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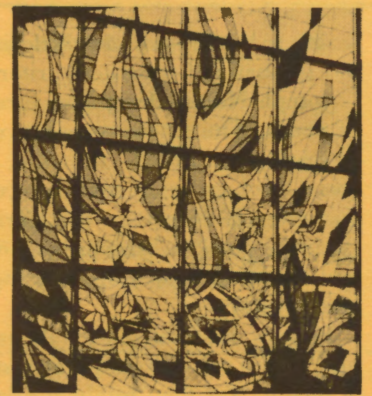

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Spiritual Dimensions in Health Care

The intent of this article is to share information about the spiritual aspects of health care. Perhaps it will germinate some food for our own spiritual pilgrimages. It reflects, among other subjects, bases for pastor-nurse teamwork, the good Samaritan role and dealing with death. Spiritual care is a necessary part of responsible health-care delivery, particularly if we believe that human beings are created by God and that man has a need to have a relationship with God the creator.

In approaching this subject, a care giver will need to reflect personally on some primary questions:

"What is your definition of hope?"

"What kinds of hope are there?"

"Why does man suffer?"

"What is meant by a sense of values?"

"What ideas and values comprise your belief systems?"

"What is your general attitude about death?"

"What are your religious beliefs about living, life, death and the hereafter?"

"What is your definition of spirituality?"

"What do you know about the will to live?"

Peggy Erickson, RN, MN, is Vice President of Nursing at Central Kansas Medical Center in Great Bend. She presented the keynote address at each of four KSR conferences in 1985 on Spiritual Dimensions of Emergency Health Care. Part of her outline is reported here for Religion *readers. Portions of this in its article form are reprinted from the* Kansas Nurse *with the express permission of Terri Rosselot, Executive Director of the Kansas State Nurses Association.*

"How firm and well developed is your faith?"

"What does your religion mean to you?"

"As a person in the helping professions, what do you think about caring for victims of AIDS, herpes, hepatitis and other communicable diseases?"

"Do you believe that life-sustaining equipment must be used on everyone?"

"Do parents have a right to refuse treatment for their seriously defective infant?"

"What do you think about bioethics committees?"

"What do you think about collaborative decision making?"

"What is the state's role and responsibility in decision making relative to ethics and life-and-death situations?"

"At what point is confidential information not confidential?"

"Is it okay to inflict emotional and financial stress on others at all costs?"

"What are often the consequences of delays on decision making?"

"What is this society's ability to pay for higher costs of health care?"

"Can this society make a commitment to pay for life-long support systems for the developmentally disabled children?"

"What is the ability of any justice system, government or bureaucracy

to make life-and-death decisions on the basis of consistent criteria?''

Joseph Nuttin designates three levels of needs. The psychophysical relates to physiological needs. On the psychosocial level are needs such as recognition and esteem. Needs on the spiritual include the need to discover life's meaning and the nature of human beings' ultimate destiny.

Persons hospitalized for illness or injury have a primary need for restoration of health. Yet they retain needs shared by all human beings. These interrelated needs include those for self-esteem, for social interaction, for recognition and for coming to terms with life's meaning and purpose. Illness is a disabling experience that impairs the functioning of the whole person even though only one system may be directly affected.

Hippocrates in the latter part of the 5th century B.C. recognized that in order to cure the human body, it was necessary to have knowledge of the whole person. As a representative of the healing profession, the health-care provider plays an important role in treating the whole person and fostering mental and spiritual health necessary for physical recovery. We know that human responses to life vicissitudes are based upon, to some extent, knowledge. People react to events and make decisions in terms of their past experience.

When they make decisions that involve what is likely to happen in the future, they rely heavily upon what they believe will occur, rather than on what they know will occur. Therefore, religious or spiritual convictions of what a person believes about the nature of life itself have a mighty impact on what he believes the future holds and thus on major physical and emotional health decisions that affect response to treatment.

One who has thought about and reached interior resolution has thought about these questions:

''Who am I?''

''Where did I come from?''

''Where am I going?''

''How do I get there?''

''Am I headed toward another life, or is this life all I can hope for?''

This philosophy of life is not based so much upon knowledge or unimpeachable evidence as it is based upon that leap into the unknown called faith. Once a person is convinced of beliefs about life and its meaning, he can sort out a hierarchy of values discerning the important aspects of life from the unimportant. This is why one's individual level of religious experience and behavior affects how one deals with crises such as illness, trauma, loss, grief and death. Firmly held religious values arrived at through careful thought are a patient's best resource for coping with illness or injury.

