How do critical care nurses perceive their role in spiritual care?
by Christine Victoria Wicks

A thesis submitted in partial fulfillment of the requirements for the degree of MASTER OF NURSING
Montana State University

Abstract:
The purpose of this study was to determine if critical care nurses recognize and accept their responsibility in meeting the spiritual needs of the patient. The researcher question asked was: How Do Critical Care Nurses Perceive Their Role in Spiritual Care? A theoretical framework was formulated based on the assumptions of the symbolic interactionist theory. A conceptual framework was formulated based on the concepts of the nursing process.

The sample consisted of 25 Catholic hospital critical care nurses and 16 non-Catholic hospital critical care nurses. The study was descriptive in design utilizing a self-designed questionnaire to gather information.

Results from the questionnaire were displayed in percentages and cross tabulation tables. Significance was calculated by the use of chi-square.

The data analyzed suggests that the critical care nurses sampled at the two acute care hospitals were cognizant that nurses have a responsibility to assess for patients' spiritual needs. However, how they perceive their role in spiritual care appears to be related to the following: whether or not the nurse was employed by a Catholic or non-Catholic hospital, level of experience in a critical care area, level of education and religious background.

Implications were made and presented for nursing education and nursing service administration. Further studies are needed in spiritual care to keep up with the growing demand and increasing expectation for "holistic nursing care."

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Signature Christine Victoria Hicks

Date July 7, 1982

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by

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A thesis submitted in partial fulfillment
of the requirements for the degree

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ABSTRACT

The purpose of this study was to determine if critical care nurses recognize and accept their responsibility in meeting the spiritual needs of the patient. The researcher question asked was: How Do Critical Care Nurses Perceive Their Role in Spiritual Care?

A theoretical framework was formulated based on the assumptions of the symbolic interactionist theory. A conceptual framework was formulated based on the concepts of the nursing process.

The sample consisted of 25 Catholic hospital critical care nurses and 16 non-Catholic hospital critical care nurses. The study was descriptive in design utilizing a self-designed questionnaire to gather information.

Results from the questionnaire were displayed in percentages and cross tabulation tables. Significance was calculated by the use of chi-square.

The data analyzed suggests that the critical care nurses sampled at the two acute care hospitals were cognizant that nurses have a responsibility to assess for patients' spiritual needs. However, how they perceive their role in spiritual care appears to be related to the following: whether or not the nurse was employed by a Catholic or non-Catholic hospital, level of experience in a critical care area, level of education and religious background.

Implications were made and presented for nursing education and nursing service administration. Further studies are needed in spiritual care to keep up with the growing demand and increasing expectation for "holistic nursing care."

Chapter 1

INTRODUCTION

The growing demand and increasing expectations for "holistic nursing care" has stimulated much discussion into the spiritual realm of man. That nurses have given "lip service" in meeting spiritual needs of patients is evident. Spiritual needs have been recognized as important by nursing educators. However, rhetoric does not get the job done. Spiritual care is often neglected in the actual delivery of patient care.

Literature states there is work to be done in this area. However, there are few research studies that have been done to assist the nurse with assessing, interpreting, and evaluating spiritual needs of patients.

The majority of people expect nurses to be interested and to care about their innermost secrets. The public image of the nurse (and hopefully they will never lose it entirely) is of an "angel of mercy." Nurses do not always like being seen according to someone else's image of what they should be, but the role often works to their advantage. If nurses are perceived as concerned, caring people, they frequently have a short cut to rapport and intimacy.

Related studies have shown that patients appreciate concern and kindness from nurses in helping them work out their spiritual needs.

Patients have expressed desire to be allowed to talk about God and their spiritual concerns to nurses. Patients have ranked prayer as one of their most important spiritual needs. Sadly enough it was found that a large percentage of nurses do not pray with patients.

Today's nurses have expanded into many roles. The role of the nurse in spiritual care is in transition. Nurses feel insecure about meeting spiritual needs of the hospitalized patient. The researcher suspects few nurses would say they are comfortable dealing with spiritual concerns of patients.

Purpose of Study

The purpose of this study is to determine if critical care nurses recognize and accept their responsibility in meeting the spiritual needs of the patient. Furthermore whether or not significant relationship could be made between those critical care nurses working in a Catholic hospital to those critical care nurses working in a Non-Catholic hospital. The research question to be asked is: How do critical care nurses perceive their role in spiritual care?

Definitions of Terms Used

Critical care nurses are defined as: registered nurses working all shifts in intensive care and critical care units in two acute care hospitals in the Great Falls area. Nurses in intensive care nursery have been excluded. The nurses may be from religious

or non-religious backgrounds.

Role perception is defined as: the attitude the critical care nurse has about the meanings and values that guide and direct critical care nurses' behavior in meeting spiritual needs of critical care patients.

Spirituality is defined as: the life principle that prevails a person's entire being; emotional, moral, ethical, intellectual, physical dimensions, and generates a capacity for transcendent values.

Spiritual care is defined as: taking an active part in meeting critical care patients' spiritual needs, i.e., sharing of prayers and reading scriptures, referring patient to a clergyman, etc.

Patient is defined as: a person who is either conscious or unconscious in a critical care unit. Patients may have either religious or non-religious affiliations.

Attitudes are defined as: one's physical and emotional position and manner with respect to another person, thing, or situation.

Meanings are defined as: having an assigned function in a language system.

Values are defined as: learned attraction or repulsion one feels toward meanings.

Spiritual needs are defined as: rituals such as baptism, communion,

and preparation for death, certain dietary regulations, keeping of special holy days, regular attendance at a place of worship, visit from a clergyman, sharing of prayer and reading scripture.

Chapter 2

THEORETICAL FRAMEWORK

Symbolic Interactionist Theory

There are two major perspectives from which roles performance have been studied in the behavioral sciences. These theoretical formulations for the study of roles and role behavior are namely the functional perspective and symbolic interactionist perspective (Hardy and Conway, 1978).

The researcher has paraphrased what authors Hardy and Conway (1978), Blumer (1969), Rose (1962) and Webster and Sobjeszek (1974) have mentioned about these two perspectives.

From a functional perspective, responses are learned through the process of socialization. These responses are reinforced in the individual by approval or disapproval of significant others. Roles emerge from these responses and become more or less fixed positions within society, to which are attached certain expectations and demands. These same certain demands, norms or values of the roles which are laid down by society are expected to be adopted from generation to generation. Thus, in the process of social interaction the group, rather than the individual, decides what they will accept, reject or transform as the basis for their responses to societal demands.

