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Defining Spiritual Care: An Exploratory Study

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An electronic search was conducted on Medline for the years 1980–2005 identified 101 journal articles with the words "spiritual care" in their title, the majority of which were from nursing journals. Content analysis performed on 28 articles judged to be most relevant yielded 250 unique descriptions of interventions, which were subsequently consolidated to form 66 discrete interventions. Twenty five professional chaplains rated each item on the degree to which they considered it to be part of providing spiritual care to patients. The patterns of correlations among the interventions suggested that most of the items fell into ten major categories and a few minor categories, with only two of the major categories being explicitly religious in nature. The article discusses these categories within the context of pastoral care.

KEYWORDS *chaplains, pastoral care, religion, spiritual care, spirituality*

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INTRODUCTION

Questions abound about the commensurability/commonality of discourses and practices that occur in differing life-worlds (e.g. cultures, occupations). This speculative concern of philosophers (e.g. Habermas, 1981; Bernstein, 1984) is also very much on the minds of health-care economists (Fenn & McGuire, 1996); health-care managers striving to control, eliminate, or create redundant health-services; and those health-care professions (e.g., chaplaincy, nursing, medicine, psychology) that often claim propriety interests in the constructs and practices of religion/spirituality.

Both discourse about and practices of religion/spirituality saturate the history of health-care. The near history of nursing indicates religious roots to that profession (Lindberg, 1998; Webb, 2002). During the medical era of health care, 1910–1980 (Vandecreek, 2002), allied health professions produced little literature regarding religion and spirituality. However, a dramatic rise in health-care literature regarding spirituality began in the 1990s (Weaver, Flannelly, & Oppenheimer, 2003). Scholarly and professional study of spiritual constructs and practices, which was once hardly respectable among health-care professionals, is becoming much more common. One may call this resurgence of interest in religion among those in health care "the return of the repressed" (Hummel, 2005).

A recent survey specifically compared the use of the terms "spiritual care" and "pastoral care" in the health-care literature (Harding, Flannelly, Galek, & Tannenbaum, 2008). The survey found the rate of articles about spiritual care mirrored the surge in articles over time about spirituality in general, and these rates continue to climb. Articles about pastoral care, on the other hand, declined steadily within the past 10 years. Increasing interest in spiritual care was evident in nursing, mental health, and general health-care journals, being most pronounced in nursing. Declining interest in pastoral care was also most pronounced in nursing.

These findings have led some chaplains to argue that the adoption of the constructs of spiritual care by other health-care professions underlines the distinct character of spiritual care provided by chaplains, under the rubric of pastoral care (Harding et al., 2008). Of course historically, clergy and chaplains themselves have held various understandings of what constitutes spiritual practice (e.g., VandeCreek & Burton, 2001). Several efforts have been made to find commonalities in practices and commensurable constructs in religious/spiritual practices among health-care professionals (VandeCreek & Mooney, 2002), in order to establish services that combine the talents of differing health-care professionals for religious/spiritual purposes, and to recommend spiritual interventions by health-care professionals such as physicians (Hummel & Kristeller, 2006). How does this literature construe spiritual care practices and are these constructions commensurable with those of chaplains and pastoral care professionals? The current study examines these questions.

METHOD

An electronic search was conducted on Medline to locate journal articles with the words "spiritual care" in their title. The search was restricted to articles in English published between 1980 and 2005 that contained abstracts. The electronic search produced an initial list of 101 citations whose titles were printed. The type of journal in which each article was published was classified (e.g., Nursing, Medical) based on the journal's title and the subject terms listed for the journal in the MEDLINE/PubMed journal database.

Identifying Spiritual Interventions

The abstracts of all 101 articles were printed and read by three judges to see if they mentioned or alluded to specific spiritual care interventions. The judges jointly decided that 53 of the articles were not relevant, and that the remaining 48 might be relevant. Copies of these 48 articles were obtained from local libraries and electronic information services. At least two judges read each article and identified every word and phrase that described activities and interventions that were ascribed as being spiritual care. Each word or phrase was recorded by typing it into one column of a spreadsheet using a separate row for each description contained in each article. In all, 250 unique intervention descriptions (or items) were recorded from 28 articles.

Consolidation, Clarification and Classification of Interventions

An iterative process was used to reduce the number items by eliminating duplicates and consolidating items in which similar interventions were expressed in different language, using the "method of constant comparison" (Strauss & Corbin, 1990). The process also entailed clarifying the meaning of the items within the context of the article in which they were contained and separating out items containing more than one intervention.

