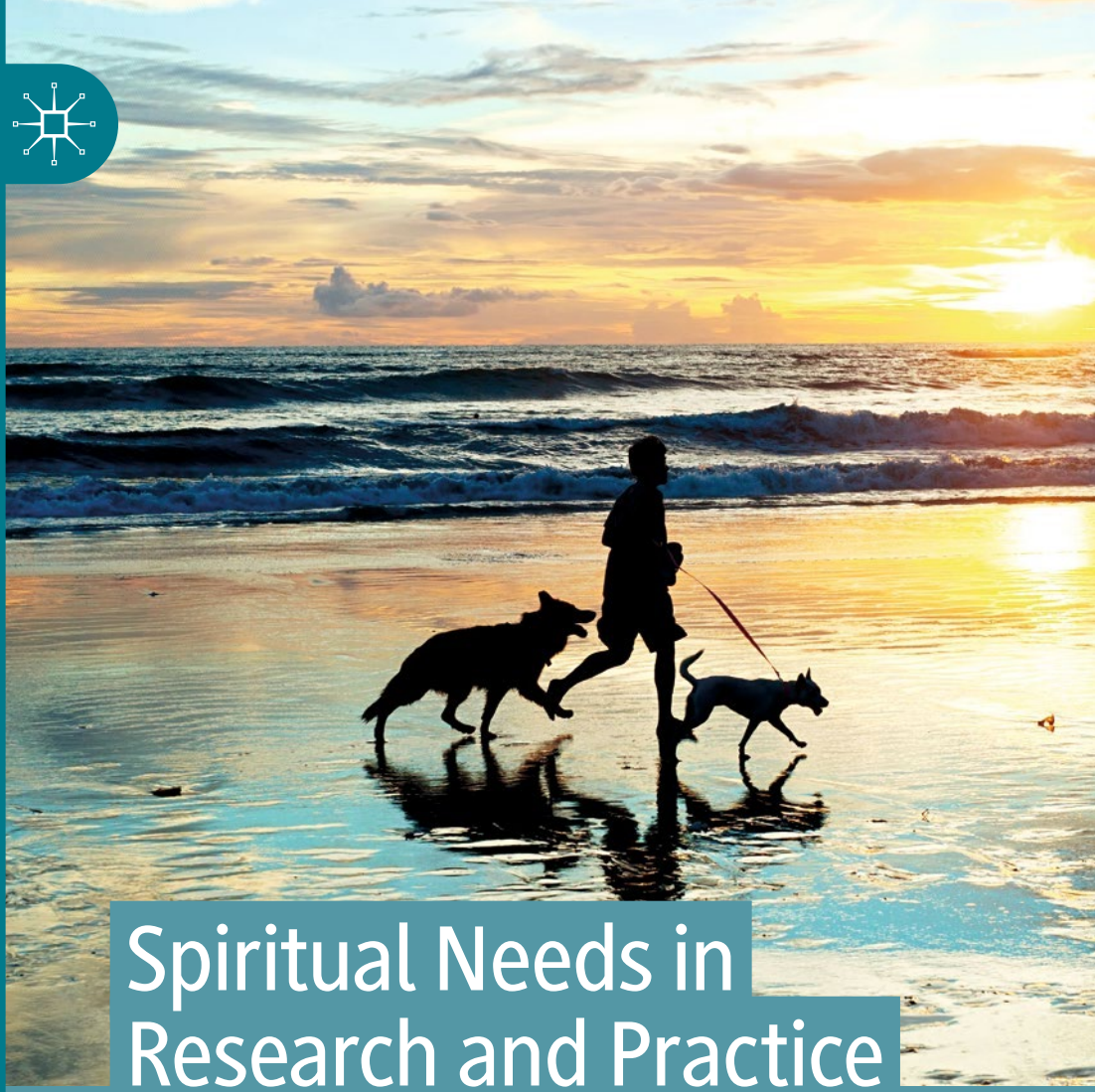

Spiritual Needs in Research and Practice

The Spiritual Needs Questionnaire as a Global Resource for Health and Social Care

Edited by **Arndt Büssing**

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Simple things make the difference:
Holding hands
A smile
Some tears
Giving hope
Being there
—Arndt Büssing

Foreword

Systematic research has shown that addressing the spiritual needs of medical and psychiatric patients can improve patient satisfaction and health outcomes. Yet the majority of healthcare professionals still ignores the spiritual needs of their patients, considering them irrelevant to healthcare and not in their area of expertise.