The researcher decided that the functional perspective of role

theory did not relate to the study proposed for investigation. According to Fish and Shelly (1978), the role of the nurse in spiritual care is in transition. Consequently, to study how the nurse perceives her role in spiritual care one would need a theoretical framework that would account for wide variations in behavior. Authors Blumer (1969), Rose (1962), and Webster and Sobjeszek (1974) claimed the symbolic interactionist approach to the study of role and role behavior has taken precedence over functional theory in attempts to explain human behavior. The major reason, these authors cited, was because functional theory did not account well enough for the wide variations in behavior which take place within complex social structures.

From a symbolic interactionist approach, the study of roles and role behavior responses are assessed, interpreted, and noted through the process of socialization. Significant others' attitudes are the basis for individual lines of action. However, when the individual engages in interactions with significant others he selects certain cues for action which, for him, have more meaning than others. Roles emerge not simply from learned responses but from organizing and interpreting cues in ones' environment. Thus, in the process of social interaction the individual, not the group, indicates to himself what he will accept, reject or transform. From this particular baseline the individual decides what type of response to make to societal demands.

The assumptions and propositions related to symbolic interactionist theory have been borrowed by Mead (1934) and Rose (1962), by either direct quotation or paraphrasing.

Symbolic interaction theory is defined by Blumer (1969, p. 5) as:

> The interaction occuring between human beings who interpret or define each other's actions instead of just reacting to them. Their responses are based on the meanings they attach to such actions. The key factor of symbolic interaction is to get inside the defining process of the actor in order to understand his action.

Assumption 1. Man lives in a symbolic as well as physical environment and can be stimulated to act by symbols as well as by physical stimuli.

A symbol can be thought of as an object or act having cultural significance and the capacity to excite a response (Webster's Dictionary, 1980).

According to Rose (1962), symbols can be transmitted through interaction with people, gestures or motions and through objects. The author claimed that most symbols are thought of as common or shared meanings and values.

A meaning can be thought of as having an assigned function in a language system (Webster's Dictionary, 1980). A value can be thought of as a learned attraction or repulsion a person feels toward meaning (Rose, 1962).

Assumption 2. Through symbols, man has the capacity to stimulate others in ways different than those in which he himself is stimulated.

According to Mead (134), this is communicated by role taking. Role taking can be thought of as the ability to get inside the defining process of the other in order to understand his action (Blumer, 1969). Role taking may also be referred to as empathy (Rose, 1962).

Assumption 3. Through communication of symbols, man can learn large numbers of meanings and values, and hence ways of acting, from other men.

Rose (1962) derived from this assumption that man can have a culture, an elaborate set of meanings and values, shared by members of society, which will guide much of his behavior. Riehl (1980) stated that through symbolic communication people learn new roles rapidly as they see which of their behaviors evoke positive responses from others.

General Proposition (Deduction) 1. Through the learning of a culture and subcultures, men are able to predict each other's behavior most of the time and gauge their own behavior to the predicted behavior of others.

Assumption 4. The symbols, and the meanings and values to which they refer, do not occur only in isolated bits, but often in clusters, sometimes large and complex.

According to Rose (1962), clusters can refer to either role or structure. The author defined role as a cluster of related meanings and values that guide and direct an individual's behavior in a given social setting (Rose, 1962). The author further claimed that structure includes the aforementioned, but also includes the relationships of all the individual roles that are expected of it; i.e., state, society, committee.

> *General Proposition (Deduction) 2. The individual defines (has meaning for) himself as well as other objects, actions, and characteristics.*
>
> Assumption 5. Thinking is the process by which possible symbolic solutions and other future courses of action are first examined, then assessed for their relative advantages and disadvantages. In terms of the values of the individuals, one of them is then chosen for action.

According to Rose (1962), the alternatives assessed in thinking are determined by what these certain alternatives mean and in terms of the individual's values. Thus, thinking is similar to trial and error behavior.

The way the critical care nurse perceives her role in spiritual care is affected by the extent of her interaction with a particular church or pastor. Another way the critical care nurse perceives her

role in spiritual care is affected by the extent to which the nurse utilizes her past and present experience in spirtual counseling. Still another way the critical care nurse perceives her role in spiritual care is affected by her own personal value system.

In summary, symbolic interactionist theory, provides an appropriate theoretical framework to study how a critical care nurse perceives her role in spiritual care.

CONCEPTUAL FRAMEWORK

Nursing Process

Authors Fish and Shelly (1978), Henderson and Nite (1978), Lichtenberger (1979), Fleeger and VanHeukelem (1977), all suggest using the nursing process to access spiritual needs. The authors claim it is an effective tool to help the nurse feel competent in actual delivery of spiritual care. According to Fish and Shelly (1978), once the nurse begins to feel more competent actually delivering spiritual care to the patient her perception of this role will become more defined.

Stanton, Paul and Reeves (1980) define the nursing process as a deliberate intellectual activity whereby the practice of nursing is approached in an orderly, systematic manner. According to VanHeukelem (1979) spiritual assessment needs to be systematic and objective, that is, knowing what to look for and doing it in an orderly manner.

Stanton, et al. (1980), further claimed that the nursing process provides a means for evaluating the quality of nursing care given by nurses. It assures accountability and responsibility to the patient. The nursing process is both reliable and valid, that is, it should be verifiable or reproducible by another person of comparable skill.

Most authors agree that four phases are considered necessary to the nursing process: assessment, nursing diagnosis or identification of the problem, intervention or implementation and evaluation (Van-Heukelme, 1979; Fish and Shelly, 1978; Murray and Zentner, 1975; and Young, 1978).

The conceptual framework for this study has been developed based on two basic assumptions.

Assumption 1. Professional nursing practice is interpersonal in nature (Stanton, et al. 1980).

The main emphasis of symbolic interactionists is upon the interactional processes through which socialization occurs rather than upon the learning processes through which socialization is achieved (Hardy and Conway, 1978).

Assumption 2. Nursing reflects awareness that man is not simply a biological organism, but also a psychosocial, and spiritual being (Stallwood, 1975).

According to authors Stanton et al. (1980), these two assumptions, that nursing is interpersonal in nature and the professional nurses

view human beings as holistic give guidance and direction to the use of the nursing process.