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Traditional religious values foster health

The values inherent in most religious traditions foster physical and mental health in their followers because they address human needs. The first of these is the belief in each person's intrinsic worth and the worth of all persons. This is essential in combating feelings of inadequacy and inferiority or of disdain for others. A faith is the ultimate triumph of good over evil—faith that God's goodness will eventually prevail. This is an antidote to the anxiety, insecurity or despair that can overcome one threatened by many evils.

Another belief is that God is a loving father. The ''ultimate'' is a base for other convictions. One conviction is that one must come to grips with the fact that one is not perfect, recognizing shortcomings, resolving to do better, laying aside the hypocrisies and deceit of daily life.

Other beliefs center around unselfish devotion to human need. This indeed is a therapeutic commitment in itself. ''Serving mankind lends meaning and purpose to life.'' Healthy interpersonal relationships can develop when forgiving and being forgiven are a part of those relationships.

Everyone has done evil to someone in a lifetime and needs to be forgiven in order to be whole and not to be broken. There is a need to be ready to forgive, to be merciful, to be reconciled and to develop a new healthy relationship. Restoration of both biological and psychological well-being will transfer into wholeness with the aid of spiritual values in place and used daily.

A Search for Meaning

So we confront the ''why'' of suffering. It's not uncommon to speak of suffering, because escape from suffering is absolutely impossible. Sooner or later we each experience suffering; we are forced to respond.

Sometimes we experience fear, flight, despair and courage. Whatever the response, an attempt to understand why we suffer is at the core of our struggle. We want to know why and how.

Suffering is defined as ''the state of severe distress associated with events that threaten the intactness of the person.'' Suffering is an experience of the whole person—body, mind, spirit. Pain is not just feeling physical symptoms, but it is also an experience of having emotional distress. Fear, stress, guilt and other kinds of emotional distress are as much a part of suffering as physical symptoms. The sufferer sees his wholeness being threatened. Each person tries to understand why. Health-care providers attempt to help patients transcend suffering and to find meaning in the context of faith and revelation.

This assistance can be accomplished only when another human being is appreciated as a complete, unique and spiritual being. The health-care provider must offer friendship, respect, tenderness and love. Patients who experience such concern from another will be better able to value themselves in moral and ethical terms, experience oneness with God and triumph over suffering and death.

Spirituality is the life principle that pervades a person's entire being and integrates and transcends one's biological and psychosocial nature. Spiritual needs are factors necessary to establish and/or maintain a dynamic, personal relationship with God. Since spiritual needs are often masked by physical or emotional symptoms, we ask how one sees another's spiritual needs? Of course, we need to know about ministering to the patient's spiritual needs.

All human beings have these dimen-

sions: physical, psychological, moral, intellectual, social, emotional and spiritual. Because a person is not complete without these dimensions, none of them can be separated from the others. Transcendence is a valuable quality of spirituality, especially as one contemplates the finiteness of life. A focus on spiritual values can sustain an individual as he experiences the deterioration of his physical body. Language sometimes limits the ability to convey the notion of transcendence inherent in spirituality.

It's important to be able to view the diverse religious orientations of individuals. An atheist rejects the existence of God and eschews doctrines of religion. A metaphysician subscribes to a philosophy or belief system that has to do with the science of being or an orderly system of the universe, but not to religion. Personal religion describes a system for those who have departed from institutional religion. Their primary source of strength comes directly from a personal God in whom they trust. The largest numbers of patients interviewed by Ann Munley subscribed to a blend of personal religion and institutional religion. They not only draw comfort from a God they trust, but they also hold to an organized system of religious thought and practice.

Institutional religion is the label used for those who give attention to rituals, practices or teachings of their organized religious affiliations. Individual religion is hidden around a data base for each person.

You must be open and well-versed on religious and philosophical beliefs other than your own. The focus is on the patient and not on the care giver.

The Fragileness of Life

Here we focus on the patient. With the approach to death, there commonly occurs an inward journey to consider the question of human existence and the meanings of life and death. Questions also exist as to whether or not one's personal belief system will be satisfactory for coping. The spiritual needs of the dying can be categorized according to four major areas.

A Search for Meaning

The essential need is the search for meaning. Each person who faces his finitude wants to look at life both past and present and realize that his life has purpose and meaning. He needs to integrate his own dying with his personal goals and values. The dying person, then, must create his own personal meaning. Studies have shown that the dying person attempts to meet a number of needs: the need to make death significant; the need to make death less fearful; the need to make death more tolerable; the need to seek knowledge of the unknowledgeable; the need to deal with the frustration death causes; the need to affirm the value of life; and the need to find meaning in suffering.

