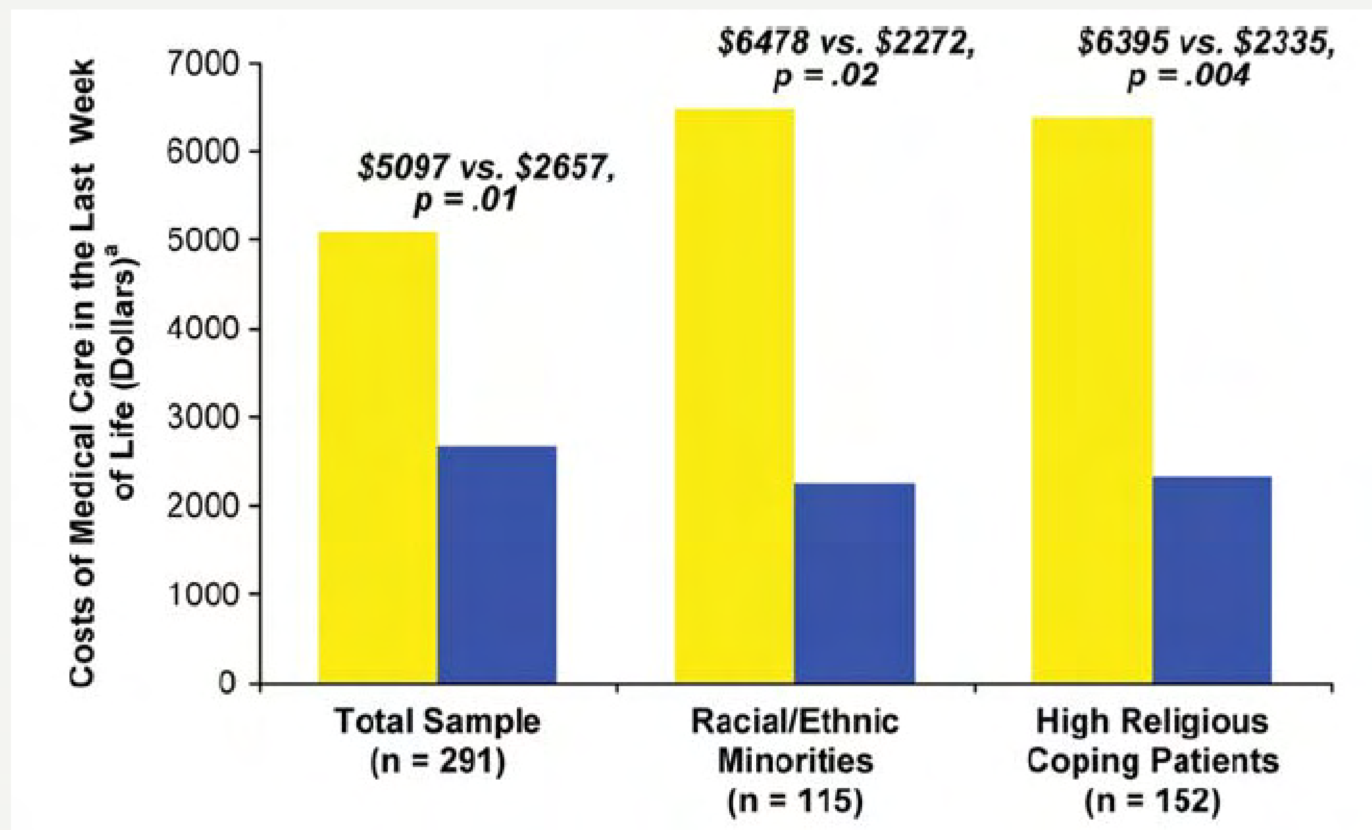


Balboni, Balboni et al.: *Cancer* 2011





Balboni, Balboni et al.: *Cancer* 2011



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Jung, CW XI, § 509

"Among all my patients in the second half of life – that is to say, over thirty-five – there has not been one whose problem in the last resort was not that of finding a religious outlook on life. It is safe to say that every one of them fell ill because he had lost what the living religions of every age have given to their followers, and none of them has been really healed who did not regain his religious outlook, and of course this religious outlook is quite independent of denomination or church membership".

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1. Jahrgang

1 | 2012

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Spiritualität in der Pflege – ein existentieller Zugang

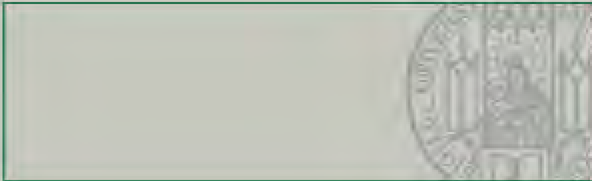
Karl Baier
Philosophische Anthropologie der Spiritualität

Elisabeth Assing Hvidt, Helle Ploug Hansen, Hans Raun Iversen
Glaube und Sinnorientierungen bei dänischen Krebspatienten in der Rehabilitation: eine taylorianische Perspektive

Arndt Büssing, Annina Janko, Andreas Kopf, Eberhard Albert Lux, Eckhard Frick
Zusammenhänge zwischen psychosozialen und spirituellen Bedürfnissen und Bewertung von Krankheit bei Patienten mit chronischen Erkrankungen

www.spiritual-care-online.de

Kohlhammer



2nd IGGS Symposion october 5-6: enregister now!

www.spiritualcare.de