In order to use the nursing process effectively nurses need to apply concepts from biological, physical, behavior science and from the humanities, in order to provide a rationale for decision making judgments, interpersonal relationships, and actions (Stanton, et al. 1980, p. 24).

Riehl (1980) claims that the fifth basic assumption of the symbolic interaction theory can incorporate the nursing process.

> i.e., Assumption 5. Thinking is the process by which possible symbolic solutions and other future courses of action are examined and assessed for their relative advantages and disadvantages in terms of the values of the individual, and one of them chosen for action (Rose, 1962).

Earlier it was established that the nursing process was a deliberate intellectual activity. Utilizing the thinking process, the nurse examines and assesses the patient in each situation.

In the assessment, the nurse ascertains the roles the patient has assumed in the past and those he currently holds, the patient's problem solving ability, his adaptability, how he has resolved similar problems in the past, how he copes with his general environment and with crises, stress, etc.

> Most importantly, the nurse observes him and the role he takes in varied situations, such as with his doctor, his family and with the nursing staff, to learn as much as possible about the defining process of this actor - the patient - which is essential to understand him. (Riehl, 1980, pg. 355)

Blumer (1969) claimed that the key factor of symbolic interaction is to get inside the defining process of the actor in order to understand his action. Thus, the nurse assesses, interprets, plans for implements, evaluates, and records the aforementioned data. Riehl (1980) compared the nursing process to symbolic interactionism in that they both are dynamic frameworks which are influenced by day-to-day input.

In summary, the nursing process provides an appropriate conceptual framework to study how a critical care nurse perceives her role in spiritual care. Nursing instructors have incorporated the nursing process in their curriculums, and emphasized its importance to the holistic approach to man.

Chapter 3

REVIEW OF LITERATURE

Past and Present Religious Influences in History

Early in nursing history religious influences largely shaped the purpose of nursing. Nursing had its educational roots in the church, not the University (Donnelly, Mengel and Sutterly, 1980; Kelly, 1975). Early history reflects a dichotomy of roles that existed between nurses. The hospital nurse was a drunken, promiscuous and a troublesome person. Her only role was tending to her patient's sick body by carrying out the doctor's orders. On the other hand the religious order, Nuns and Sisters, were concerned more with the souls of their patients than with their bodies (Donnelly, et al. 1980).

Florence Nightingale, founder of modern nursing, recognized the need to integrate the biological, psychosocial, and spiritual components of man into the whole person. She considered her choice of a life of nursing service to be a response to a call from God. She also recognized the need for nursing to be taught in schools in order to promote competent holistic care (Isler, 1970).

Today much is written about integrating the spiritual dimension of man into the biological and psychosocial dimensions. Nursing literature has reflected an awareness of the spiritual dimension of

man. However, it is the spiritual aspect that is most often neglected or only mentioned with regard to religious beliefs that affect therapy. According to Stoll (1979), philosophies of nursing characteristically state that nurses are educated in the holistic approach. But admittedly the spiritual dimension of nursing care is more elusive than the physical or emotional. Nurses are aware of their neglect with spiritual care and choose to ignore it by using the excuse that they do not have the time (Young, 1978).

Henderson and Nites (1978), believed that if people are to be viewed as a whole, then their moral, ethical, spiritual and religious values can not be ignored. Both authors think that the nurse should be more adequately educated in spiritual care. Wessman (1978), stated that preparation for spiritual care demands no less discipline or knowledge than emotional or physical care. According to Brill (1978), the spiritual component of man is as important as his physical, social, intellectual, and emotional components. This particular author believes that to ignore or deny the spiritual aspect because of our incomplete understanding of it would be to deny the totality of the individual. Hoyman (1967), pointed out that up to a certain point, both in man and animals, health is based upon physical, mental, and social well-being. But of all living things only man's health has a spiritual dimension that is inextricably related to, but goes beyond, the physical, mental and social.

The literature review thus far has found a few authors that detailed their descriptions of the nature of man. Patey (1977), stated that it used to be fashionable to speak of man as being made up of three parts, body, mind and spirit. However, man can not be divided up into these clearly separated parts. Man is all of a piece. There is not a dividing line between the physical, mental, and spiritual. Each is to be thought of as dependent upon one another. Tillich (1967), rejects the phrase levels of life. According to this action man should not be considered as a composite of several levels, such as body, soul, and spirit, but as a multi-dimensional unity. The use of the term dimension was to indicate that the different qualities of life in man are present within each other and do not lie alongside or above each other. Therefore one can expediently, but not necessarily, distinguish the biological, psychosocial, and spiritual dimensions. Ashbrook (1967), and Stallwood (1975), have comparable conceptual models of the nature of man. Ashbrook (1967), felt the most obvious dimension is the physical level of a sick body, whether it be a broken bone or malignancy. Intertwined with this is the second dimension of the emotional level of the sick mind, resulting from distortions and frustrations in one's significant interpersonal relationships. Finally, infusing both is the dimension of the spiritual level in which a person lacks adequate meaning for life. This same author

believed that all three dimensions interpenetrate each other to hinder the individual from fully relating to himself, to others, and to God who is the ground and source of life. Stallwood's model (1975), also depicts the whole person, whose parts are integrated. The model was illustrated by drawing outer, middle, and inner circles. The outer circle represented the biological (the part of man in touch with the world through five senses) the middle circle represented the psychosocial, termed soul in theological language (the part of man which is selfconscious, expressed through the intellect, emotion, will and the moral senses) the inner circle represented the spirit (the part of man which is God-conscious). According to this author the spirit is the most difficult to comprehend because it is an inner and unseen part of man. However, it is not to be neglected because it is understood as that part of man that experiences or has the potential to experience a relationship with God. None of these three parts is independent but rather inderdependent (VanHeukelem, 1979).

Although spiritual needs have been recognized as important by educators, nurses, psychiatrists, clergy, etc., spiritual care is often neglected in the actual delivery of patient care. Fish and Shelly (1978), believe that the major objection of most nurses to meet the spiritual needs of patients is the feeling that a patient's relationship with God is a private matter into which we should not

pry. Admittedly nurses do move into areas of a patient's life which he would normally take care of himself. Nurses ask about bowel movements and menstrual periods, without thinking. However, nurses need to remember that spiritual intervention is appropriate if they care about their patient's spiritual life as much as they care about their physical and emotional well being. According to Israel (1977), the spirit of man is the greatest ally of all to those involved in the healing profession. This author believes that while the spirit pulsates within an individual he will continue to cooperate consciously and unconsciously with the medical agencies of healing. However, if spiritual care is neglected and the spirit is quenched, the individual will flounder and succumb even in the face of the most expert treatment.