The significant issue is that each person must articulate his own meaning of death. No one can do it for him. An essential part of finding meaning must be submission to death. Tension between "hanging on" and "letting go" and as the spiritual crises is met, the individual can experience a sense of fulfilling his destiny and of yielding to the natural order of the universe.

Sense of Forgiveness

The second need entails forgiveness. As dying people review their lives to arrive at suitable meaning, guilt may surface as they consider unfulfilled expectations for themselves or acts of omission or commission toward themselves or others. To relieve this spiritual pain, the dying person must have a sense of forgiveness. Some studies have shown that people who see God as loving and forgiving tend to experience a more peaceful death. The image of God is usually influenced by parents, religious leaders and authority figures. Persons often attribute characteristics of God to either real or idealized those of their parents. Less religious and more secular conceptualizations of "God" are usually referred to as a "guiding power" or "a force." Realizing that agnostics do not believe in God, they find acceptance in nonfulfillment or incompleteness as a feature of life. They make the most of life remaining to them. It is important that we allow others to have their own belief systems.

The Need for Love

One of the spiritual needs of the dying is surely the need for love. Regardless of the individual's belief in God as a source of love, love is experienced through human relationships. Love can be demonstrated to the dying person in words or acts of kindness. It can also be communicated by one's silent but compassionate presence. Love given to the dying must be unconditional. Some patients are easy to love because they have accepted their impending death. Some have few demands. Some respond to the love that is given.

The need for love is universal even for those who are not lovable and who seem unresponsive. Family and friends are commonly a source of love for the ill or critically injured. Sometimes professional care-givers can serve as a love source when family or friends can't or won't be present. There are times, however, when the health-care provider cannot provide this love because of unmet needs of his own.

The Need for Hope

In the fourth place, hope is an innate feature of human existence. Hope connotes the possibility of future good and is based on reality. Dying persons must have both concrete and abstract hope to carry them through the dying process. Concrete hope consists of objects of hope that are within the person's experience, for example, freedom from pain and the ability to perform tasks.

The degree of hope fluctuates throughout the dying process because the person's life changes, and one's perception of reality changes. Abstract hope is equated with transcendent hope. Transcendent hope is characterized by more time-distant and abstract goals than concrete hope is. Transcendent hope tends to incorporate philosophical or theological meanings that lift the individual above the concrete hopes.

Hope is necessary not only for one's remaining life but also for the time after death. Most people express some type of belief in an afterlife. They often find satisfaction and a sense of well-being in holding on to their beliefs. Some believe in a union with deceased loved ones; some believe is a union with God; some believe in a superior alternative to the present existence; some do not believe in an afterlife; some believe is a transfer of physical energy; some may hope to be remembered with respect to their unique individuality and some may hope to leave a legacy in their children or in their life's work.

One must establish a data base on the patient. Particularly in an emergent situation, it is essential that the health-care provider know general demographic information about the patient so that at least broad generalizations can be made relative to region. As the situation allows, gather more information and employ the "therapeutic use of self" modality through which one becomes empathetic, vulnerable, expresses humility and makes a commitment. The health-care provider must have a sound knowledge of not only his chosen religion and faith, but must have also a working understanding of many other religions and belief systems before readily and easily assessing the spiritual needs of another individual.

Whatever one does in the process of assessing and ministering to another's spiritual needs, the desired goal is to help the patient establish and maintain a dynamic relationship with God. The ideal situation is for the health-care provider to intervene at the level of the patient's faith and understanding.

The health-care provider must realize that for every human being there is a need to know:

1. The meaning and purpose of life in one's own terms.
2. That one is loved and is related to the entire universe.
3. That one has been forgiven and has forgiven.
4. That there is an eternal need for hope.

Providing Spiritual Support to the Dying

Any caring human relationship automatically includes spiritual support. Human warmth is essential to spiritual support but human warmth alone may cheat the patient of spiritual actualization. Munley, again, suggests that spiritual support must include respect for the diverse beliefs of patients, willingness to discuss matters of spirituality with patients and provisions for the rituals and sacraments of organized religion. The end goal must be to meet the spiritual needs of the terminally ill or of the injured.

To be able to minister to the spiritual needs of the patient, the health-care provider must be comfortable with spiritual matters. The person must have excellent verbal and nonverbal communication skills. The care provider must be able to demonstrate empathy. This calls for the ability to become involved with the dying or injured in all dimensions. The patient's spirituality is clearly an integral part of his total health.