The process began by sending copies of the spreadsheet to each of four judges who coded each item in a separate column labeled with their name. The coding was accomplished by copying the language from the initial list into their designated column, modifying the wording, or re-describing the intervention in their own words. The completed spreadsheets were sent to a fifth researcher who facilitated and moderated the process. The moderator transferred the codes from each judge into a single spreadsheet, with one column designated for each judge's codes. The moderator then read all of the codes from each judge, concentrating on areas of general agreement, but different wording. The moderator attempted to conceptually consolidate

the items by putting each judge's interventions into common terminology as near as possible, creating a new column for each judge. This was done by selecting the wording used by one of the judges to serve as an exemplar for the wording of each intervention's description. The new columns were sorted by their descriptions so that those interventions with identical descriptions were now grouped together.

The spreadsheet was sent to each judge displaying only four columns: the column that contained the original list of interventions; the column he or she used to code the interventions; the column that contained the moderator's suggested language; and a column for the judge to code the interventions once more. All other columns were hidden. Each judge independently coded the 250 items again in the designated column. Upon reading the revisions suggested by the moderator, they could decide to accept or reject the suggested terminology or write a new description.

The judges and the moderator later met together to reach agreement by consensus on the interventions and their descriptions. This process yielded a total of 66 discrete interventions. Finally, five judges read the 66 interventions and sorted them into categories, with the final selection of categories determined by majority opinion.

Chaplain Opinions about the Interventions

The next step was to put the 66 interventions into a questionnaire format that asked chaplains to rate whether each of the interventions was an element of spiritual care, from their own perspective. The questionnaire was distributed to a convenience sample of 30 chaplains, 25 of whom completed and returned the questionnaire. Specifically, the survey asked the chaplains to rate the "extent you agree that each of the items is part of providing spiritual care to patients, whether it is provided by a chaplain or another member of the health-care team." The response categories and their scoring were: 1 = strongly strongly disagree, 2 = disagree, 3 = uncertain, 4 = agree and 5 = strongly agree.

The questionnaire distributed to the chaplains simply listed the 66 interventions in alphabetical order by the first word of their description. The interventions were not broken into categories as they are in the Results section, nor were they categorized in any way.

The average rating for each intervention was calculated based on a 1–5 scale, as indicatedpreviously. Intercorrelations were performed on the items within each category, and Cronbach's alpha (α) was conducted for selected groups of interventions which were found to be inter-related.

RESULTS AND DISCUSSION

As mentioned in the Methods section, an electronic search of Medline located 101 articles published between 1980 and 2005 that contained the words

TABLE 1 Percentage Distribution of Articles in the Initial and Final Samples by Journal Field

	Initial sample (N = 101)	Final sample (N = 28)
Nursing	61.4	89.3
Medicine	10.9	3.6
Palliative care	7.9	
Health services	9.9	7.1
Pastoral care/chaplaincy	8.9	
Healthcare ethics	1.0	

"spiritual care" in their titles. Twenty-eight of these were found to contain descriptions or examples of activities the articles' authors considered to be spiritual care.

Table 1 shows the percentage of articles about spiritual care that were identified in different types of journals. The left-hand column gives the percentages for the initial sample of articles (N = 101) which contained the words "spiritual care" in their titles, and the right-hand column gives the percentages for the final sample of articles (N = 28) which provided one or more examples of specific "spiritual care" interventions.

As seen in the table, nearly two-thirds of the articles that contained spiritual care in their titles were published in nursing journals and close to 10% were published in medical journals. Four of the nursing articles were in palliative nursing and four were palliative medicine journals. About 8% of all articles were published in other hospice and palliative care journals.

Articles in health-services journals accounted for nearly 10% of the 101 articles on spiritual care, with half of these published in *Health Progress*, the official journal of the Catholic Health Association of the United States. Another 9% were published in the *Journal of Pastoral Care and Counseling* and the *Journal of Health Care Chaplaincy*.

Only 28 of the 101 articles contained specific examples of spiritual care interventions. Of the 28 articles, nearly 90% were published in nursing journals. One was published in a medical journal and two were published in health-services journals. One of the two was published in *Health Progress*.

The 28 articles in the final sample contained a total of 250 unique examples of spiritual care interventions. Qualitative analysis yielded 10 categories of interventions: two categories containing 15–18 items each, three categories containing 6–8 items each, and five categories containing 2–3 items each. The ten categories of interventions identified by the judges were: religious, spiritual, counseling, emotional support, advocacy, presence, respect, communication, adjunct therapy, and other care. Tables 2–7 list the interventions that fell within each category.