Lichtenberger (1979), stated that because God has created each person for Himself, He made that person with specific needs. When those spiritual needs are not met, people begin to cry out for their rights. According to Piepgras (1968), a patient has a right to demand that his spiritual needs be accepted on the philosophical level that they are presented. The nurse is to meet his spiritual needs by not going outside the religious sphere and draw upon unrelated incidents and comparisons just to keep a conversation going.

According to Travelbee (1971), nurses have been well trained

not to talk about spiritual needs. This author believes that the opinion of nursing problems is related to the person's inability to find meaning in their suffering. This, as was pointed out by the author, was chiefly related back to a lack of spiritual care.

Purpose of Religion

Religious or spiritual belief, whatever it might be, has been reported to serve many purposes in an individual's life. Religious and spiritual beliefs have been closely aligned with health practices throughout history. Byrne and Price (1979), cited a composite of needs that religion fulfills which could influence health. The need for worship or showing reverence for or devotion to a deity, illustrates that humans seek a power greater than themselves. Religion fulfills the need to find meaning in life when faced with despair. Other voids cited by the authors that religion fulfills are the needs to understand the nature of reality and to explain or accept longsuffering. Religion helps to interpret why something had to happen as part of God's plan. God's plan not being understandable at the moment, but having meaning in a greater plan. According to the authors, religion fulfills still other voids to deal with quiet and the need for feeling that one is doing something in a time of helplessness. Religion offers the opportunity for prayers, rituals of purification, confession, etc. The last void

worth mentioning that religion fulfills, as cited by the authors, is the need for strength in face of the unknown or in times of crisis. The authors believed that in a situation where one loses control, such as surgery, one depends more on God. Although religion fulfills many purposes in an individual's life, the authors think it is often ignored as a demograhic variable in relation to health.

Man is a creature who seeks for meaning in life. Though the individual may not be an actively practicing member of any faith, the person will have doubts and fears regarding the "why" or "how" of life. According to Israel (1977), the issues raised by particular questions as "why" or "how" are the groundwork of the world's religions. The authors think that mankind cannot aspire to its full glory until it has included the religious dimension in its apprehension of reality.

Illness as it Relates to Religion. Doubts and fears regarding the "why" or "how" of life are emphasized during illness. Fish, in a 1973 thesis, attempted to formulate a conceptual model of man and his needs and apply it to the experience of illness. The conceptual model was based on Biblical presuppositions. According to the author, persons experiencing illness may have concerns regarding spiritual relatedness, future ability to accomplish something and their own spiritual identity. The author claims that scientific

explanations to these concerns supply a partial meaning but not the full meaning. For that, the author believes one must probe beyond the physical into the things of the spirit. Thus, illness involves the reactions of the spirit and the soul as well as a physical response of a biological body.

Zeller (1967), and Stoll (1979), both believe that some people think that illness and disease are related to past sins or guilt for failing to meet some standard of conduct. Derivations of these words reveal the origin of the notion that health is related to integrity as sickness is to sin (Webster's Dictionary, 1980). Both authors cited that due to the historical derivations people experiencing illness and disease thought their lives were being brought under judgement. According to Stoll (1979), and Piepgras (1968), the nurse often desires to ignore such a concept of illness as a form of judgment. However, the nurse should accept the concepts and look at the meaning of the experience with the patient. Piepgras (1968), states that consistent suppression of spiritual longing leads to spiritual death. Questions may be raised as to what life is all about when a person is confronted with illness or disease. However, according to Levy and Striffler (1974), and Lichtenberger (1979), hospitalized patients who take their religion seriously are unlikely to express their spiritual needs verbally or directly. Levy and Striffler (1974), think that the patient's

religion is significant in major health crises and newly diagnosed serious or chronic diseases. Critical care nurses are usually the first or last member of the health team to encounter these types of patients. The nurses need to be mindful that religion may be a complicating factor in the patient's recovery. According to Kelly (1975, p. 223) "nurses must realize that the nature of the spiritual care the patient receives can have a direct effect on the speed and quality of his recovery." Religious beliefs may also affect illness in other ways. Pumphrey (1977), thinks that patients are often hesitant to discuss religious restrictions. The author proceeds to discuss some of the religious groups that deny the reality of spiritual and physical discomfort which may predispose patients to deny medical treatment. The author mentions that other religious groups may resist medical therapy because of the belief in modern science advocating false teachings such as evolution. Still other religious groups support medicine in general but object to certain practices. The nurse needs to be aware of environmental and covert cues when assessing a patient for religious restrictions or spiritual needs.

Evolvement of the Nurses' Role in Spiritual Care

Fish and Shelly (1979), and Simone (1971), believe that nurses are at an advantage to assess the patient for religious restrictions or spiritual needs. The reason these authors think this way is

because nurses are involved with the patient only during the course of the illness. Nurses have not know the patient when they were strong, self-sufficient people. Consequently, the patient does not usually feel he has to maintain an image of strength. For this reason the authors think that when illness affects a person's faith, that person may feel more comfortable talking about it to a nurse than with others. Simone (1971), stated nurses should realize that especially during illness patients are sensitive to others' influences. It is at this time patients are most in need of the supporting presence of a person who can make real for them the love and presence of God. The author believes that because of this, nursing presents a great opportunity for helping others reach their destiny of God. She stated that nurses must recognize the fact that everyone needs someone to be with them.