A willingness to be involved with the patient is extremely important for the person who wants to be helpful to the dying.

Know thyself is a key motto for anyone who wishes to be more comfortable with spiritual matters. One who has come to grips with his own spiritual needs clearly has an advantage in helping patients with their spiritual needs. One who has struggled with his spiritual journey in this life will be better able to help another with his spiritual pilgrimage. One who is assisting another in spiritual growth must also be aware of his own sources for spiritual support, renewal and growth. One cannot give what one does not have.

A broad working knowledge of various religious beliefs, religions, cultures and spiritual leaders is a must for health-care providers in this complex world. It is well to assess these four areas of concern when caring for any patient:

1. The person's perception of God or diety,
2. The person's source of strength and hope,
3. The significance of religious practices and rituals,
4. The person's perception of the relationship between his spiritual belief and his state of health.

An attitude of hope or hopelessness is transmitted nonverbally and is likely to influence verbal communication. Perhaps one can share feelings of hopefullness by identifying and sharing concrete hope objects such as peaceful and dignified death. For the person who seems to lose hope, the care provider can bring love and physical comfort to the patient.

Another important feature of communication with the terminally ill or injured is the ability to be with the person during the times of despair. Silence is often the very best and most significant communication tool expressed through nonverbal techniques of presenting oneself as open and accepting to the feelings that the patient expresses and feels. Empathetic listening is imperative to allow the patient to direct the conversation, to identify his own problems and to formulate his own solutions and goals. A willingness to be involved with the patient is extremely important for the person who wants to be helpful to the dying. Some patients aren't willing to talk about their spiritual problems or needs; but if the door is open for a talk when the person is willing, this quite often is the best approach. Anyone who risks becoming intimate with another person on any level must be willing to be hurt, to experience pain and bereavement when the relationship ends.

Guidelines for giving support

1. Don't impose personal beliefs on patients or their families.
2. Try to respond to patients out of their own background.
3. Do not proselytize.
4. If you can't give the spiritual support one needs and is asking for, get someone who can.

You must be open and well-versed on religious and philosophical beliefs other than your own. The focus must be on the patient and not on the care giver.

Intervention for Meeting Spiritual Needs

Prayer counteracts the loneliness of dying by offering the individual intimacy with God and another human without the need for confession. Shared prayer can be a means of bringing love, human and divine, to the patient. Prayer also holds transcendent and mysterious qualities and therefore conveys hope for the present and the future. Offering prayer focused on conditions that the client is unable to talk about allows the patient to deal with the matter in an acceptable way. Prayers convey to the patient that he is loved and understood.

The care giver should be ready to reach out and touch; this provides strength and closeness.

Prayer can miss the mark. It should not be used to strip the patient of his defenses. No one should expect someone to discuss issues not ordinarily discussed. Prayer should not be used to avoid the patient or his dying. Medita-

tion provides a way for gaining insight into oneself. It sometimes can give meaning to the situation. It is also an opportunity to quiet oneself and to achieve a sense of peace. Meditation is available to the secular and to the religious. It may be used for relaxation, pain control or transcendence.

Spiritual care promotes health and contributes to the well-being of the whole person. Spiritual care also promotes hope. "Hope" connotes the possibility of future good and is based on reality. We begin to meet our patient's spiritual needs by understanding our own needs and by understanding how our own needs are met. It is well known that the more one has struggled with his spiritual pilgrimage, the more understanding, perceptive and astute one is in providing spiritual care for his fellow man.

"And what is an important as knowledge?" asked the mind. "Caring and seeing with the heart," answered the soul.

—Flavia

The Spiritual Connection of Eternity

Stephen E. Fletcher is a Baptist minister in Westmoreland. In addition to his divinity degree, he has the master's degree in Philosophy. His introductory remarks at the 1986 series of conferences are excerpted here. Entitled "The Spiritual Connection" he lays a theological basis for spiritual maintenance of care givers and receivers. He is the chairman of the KSR state committee on conferences.

We are trapped in the Western mythos of the empirical. We are children of our culture. We have brought the myth of two domains—the space-time domain of the empirical and the eternal domain of the spiritual. We are smart under a subtle slur—only the crude among intellectuals make it explicit—in thinking that religion is superstition made respectable.