This volume makes a major contribution to clarifying why assessing and addressing spiritual needs are so important and how to do so quickly and efficiently. In addition, this volume addresses a wide range of perspectives on the spiritual needs of patients, from theology to philosophy to medical/psychiatric. Spiritual needs of patients are examined in different settings, countries, religions, and illnesses, and thus will be useful to many different practitioners throughout the world. In addition, the views of physicians, nurses, social workers, volunteers, and chaplains on how to assess and address the spiritual needs of patients are explored, as well as opinions on who should be responsible for doing so. Here are some of my views on how this might work, views that are quite consistent with most of what the authors of this book are presenting.

Every person on the healthcare team has a unique and specific role in identifying and addressing the spiritual needs of patients. Physicians, nurses, and social workers are ideally positioned to early identify patients' spiritual needs through taking a spiritual history, since they will be seeing all patients and will be in charge of taking an initial clinical history (in which the spiritual history should be embedded as part of the social history). The physician should be the person who is responsible for conducting the spiritual history to identify spiritual needs. If the physician fails to

do so, then the next person in line is the nurse. However, even if the physician takes a spiritual history, there may be aspects of nursing care that may require that the nurse do one as well, but only after reviewing the information that the physician has collected. Finally, if the physician or nurse both fail to conduct a spiritual history, then the social worker should be next in line. Again, however, there may be specific aspects of the social worker's duties that may require that he or she ask some additional questions to clarify the patient's spiritual needs, particularly when arranging for discharge from the hospital when unmet spiritual needs (that could not be met in the hospital) may need to be addressed in a community setting or at least followed up there. A similar procedure should be followed for medical outpatients, and for patients receiving mental healthcare in various settings.

One might argue why trained pastoral care workers or chaplains shouldn't be those who screen patients for spiritual needs. At least in the United States and also in most European countries, they simply do not have time enough to see everyone. Pastoral care staff is inadequate to meet the great need, so they are often limited only to seeing those who are referred to them.

Except for very simple types of spiritual interventions for addressing immediate spiritual needs (such as praying with a religious patient after being requested by the patient to do so), most spiritual needs should be addressed by the only healthcare professional with the training to do so, i.e., the healthcare chaplain. This is especially true for more complex kinds of spiritual needs, and spiritual needs can become complex very quickly. An example is the patient feeling that their medical or psychiatric illness is a punishment from God or the patient feeling angry at or unloved by God or deserted by their faith community. Such beliefs and feelings require an expert to address them, one who has been extensively trained to do so. The family physician does not do open-heart surgery for someone who needs a coronary artery bypass, but rather refers the person to a surgeon who has been trained to do so. The person in the healthcare system who has the experience and training to address spiritual needs is the healthcare chaplain. That person is equipped to address all but the most simple of spiritual needs. However, in order for the chaplain to address the spiritual needs of patients, other healthcare professionals need to refer the patient to the chaplain. Nurses tend to be the healthcare professional (at least in the United States) who is most likely to refer patients to the chaplain, but it should not only be the nurse or the social worker. Again, the physician

is in charge of coordinating the healthcare of the patient, including the addressing of their spiritual needs. The reason is, as I have already noted above, because addressing of spiritual needs affects the mental and physical health of the patient, including the response of the patient's medical condition to treatments that are being prescribed by the physician. In my opinion, if the physician ignores the spiritual needs of patients, then that physician is not practicing the standard of care today, which involves addressing the whole patient and all aspects of their life that can influence their medical condition (psychological, social, and, yes, that includes spiritual influences).

Thus, this volume breaks new ground in providing a comprehensive examination of spiritual needs of patients, whether they are religious or not, needs that are directly related to their medical or mental healthcare. The research that is now showing the powerful effect that religious and spiritual beliefs have on physical and mental health has been ignored for too long. This book is a giant step in mainstreaming the assessment and addressing of spiritual needs into the practice of healthcare across multiple disciplines and multiple religions. Bravo to the many authors who have contributed to this work.

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I am further grateful to my wife Claudia, my son Oliver, and my daughter Annika for being family and supportive friends. Thanks a lot for being around. May you all be guided and sheltered.

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CHAPTER 1

Introduction

Arndt Büssing

Background

During the last decades there has been a significant increase in the number of studies that underline the relevance of a person's spirituality as a strategy to cope with difficult life situations, as a general resource of hope, hold and orientation in life, and, depending on the religious background and worldview, as a source to connect with that which is Sacred, with others and with creation (nature/environment).