Religious Background of the Nurse. The religious background of the nurse and patient plays a predominant part in the way the nurse perceives her role in spiritual care. To comprehend the truth of this statement one need only reflect upon some basic premises of the symbolic interactionist theory. Mead (1934), stated that humans act toward things on the basis of the meaning things have for them. The author further postulated that the meaning and values of things are derived from social interaction with one's own group. Thus, a person's religious background, upbringing and what that person has

been taught by example or word helps the individual to formulate personal religious beliefs. A study by Tate and Miller (1970), found that those people with more of a religious background demonstrated more importance to the values of salvation and forgiving. Ideally a nurse should be able to respond to each patient's spiritual needs as naturally as she would respond to his physical needs. Pumphrey (1977), Kelly (1975), and Piepgras (1968), believed that nurses with religious backgrounds would most likely feel uncomfortable responding to a patient's spiritual need particularly if his beliefs differed from their own. A survey was conducted by Kramer (1957), to determine the attitudes and knowledge of nurses concerning spiritual care of the patient. The researcher reported that only five nurses from a sample of eighty would be tolerant of different religious health practices. However, Piepgras (1968), and Kelly (1975), perceive that the believer of one faith will often recognize the spiritual need in a person whose faith comes from a totally different frame of reference. The authors stated that a nurse without a religious background will not be able to comprehend the deep spiritual need that some people experience. According to Byrne and Price (1979), health workers with minimal religious background may not fully realize the profound affect religion may have on patients lives. Henderson and Nite (1978), believe that nurses feel hampered by ignorance in their efforts to

help persons with different religious beliefs. However, the authors claimed that the more spirituality or religious background a nurse has, the more comfortable that nurse is in discussing spiritual questions. From this claim, these authors further postulated that it would be more likely that patients would confide in them. Nelson (1977), conducted a survey on how nurses perceive their role in the spiritual dimension of nursing care. The researcher found that a major factor influencing the nurse's role in the spiritual dimension is the quality of her own relationship to God. From these various viewpoints the researcher is assuming that a critical care nurse with a religious background will be more effective in actual delivery of spiritual care.

Religious Background of the Patient. According to Byrne and Price (1979), the ability to cope with chronic illness may be better among the religious than the non-religious. Israel (1977), pointed out that those persons who believe their physical bodies are the sole source of identity also believe that death to their physical body means extinction of their existence. These persons who do not have spiritual beliefs may be difficult to comfort when they face critical illnesses. Pumphrey (1977), claimed that a patient without spiritual beliefs confronts conditions beyond his control, he will have difficulty admitting his helplessness. The author thinks the

patient may attempt to prove his strength with angry outbursts, blaming nurses for their shortcomings. Because the nurse should be concerned about the kind and quality of spiritual care rendered she needs to be familiar with the patient's religious background.

Evolvement of Nurse and Patient Roles through Symbolic Interaction

Once the patient arrives in the critical care unit roles between the nurse and patient have automatically been assumed and identified. According to Hardy and Conway (1978), interaction proceeds as roles are identified. Blumer (1969), explains the process of symbolic interaction further. Symbolic interaction involves ascertaining the meaning of the actions or remarks of the other person and conveying indications to the other person as to how he is to act. Participants fit their own acts to the ongoing acts of one another. As participants take account of each others' ongoing acts, they have to arrest or adjust their own attitudes. From this viewpoint learning of roles between patient and nurse are a two-way process in which they are mutually influenced. According to Ashbrook (1967), if nurses avail themselves of ministering to patients, they cannot help but be influenced, by that patient. Consequently, it is only as the nurse is influenced by the patient that the nurse is able to have an influence on the patient. The nurse needs to be aware of the significance in an interaction with

the patient in order to assess for a spiritual need. Snyder and Wilson (1977), maintain that the interactionist process occurring between the patient and nurse, although at times subjective, is worthy as part of the assessment.

Role Taking. During the interaction process the nurse and patient take roles from each other. Hardy and Conway (1978), acknowledge that role taking or the ability to imagine oneself in place of the other and see things as that person sees them, enables the nurse to anticipate the response of the patient to her own behavior. Mullins and Barstow (1979), equate role taking with empathy. When a nurse incorporates empathy into her skills she can understand and predict her patient's feelings and actions more accurately. The nurse must grasp the patient's perspective to assess what the circumstances impinging on the patient mean to him. The authors felt that to give any kind of support to patients, a nurse needs the quality of empathy. A study on therapeutic relationships by Traux (1975), showed nurses scored lower on a measure of empathy than did seven other groups. According to Fish and Shelly (1978), if a nurse relates to the person instead of the illness she can be a channel for the expression to a patient of God's offer of meaning and purpose, love and relatedness, and forgiveness. Israel (1977), stated that once the spirit of one person can flow unimpeded through

the weakened spirit of another, the other can be brought back where God, however, we may conceive this supreme being, reigns supreme.

Interpretation of Objects. The evolvement of the nurse's role through interaction with the patient involves interpretation of the patient's objects, gestures and attitudes. According to a symbolic interactionist, Blumer (1969), objects consist of whatever people indicate or refer. "People are prepared to act toward objects on the basis of the meaning that the objects hold for them. All objects are formed and transformed by the defining process in social interaction." (Blumer, 1969, p. 11).

Booth (1967), described the body as an object. The body speaks a basic language through the healthy and unhealthy functioning of its organs. Each organ not only supports the life of the body, but also serves a specific relationship between body and environment. The author claimed that in the state of illness the person is alienated from the object of the affected function. According to the author the body always expresses the soul and more impressively in illness. Fish and Shelly (1978), and Stoll (1979), describe more obvious objects such as articles in a patient's room that may reflect his or her concerns, values, and beliefs. These could be religious devotional books, cards, Bible, rosary, etc. The symbolic meaning of such objects can be comforting to a patient in the

strange environment of a hospital. According to Simone (1971), the person whom the nurse meets in the hospital is greatly influenced by his environment of accelerated change, increased technology, etc., all of which lead to a mistrust of others. A sterile, impersonal environment, such as an intensive care unit, in which a person is alienated from his familiar objects and made dependent on new objects may create critical spiritual needs. Pumphrey (1977), claimed that patients may describe troublesome dreams that express spiritual conflicts in symbolic forms.

Interpretation of Gestures and Attitudes. The evolvement of the nurse's role through interaction with the patient also involves interpretation of the patient's gestures and attitudes. According to Ashbrook (1967), and Booth (1967), it is recognizable that a person is intimately related to his disease. These authors think that by one's expressive gestures, color of skin, etc. the existential situation can be spelled out. Booth (1967), believes that the biologic function is used as a mere gesture, but a gesture which realistically affirms a social attitude. Symbolic interactionist, Day (1975, p. 174), stated "a person interprets the intentions of the gestures of others and then makes his response based on that interpreted intention." Thus, nonverbal and/or verbal gestures are symbols which can show the intentions of others.

Fleeger and Homes (1977), believe that articulating our gestures and attitudes helps us discover who we are, why and how we do what we do, and where we go from there. From this viewpoint the authors claimed that the degree of spiritual wholeness in the nurse will influence her ability to identify and meet spiritual needs.