Religious interventions formed the largest category, encompassing a total of 18 interventions (see Table 2). Correlation analyses indicated the

TABLE 2 Religious Category of Interventions Identified by Five Judges

Religious Support and Resources (α = .874)
1. Praying with patients
2. Talking about God with patients
3. Discussing religion with patients
4. Providing religious support religious
5. Providing religious items
6. Providing religious materials (e.g. books)
7. Providing religious music
8. Encouraging religious practices
9. Encouraging religious development
10. Referring patients to religious resources
11. Reading religious/spiritual materials to patients

Prayer, God and Commitment (α = .638)
1. Praying for patients
2. Inquiring about patients' relationship with God
3. Inquiring about patients' images of God
4. Assisting in religious recommitment

Unrelated Items
1. Religious witnessing
2. Discussing beliefs and values with patients
3. Consoling patients through means

interventions fell into two subcategories or subsets. The first subset, which is labeled Religious Support and Resources, consisted of eleven items, with a substantial alpha (α = .874). The items in this category appear to constitute some of the widely agreed upon practices of pastoral care, such as praying with patients, talking to them about religion and God, providing various religious materials, and so forth. Although every item in the subset was not significantly correlated with every other, the Cronbach alpha indicated they form a common dimension. The few studies that had examined what interventions chaplains actually use have found that prayer is a very common intervention, whereas performing rituals and providing religious items or reading materials are much less common (Flannelly, Weaver & Handzo, 2003; Handzo, Flannelly, Kudler, Fogg, Harding, & Hasan, 2008; Spidell, 2005).

TABLE 3 Spiritual Category of Interventions Identified by Five Judges

Spiritual Support and Resources (α = .796)
1. Facilitate finding meaning or purpose
2. Enabling existential empowerment
3. Supporting spiritual inquiry
4. Suggesting spiritual resources
5. Providing spiritual guidance
6. Promoting spiritual fellowship
7. Providing inspirational books

Unrelated Item
1. Helping patients to prepare for of end life/death

TABLE 4 Counseling Category of Interventions Identified by Five Judges

Counseling Skills and Activities ($\alpha = .849$)
1. Authentic communication
2. Establishing rapport/connectedness
3. Establishing therapeutic relationship with patient
4. Emotional enabling
5. Enabling hope
6. Encouraging the expression of feelings
7. Encouraging self assessment and reflection
8. Encouraging reflection
9. Facilitating closure
10. Therapeutic exploration of patients' issues

Unrelated Items
1. Active listening
2. Addressing family issues/conflicts
3. Encouraging positive thinking
4. Encouraging the patient to reminisce
5. Sharing, self-disclosure

The second subset in the religious category of interventions was composed of a somewhat less cohesive group of four items ($\alpha = .638$) that included praying for patients, assisting them with religious recommitment, and asking them their views about, and their relationship with God. It is noteworthy, perhaps, that there was no statistically significant correlation between praying with patients and praying for patients. Nor was there a significant correlation between simply talking to patients about God and making more specific inquiries about God. However, it should be kept in mind that the sample size is very small (N = 25 chaplains).

The remaining three interventions in Table 2 were not correlated to each other or any of the other interventions in the table. That the items "Religious witnessing," "Discussing beliefs and values with patients," and "Consoling patients through religious means" were not significantly related to these other items is striking, given that those items represent means of pastoral care recognized in the history of many religious traditions. That the pastoral care providers did not associate these items may reflect the degree to which they are associated with practices not engaged in to the degree that they once

TABLE 5 Emotional Support Category of Interventions Identified by Five Judges

Empathy, Caring and Comfort ($\alpha = .769$)
1. Communicating empathy to patients
2. Comforting patients
3. Consoling patients through non-religious means
4. Demonstrating caring and concern
5. Providing emotional support

Unrelated Items
1. Trying to brighten their day
2. Using humor

Table 6 Advocacy Category of Interventions Identified by Five Judges

Conveying Needs ($\alpha = .728$)
1. Cultural brokering
2. Communicating patients' needs/concerns to others
Referral and Follow-up ($\alpha = .519$)
1. Referring patients to other chaplains or clergy
2. Extension of care (extra follow-up)
Unrelated Items
1. Advocacy
2. Providing access to a quiet place

were. For example, religious witnessing and discussing beliefs and values with patients may seem contrary to the contemporary pastoral practice of "letting the patient set the agenda." Also, some in contemporary religious life view the offering of "consolation" as a "thin substitute" for emotional healing (Hummel, 2003).

Table 3 shows that all but one of the eight interventions in the spiritual category formed a single dimension, according to their inter-correlations. The alpha value for this Spiritual Support and Resources dimension was fairly high ($\alpha = .796$). Helping patients to prepare for end of life/death was not correlated with any of the other interventions. Again, the unrelated items refer to a classic pastoral care function, tutoring persons in *The Ars Moriendi* or the Art of Dying (cf. Faust, 2008; Strohl, 1989; Wicks, 1998). Since end-of-life care is a critical aspect of pastoral care, an attempt was made to see if this item was related to any of the items in the previous table. Surprisingly, perhaps, it was significantly correlated with only one item in Table 2—"praying with patients"—but the correlation was extremely high ($r = .80$).