However, spirituality is a complex and multilayered construct. And because of its complexity, its definitions and also the measures involved are heterogeneous and diverse (ranging from inclusive to exclusive definitions and approaches, and from unidimensional to multidimensional constructs) (Büssing 2019). The different layers of spirituality could be exemplified as *Faith/Experience* as the core, related *Attitudes* and subsequent *Behaviors*. With respect to the core aspect, a person may have specific own

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experiences with that which is Sacred or might have to follow the belief concepts of a religious tradition. Both the own experience which has to be integrated into a person's life concept and the adopted belief concepts of specific religions may shape peoples' *Faith*, which in turn could influence their *Attitudes*, "their (cognitive) beliefs, their (emotional) hopes and also their trust in a transcendent source" (Büssing 2019). The aforementioned layers will further influence their *Behaviors*, "the related ethics, social and health behaviors, and the use of distinct rituals (i.e., prayer, meditation)" (Büssing 2019). The experiential core aspect of spirituality is difficult to access (best in narratives), while the secondary indicators (i.e., religious trust, belief in a helping God, feelings of awe, compassion, altruism and charity, prayer and meditation) can be more easily assessed and measured with standardized instruments. Several of these indicators are not exclusive for religious persons but can be found also in nonreligious persons. These indicators *are* not 'spirituality' but they may be related to its distinct aspects and layers.

To assess a person's spirituality, one has to thus assume a complex set of 'indicators' which may all have differential meanings in one's life. These are shaped by a person's religious socialization, cultural influences, certain life experiences, personality factors and so on. In-depth biographic interviews may elucidate that a person's spirituality is not a fixed state, but a continuous development process (with phases of standstill, growth and decline). During the different phases of one's life (the biography), certain aspects may change their relevance—and the centrality of specific beliefs and practices may also change. Some may have lost their faith, others may experience phases of religious struggles and spiritual dryness, and some may reach states of 'enlightenment' or closeness with the Sacred.

While it is true that certain aspects of spirituality are related to positive health behaviors and lower risk factors, and more effective coping strategies and higher well-being, it is nevertheless problematic to recommend becoming 'more' spiritual in order to improve health and revert illness, or to assume that 'being' spiritual protects against the unpredictability of life. Generally, spirituality cannot be prescribed and used as a remedy, while for some spirituality-based treatments it can nevertheless be appropriate and beneficial. As most of us live in rather pluralistic societies with different worldviews, religious beliefs, social standards and ethical values, it is difficult to establish concepts that are ubiquitously valid. Spiritual issues and concerns might be important for several persons, but not for all. Some would see themselves as neither religious nor spiritual, while others are

either religious or spiritual, or both. However, even the putatively nonreligious/non-spiritual individuals may be interested in distinct 'spiritual' issues, but these are mostly not related to specific religious doctrines and faith traditions. They might be too rapidly labeled as 'nonreligious' and thus disregarded.

Therefore, it might be more appropriate to ask people what they need instead of providing what they might not want. The latter attitude refers to a paternalistic approach (which is often found in health-care professionals and religious leaders), while the former refers to a person-centered attitude of respect and humbleness. One attitude means "You should follow my recommendations!", and the other, "How may I help you?". In 1970, Zen master Shunryu Suzuki recommended a "beginner's mind" instead of an expert mind (Suzuki 2006). One mind is open to face the world as it is and listens, while the other already knows and gives answers because of the acquired expertise. "In the beginner's mind there are many possibilities, but in the expert's there are few" (Suzuki 2006). This means, when we listen to what people need and then ask how we may help and support them, we show interest in their specific concerns and value them as individuals with their own biography, hopes and expectations, as well as fears and worries, and try to find ways to care compassionately. This rather open and contemplative view "allows us to discover in each thing a teaching which God wishes to hand on to us, since 'for the believer, to contemplate creation is to hear a message, to listen to a paradoxical and silent voice'", said Pope Francis citing Pope John Paul II (Francis 2015, Chapter 85). Mindfully listening to the "silent voices" of others thus approves their dignity and respects their value and purpose (even if they cannot see these by themselves), and is also a spiritual act of humility and compassion that may enrich and transform the life of both the caregiver who receives and the receiver who gives, too. This underlines the interconnectedness within the field of spiritual care.

This book focuses on the assessment of a person's spiritual needs using the *Spiritual Needs Questionnaire* (SpNQ), an established and internationally used standardized questionnaire. Experts from different professions and cultures discuss the theoretical background of spiritual needs (from philosophical, anthropological, theological, ethical and health care perspectives), describe the tool's application in different groups of persons from varying cultural and religious backgrounds and with different health conditions (those with chronic diseases or special needs, and healthy persons, whether they are adolescents, adults or elderly) and subsequent