Principles of Self, Self Concept and Significant Others. To understand more fully how the nurse perceives her role in spiritual care one needs to take into account the symbolic interactionist principles of self, self concept, and significant other. The self emerges from assuming an organized set of attitudes from others. It is a hierarchy of roles that can be taken of and predicted fairly accurately by others (Rose, 1962). As a result of having a self, Mead (1934), saw the person selfinteracting, requiring that person to meet and handle his world through a defining process of judging, analyzing and evaluating the things he has assumed from others instead of responding to it. This process forces the person to construct his action instead of newly releasing it. What this means for the nurse is an ongoing awareness of how her attitudes and patterns of behavior might surface in relationships with her patients and a need to repeatedly reflect where her patient is in relation to her. According to McCormack (1976), a deep threat associated with spiritual experience is that of loss of self. The

author claimed that this loss of self can prevent one from gratifying their need for spiritual experience. Israel (1977), claimed that religious tradition has taught mankind that those who are able to sacrifice their self interest to service the world will grow into a knowledge of the true self or self concept.

The true self or self concept emerges when the individual is able to perceive himself as a whole. It is a series of selves that make up the self concept. Once defined the self concept can take on characteristics and attributes not part of its constituent roles (or other selves). Thus, the self concept is purely the personal aspect of the individual (Rose, 1962). It is this personal aspect of the individual or inner life that Kaiser (1981), claimed Ira Progoff believes people refuse to discuss. According to this author, Progoff relates a person's inner life to spirituality. The author further described a tool (The Intensive Journal System) that Progoff has developed to enable persons to view into their true self or self concept. This tool is one way that attempts to get persons in touch with their inner life or spirituality. However, inner beliefs and innermost needs may be expressed in various ways. According to Young (1978), a clear focus of the self concept is needed in order to perceive clearly the identity of others, thus not confusing one's own feelings and needs with those of the patient. Lichtenberger (1979), and Israel (1977), describe man as a human spirit which

means his true self or soul. Israel (1977), further defined spirit as that power which impels the soul forward to discover new facts, make new relationships, etc.

According to Fish and Shelly (1978), the use of the true self is one of the four major resources available for meeting spiritual needs. The authors further defined listening, empathy and commitment as some of the key elements in the therapeutic use of the true self. Consequently, it is imperative for a nurse to evaluate her own relationship with God. Nurses who feel alienated from God or doubt His involvement in people's lives will find it difficult, if not impossible, to assist a patient spiritually. VanHeukelem (1979), believes that for nurses who have not resolved their own spirituality, talking with patients about spiritual concerns can be a real threat. Interestingly enough Gebbie and Laving (1974), identified an altered self concept as part of the tentative list of nursing diagnoses at the first national conference on classifying nursing diagnoses.

The concept of the significant others (reference group) and socialization are central to the symbolic interactionist theory. Each individual is shaped through the socialization process. The reference group or significant others provide the individual with sources of values, attitudes, norms, and goals that he selects in guiding his behavior (Hardy and Conway, 1978). Although each

individual is shaped through the socialization process, it does not follow that selves will be alike because each individual has experienced the socialization process from different perspectives. Earlier it was mentioned that the self was a hierarchy of roles taken of and predicted fairly accurately by others. These roles which are highly valued are termed the reference group (Rose, 1962). However, these highly valued roles by the individuals can either exert positive or negative referent influences on the individual. A positive referent relationship exists when the reference group is more similar to the individual's attitudes. In a negative referent relationship the individual may be forced into having the relationship against his personal values and is obliged to act in accordance with the expectations for him in the relationship (Rose, 1962). A study conducted by Schwartz and Ames (1977), illustrated referent groups as source of influence. The authors found that the referent group's influence was greater when they were similar to the individual. However, it was also shown that negative referent others can have significant influence. Thus in the enactment of their professional roles, actions of health care professionals are strongly influenced by their perception of the norms and values of those groups.

In the critical care units a patient is alienated from his reference groups or significant others. The significant others that

do come in contact with the patient relate to him as an illness more than a person. They really do not know what to say to the patient as they attempt to handle their feelings. While the nurse relates to the patient in the context of his illness, she should relate to the person not the illness. Goslin (1969), stated there is some evidence that individuals vary considerably in the degree to which their significant others are personalized. The author claimed that the more clearly personalized the significant other, the stronger will be its effect on behavior. From this viewpoint one could assume that the close proximity which a critical care nurse has to her patient could be thought to be a source of influence on the patient. According to Fish and Shelly (1978), a nurse may be one of the few people who can stand with a patient in his suffering and help him deal with it. The authors also believed that a patient's behavior toward personnel can be a strong indication of his relationships with his significant others. If a person is uncooperative, demanding, withdrawn, etc., for no apparent reason, the authors believe the behavior may stem from difficulties in significant relationships, including a person's relationship with God. According to Fish (1973), whether the person is well or ill he is ultimately on a quest for faith in a significant other. Therefore, interpersonal relationships with reference groups can be significant indicators of a patient's spiritual well being or

distress.

Nurses' Perception of Their Role in Spiritual Care

Nurses have many different perceptions of what their role should be or should not be in actual delivery of spiritual care. The way in which the nurse perceives her role in spiritual care will influence its actual delivery. According to Riehl (1980), there are shared meanings and values within the hospital by which individuals and groups are stimulated to act. These norms are not, however, shared with the patient. The author claimed by recognizing that patients initially do not respond to the norms of the health care system, nurses are uniquely able to discover the norms to which individual patients respond (because of their close proximity to the patient). The author believed that because the patient is not part of the health care delivery system, the responsibility for teaching the patient how to react to a world of unfamiliar objects, norms, etc. lies with the nurse.

According to Travelbee (1972), the nurse's role is to help sick people find meaning in illness, or accept the reality of it. The author claimed the reason that nurses have difficulty in perceiving their role is because nurses have been educated to believe their role is that of the healer. Nurses have failed to recognize some illnesses of hospitalized patients are incurable. According to

Vaillot (1970), the nurse's role was to help the patient live as fully as possible; to assist him to get well, get better, or live within his limitations. Simone (1971), claimed that a nurse should be preoccupied with establishing a nurse-patient relationship on mutual trust and respect. A nurse who believes man was created in the image of God, should relate in verbal and nonverbal ways that her patient is important and that she holds him in reverence.