A kind of schizophrenia is normative to Western thought; we are living in two worlds at once, the material and the spiritual, and it is hard to hold the two together. Are we doomed to accept the dualism of our Western mythos? Are the separate domains—the material and the spiritual, the space-temporal and the eternal—simply the way it is?

Here is my simple solution—a shift in perception, a Copernican shift. What if eternity is not an extension of time but an entirely different dimension breaking into time all the time? What if eternity is a vertical breaking into horizontal time at the crossing-point of *now*? This would mean every moment is an eternal (*spiritual*) moment. We are in eternity *now*. Everything is in eternity; everything is eternal, not in terms of enduring forever but in terms of having spiritual "depth."

Get this! All reality exists with a measure of both materiality and spirituality. In our ignorance of the spiritual we have studied the material world with only one eye, as it were, flat, without depth perception. Now, with both eyes open, we see that some things like rocks have a large measure of materiality and an infinitessimal measure of spirituality, but a measure, nevertheless. Other things like trees have a little larger measure of spirituality—call it life. Animals have more yet—call it purpose or purposeful mobility. And human beings have most of all—call it intelligence. There is nothing without spiritual significance, however thin it may be. Albert Schweitzer's "reverence for life" can be expanded to a reverence for all things. All things are holy.

"Religion & the Constitution" 1987 Essay Contest

Competition among Kansas high school students in writing essays about a phase or application of religion is sponsored by the KSR. This year's theme celebrates the bicentennial of the U.S. Constitution.

High school students submit essays to their respective county clergy association who determine the best essay from the county and forward it to Lawrence. A KSR committee determines state winners and awards prizes: first place, $300; second, $200; third, $100. Winners are brought to Lawrence for a visit on the campus. County winners receive $25 prizes.

KSR Scholar Named

Susan Elkins of Lawrence was designated KSR Scholar for 1986-87. She is the first to be named this year by the religion faculty. She is a full-time graduate student.

Board Adds New Member

Recently added to the Board of Governors is John Lungstrum, Lawrence attorney. Glee Smith of Larned is President of the group, which works to relate the KSR to the Kansas business community. With the newest addition, 10 members serve on the board.

Traverse Log

The future of religion is in a misplaced crystal ball. But the present suggests some directions we should examine.

Self-imposed isolation is one of them. It is a bonus of our culture. People can immunize themselves from the outside. We ride in air-conditioned cars with tinted windows. This shuts out traffic noise and enriches privacy. Joggers and skateboarders wear earphones to help detach themselves from the rest of us.

Trekking through this world in our own shell, hearing as few of its sounds, seeing as little of its sights as possible support the religious practice of inwardness.

Lest we are tempted to think this makes a theological basket case, I point to the meditative mysticism that some (especially the young) people practice with excitement. The presence on the campus of a variety of intense religious fellowships—some quite ephemeral—illustrates the direction inward. It is real, markedly individualistic and characteristically sectarian.

But religion is not that simply tucked away from the whoop and holler of our world.

Pluralism is a second fact of life. Various approaches exist simultaneously that will not go away; they will not be uprooted or ignored. The old notion of my position being a mighty fortress surrounded by other cultures that are erroneous and bad has slipped quietly away. No amount of gasbagging will bring it back.

Religion has to live with what is here now. This precludes any attempt to reconcile, or to syncretize, or to generalize divergent religious strains. After all, there may be truth somewhere else too. Pluralism accepts these differences; it works to preserve them intact. That may cause an adrenalin surge, but it is the health of (at least) the American way.

A third color is cast on the picture, the world scope of modern problems. Whereas once upon a time (our time) the thrust of religion was local, now it is worldwide. Back in the days of the ''town'' sociometry, the local church was worrying about saving the sinners in Paw Paw. Today what happens in world commerce affects Paw Paw. Hungry South Africans are as close as the neighbors' kids playing on our lawn.

Let us try to weave these strains together.

On down the pike ahead (yep, another future prediction) religion will need a new fabric. It will need added weft which designs a major transformation from its current divided and exclusionist condition and transmits values to challenge the world's crying problems.

Futurist Earl D.C. Brewer talks about a ''global community'' that can confront world crises, such as overpopulation, food shortages and nuclear arms. Brewer suggests that religious unity for global function is in the offing.

Perhaps at least the major religious families (in the West, i.e. Judaism, Christianity and Islam) can cohere for global impact! That's our mission now.

Like the rider of a Roman team with one foot on each horse, we ride into world need—that goal to be accomplished with allowance for personal expression and for dependence on pluralism. I invite suggestions on how we do this.

Hang on, kids; the chariot for the future has already taken off.

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