Table 7 Other Categories of Interventions Identified by Five Judges

Presence ($\alpha = .675$)
1. Being present
2. Being available
Respect ($\alpha = .727$)
1. Being open to patients' beliefs
2. Being open to patients' feelings
3. Showing respect for patients
Communication ($\alpha = .730$)
1. Communicating with patients
2. Communicating clearly to patients
Adjunct Therapy
1. Art therapy
2. Using therapeutic touch
Other Care
1. Providing routine nursing care
2. Providing holistic care
3. Reading other materials to patients

The second largest category identified by the five judges was counseling interventions that had no specific religious or spiritual component (see Table 4). Ten of the interventions formed a highly cohesive dimension ($\alpha = .849$). Among the five unrelated interventions in the table, four had positive but non-significant correlations with one or two other interventions. Three of the unrelated items were "positive" religious practices. Might chaplains see these items as unrelated to their offer of Counseling Skills and Empathy because they are perceived to preclude, neglect, or are not balanced by items of religious or spiritual struggle (Fitchett et al. 2004)?

A separate category of emotional support was identified (see Table 5), although some judges placed some of the items in the counseling category. Of the seven interventions in this category, five formed a common dimensions ($\alpha = .769$). Here too, the unrelated items are clearly "positive" interventions.

Table 6 lists six interventions the judges classified as advocacy. The six interventions fell into three subcategories on the basis of the correlational results. The first is a two-item subset of Conveying Needs, by cultural brokering or simply conveying patients needs and concerns to others ($\alpha = .728$). The alpha level is relatively high given that the dimension consists of only two items. The second subset also consists of two-items, but they do not fit together nearly as well: Referral and Follow-up ($\alpha = .519$). Oddly, the item Advocacy, itself, was not correlated with any of the other items in the table. However, the term advocacy, when used by itself (as opposed to patient advocacy) in the chaplaincy literature often refers to advocating for the profession, which chaplains might not think is appropriate.

Table 7 contains the remaining five categories of interventions identified by the judges. Three of the categories formed relatively cohesive dimensions: Presence ($\alpha = .675$), Respect ($\alpha = .727$), and Communication ($\alpha = .730$). The interventions in the other two categories were not correlated with one another. Four of the five items in these two categories were some of least likely interventions to be endorsed by chaplains as examples of spiritual care. The only item among the five that a majority of chaplains agreed was a spiritual care was "providing holistic care." Spidell's (2005) survey of over 150 chaplains found that chaplains themselves make use of therapeutic touch and art therapy very rarely.

GENERAL DISCUSSION

Our literature revealed that spiritual care is more widely discussed in nursing than any other health-care profession. Content analysis conducted on those articles that explicitly described spiritual care interventions suggested that

most of these interventions can be grouped into several general categories. Only a few of these categories, however, encompass explicitly religious or spiritual interventions. Nevertheless, the small group of chaplains we surveyed generally agreed that most interventions that were considered to be spiritual care by nurses and other health-care professionals were spiritual care from their perspective. A small study by Emblen and Halstead (1993) likewise found an overlap between what chaplains and nurses considered the spiritual needs of patients to be. It would be valuable to find out what other professional chaplains believe constitutes spiritual care, and to what extent they think pastoral care is different from spiritual care.

Some interventions do not fit as neatly into the categories we created even though they are an important part of pastoral care. In the case of end-of-life care, for example, this may be so because it represents a critical type of care rather than a specific type of intervention. Active listening, on the other hand, may not fit into a specific category because it is a universally used therapeutic technique. Other interventions may not have fit together because of the small sample size on which the correlations were based. If a larger sample was used, one could better determine the relationship among the items and test the adequacy of the categories themselves using factor analysis.

The rising interest in spirituality among various health-care professions has given pause to some professional chaplains. VandeCreek (1999) called chaplaincy "an absent profession" because it was virtually missing from the discussion about spirituality and health in the health-care literature. VandeCreek (1999) was concerned that the "lack of involvement by chaplains ... can lead to a variety of consequences, including the assignment of spiritual care delivery to other professions' (p. 418). O'Connor (2002) has expressed his concerns more dramatically, saying: "it is easy to imagine in the near future when a nurse who specializes in spirituality will be teaching chaplains on spirituality and health-care using the research in the field (p. 191). This is not intended as a criticism of nurses, who are considered to be the natural allies of chaplains (McClung, Grossoehme, & Jacobson, 2006; VandeCreek, 1997; Weaver & Flannelly, 2004; Weaver, Koenig, & Flannelly, 2008), and whom some chaplains (at least) recognize as spiritual care providers (Cavendish et al., 2007). To be sure, some chaplains believe that they are the primary spiritual care professionals of the health-care field. However, the present findings indicate there is common ground among nurses and chaplains about what constitutes spiritual care and what that care entails.

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