Piepgras (1968), claimed that nurses should recognize a patient's need for a dependent relationship. She felt the nurse could help the patient to transfer this need to a trust in God. From there the nurse should and can work to assist the patient to take responsibility for his/her own progress. Henderson and Nite (1978), and Wessman (1978), postulated that nurses should enable the patient to continue the forms of worship that bring them comfort. The authors believed that a nurse should not impose her own beliefs, but use verbal and environmental clues from the patient as entry points.

Scott (1978), claimed that the nurse is responsible for coordinating the actual delivery of spiritual care. The author believed that a nurse is ethically responsible for using her assessment and goal setting skills in order to provide well rounded and thorough care. In the surveys conducted in spiritual care by Kramer (1957), and Nelson (1977), both researchers studied nurses'

perception of their role in actual delivery of spiritual care. From a sample of eighty registered nurses, Kramer (1957), reported that 94 percent of the nurses thought they should administer spiritual care to patients. However, only 57 percent of the nurses felt capable of actually rendering spiritual care. Nelson (1977), interviewed twenty-seven nurses and reported that nineteen nurses believed that the spiritual dimension of nursing care should be a part of the nursing responsibility.

Stoll (1979), and Fish and Shelly (1978), think that the nurse is responsible for incorporating a patient's religious practices, beliefs that affect medical therapy, and spiritual needs on a nursing history. Stoll (1979), claimed that at present, the spiritual portion of most nursing histories merely identifies the person's religious affiliation. Authors Fish and Shelly (1978), and Bertholf (1979), decided that an evaluation of the strength and meaning of a patient's religious practices could prove valuable in assisting him to establish and/or maintain a dynamic, personal relationship with God. The authors believed incorporating a spiritual portion in a nursing history would help the nurse to intervene more specifically at the patient's level of faith and understanding. From these various viewpoints the researcher is assuming that the more critical care nurses perceive their role in spiritual care the more they will indicate that a nursing history

form should contain a spiritual portion.

Interestingly enough, nurses believing that their role is to be concerned about the patient's faith, at least in himself, prompted the nursing diagnosis of alerations in faith, to remain on the tentative list of nursing diagnoses. This list was compiled at the first national conference on classifying nursing diagnoses (Gebbie and Lavin, 1974).

Role Strain From Symbolic Interactionist Perspective. Through symbolic interaction people learn new roles as they see which behavior elicits positive and negative responses from other (Riehl and Roy, 1980). A doctoral dissertation on role overload and inequity was conducted by Hardy (1971). In the doctoral dissertation the researcher postulates that development of new roles may lead to role strain. The researcher identified components of role strain to be role conflict, role ambiguity, role incongruity and role overload. The researcher found that as role overload increased both social interaction and time required to perform a task decreased.

According to Goslin (1969), and Hardy (1971), significant others can and do knowingly speak and act in ways that reflect to the person a perception of himself. However, this does not necessarily coincide with the way he is perceived by these others. They deliberately conceal from him how his behavior and attitudes

affect them. The individual is faced with incompatible or mutually exclusive role demands. Consequently, when the individual acts out of the reference group's norms for himself role conflict results.

Hardy (1971), claimed that role ambiguity results from lack of information or vague demands that creates difficulty for the individual attempting to carry out their roles. Goslin (1969), gave a couple of examples of role ambiguity from a symbolic interactionist perspective. One distortion resulting from role ambiguity occurs in interpretating the meaning of gestures and acts. Thus, minor differences between the nurse and patient may produce misinterpretations which result in communication barriers. Still another distortion resulting from role ambiguity that Goslin (1969), mentions is a deficiency in empathetic capability. Earlier it was mentioned that a nurse needs to incorporate empathy or role taking into her skills in order to give support to her patients. Thus, a deficiency in empathy could effect her role taking ability and hence development of self perceptions.

Studies by Mullins and Barstow (1979), and Hardy (1971), found that role incongruity results when an individual discovers that expectations for his role performance run counter to his own attitudes and values. A nurse who feels inadequate in delivering spiritual care may retreat from the inclination to seek adequate support.

Hardy (1971), claimed that in discussion of role overload, lack of time is identified as a distinct barrier to fulfillment of role demand. Interestingly enough, a study on the spiritual needs of a hospitalized patient by Brown (1972), resulted in many patients giving the response, "nurses are too busy to give me spiritual support."

The nurse has feelings of uncertainty in moving into the role of spiritual care. By failing to sufficiently instruct the nurse in the role of spiritual care, role stress occurs. Hardy (1971), claimed that a person's response to stress is influenced by his resources, level and form of education, his performance level, adaptive skill, and other characteristics. From this viewpoint, the researcher is assuming that a critical care nurse with more experence and knowledge of her role will be more effective in actual delivery of spiritual care.

Spiritual Need Assessment

Kelly (1975), and Stoll (1979), admitted that attempting to meet spiritual needs may produce some discomfort, particularly if there is uncertainty about the appropriate approach. However, the authors think it is necessary for the nurse to meet these needs since nurses are concerned with the holistic approach to nursing care. Some nurses have recognized they have problems assessing a patient's spiritual needs.

Authors VanHeukelem (1979), Fish and Shelly (1978), and Ashbrook (1967), have all identified three categories comprising a spiritual need. The categories are a need for meaning and purpose in life, need for love and relatedness, and the need for forgiveness. The authors claim that all three categories are needed to establish and maintain a personal relationship with God. Fish (1973), defined these categories explicitly while developing a conceptual model of man. A need for a frame of orientation in view of the concept of man as a spiritual being is essentially a need for meaning and purpose. Man "seeks meaning and purpose for the events of his life apart from himself and the created world he lives in and knows and perceives with his senses." (Fish, 1973, p. 47). According to the author the need for love and relatedness encompasses the need for forgiveness. "All people are frequently spiritually isolated people and may feel very far from the love and forgiveness of God." (Fish, 1973, p. 55). This spiritual isolation can be of significance to the patient who is experiencing the sterile hospital environment and/or absence of a spiritual ministry.

Fish and Shelly (1978), admitted that planning for spiritual care may seem unrealistic. However, these authors further pointed out that there are occasions when not meeting spiritual needs consumes more time and energy than it would take to meet them. Henderson and Nite (1978), offered a list of steps nurses might take

in helping patients meet their spiritual needs. Some of those listed included learning about patients religious practices, beliefs and attitudes that could affect medical therapy, referring to clergy when requested by patients, and learning to administer sacraments. Also included was the reading of religious literature of prayers to the patient, allowing patients to keep religious articles in the room and enabling patients to continue religious practices if at all possible.

Fleeger and VanHeukelem (1977), believe that the spiritual dimension has finally been recognized as legitimate concern by professional colleagues at the third annual nursing conference on classifying nursing diagnoses. The tentative diagnosis of alterations in faith was changed to faith in matters related to spirituality. Data fell into headings of spiritual concerns, spiritual distress and spiritual despair. Etiology and defining characteristics were listed under each heading.

Nursing Process. Spiritual assessment can be done by nurses utilizing the nursing process. Authors, VanHeukelem (1979), Fish and Shelly (1978), Murray and Zentner (1975), Young (1978), and Lichtenberger (1979), have all advocated utilizing the nursing process to identify spiritual needs. The steps in nursing process; assessing, interpreting, planning, implementing and evaluating can

help a nurse to minister responsibly to the realm of spiritual needs. According to VanHeukelem (1979), utilizing a systematic and objective approach, such as the nursing process, eliminates potential hazards of relying on intuition and fulfilling personal needs when assessing spiritual concerns. Like symbolic interactionism, the nursing process is a dynamic process that is influenced by day-to-day input.

Fish and Shelly (1978), advocate using the nursing care plan to show that spiritual assessment is being done by the nursing process. The nursing care plan should outline the patient's needs with appropriate nursing measures to meet them. According to the symbolic interactionist theory meanings are handled through an interpretive process by the persons dealing with things he encounters. Mead (1934), believed that meaning arises in the process of interaction between two persons. However, individuals differ and even the most carefully thought out nursing care plan by the nurse with regard to spiritual care may have its problems. Therefore, the patient's spiritual needs should be routinely assessed and recorded by the nurse.

Much has been written about including spiritual assessment as part of the nursing process. It has been documented for some time that the nursing care plan would be most appropriate to record the patient's spiritual needs. However, the researcher is assuming that

nurses are not outlining the patient's needs with appropriate nursing measures on the nursing care plan and/or Kardex. By utilizing the nursing process the nurse can try several approaches to meet spiritual needs regardless of the patient's faith.

According to Fish and Shelly (1978), spiritual intervention can give a patient a sense of security and comfort in what may be a frightening, sterile, foreign environment. VanHeukelem (1979), stated that a patient's own philosophy needs to be respected. He is not to be coerced into discussing spiritual matters or into receiving any sort of spiritual aid. Thus, a nurse needs to establish a relationship based on mutual respect and trust before spiritual intervention takes place. The author also thinks that it is crucial for a nurse to have an understanding about the importance of various religious customs and rituals before spiritual intervention takes place.

Fish and Shelly (1978), believe that the nurse is responsible to provide a good listening ear, empathy, and commitment before she can be effective in actual delivery of spiritual care. In a research project by the Nurses Christian Fellowship (1970), it was found that patients recognize that nurses can assist them with their spiritual struggles by just listening. According to Murray and Zentner (1975), a nurse must listen carefully and ask questions to determine the patient's meaning of terms such as saved, sanctified, etc.

Authors Fish and Shelly (1978), and Ludemann (1968), stated empathy involves observation-collecting facts about a patient's affect, behavior, etc. They contended that by the nurse's ability to enter the spirit of another, the nurse can assess the patient's needs and provide effective nursing care. Authors Sheahan (1979), and Fish and Shelly (1979), stated that empathy is more instantaneous in a mature nurse.

Zeller (1967), claimed that involvement or personal commitment is missing from many lives and it is involvement that gives meaning to human relationships. According to Fish and Shelley (1978), if nurses have a commitment to caring for the whole person then they cannot claim lack of competence, lack of interest, or lack of responsibility in the area of spiritual needs.

Specific Interventions. The nurse can make use of specific interventions that will assist in meeting the spiritual needs of the patient. According to authors Pilster-Pearson (1980), VanHeukelem (1979), Fish and Shelly (1978), Wessman (1978), Scott (1978), Pumphrey (1977), and Kelly (1975), these include the use of prayer, scripture, provision for the practice of religious customs, talking about specific spiritual concerns, and referrals to the clergy. A thesis on nurses' responses to patients' spiritual needs was conducted by Chance (1967). From a sample of thirty-seven nurses

the researcher studied a variety of nursing actions to meet spiritual needs of patients. The researcher reported that conversation, listening, encouragement and prayer were the most frequently used methods of aiding patients spiritually.

A thesis on the spiritual needs of a hospitalized patient by Brown (1972), found that most patients wanted an offer of prayer by the nurse. In a study by Martin, Burrows, and Pomilio (1976), the researchers reported that 75 percent of the nurses stated they would feel comfortable reading the Bible or praying with a patient. However, according to the patients 50 percent of the nurses did not read the Bible or pray with them. A survey on the spiritual component in coping with breast cancer was done by Bertholf (1979). Many of the forty-seven females facing breast cancer that were interviewed reported that the nurses were too busy answering telephones, carrying out orders, distributing medications, etc., to be concerned with their spiritual needs. In fact 90 percent of these patients indicated that they had not received religious support from the nurses. Kramer (1957), reported that five nurses out of a sample of eighty mentioned listening to the patient as an aid to spiritual fulfillment. Ten out of eighty nurses mentioned they knew different religious practices that affect medical therapy. Two nurses out of the eighty actually read religious literature to the patient. Only one out of the eighty mentioned she would pray

with the patient. Only 30 percent of the nurses felt that they should determine if a spiritual need warranted referral to the clergy and initiate action for it. According to Fish and Shelly (1978), part of the difficulty in defining the role of nurses in spiritual care, as distinct from the role of the clergy, is that both roles are in transition. Both nurses and clergy feel insecure about meeting the spiritual needs of the hospitalized patient. The authors think that as both the clergy and the nurse become more confident and aware of their separate contributions to spiritual care, they can begin to work together. From these various viewpoints mentioned the researcher is assuming that the critical care nurse is not utilizing the clergy as a major resource in actual delivery of spiritual care. It seems apparent that the nurse cannot give spiritual care unless she perceives its importance as part of her role.

SUMMARY OF REVIEW OF LITERATURE

A review of the literature indicated that many authors are aware of the fact that the concept of health is changing to mean wholeness. Thus, much has been written on the integration of the whole man. The bio-psychsocial aspects of human nature have been extensively defined and developed. From the literature review one may assume that much has been written on the spiritual aspects of