A review of spiritual assessment in health care practice

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ABSTRACT

- The recent surge of interest in links between spirituality and health has generated many assessment approaches that seek to identify spiritual need and suggest strategic responses for health care practitioners.
- The interpretations of spirituality made within health frameworks do not do justice to the way spirituality is understood in society in general.
- Spiritual assessment should not impose a view or definition of spirituality, but should seek to elicit the thoughts, memories and experiences that give coherence to a person's life.
- Spiritual assessment tools should not be used without adequate exploration of the assumptions made. Assessment processes need to be adequately conceptualised and practically relevant.

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Carrying out spiritual assessments in a health care context clearly involves making assumptions about the relationship between spirituality and health. Such assumptions are frequently not even made explicit, let alone subjected to critical examination. This is unfortunate, as relating spirituality with health invites dissonance,[1] and the simplest way to reduce dissonance is to assimilate one concept into the framework of the other. While this may lead to clarity, it does so by undermining utility and credibility from the point of view of the discipline that is subsumed. In health care literature, spirituality is usually interpreted from within one of three major models of health: biomedical, biopsychosocial or social.

From a biomedical perspective, in which health is implicitly defined as the absence of disease, spirituality lies beyond the scope of medical expertise: it is seen as the private concern of the patient. The worldviews of biomedicine and spirituality are incommensurate, although some recent attempts to study the biology of spirituality suggest a convergence of interests.[2] Pragmatically, spirituality may be seen as beneficial if it prevents disease or prolongs life — that is, if it promotes biomedical interests and clinical goals. In this view, clinicians should not attempt to offer spiritual care, although they might make referrals to address it. Health care institutions may provide spiritual care, usually in overtly religious ways, with spiritual assessment being performed at admission using the criterion of religious affiliation. For a patient to declare a religious affiliation does not mean that religious/spiritual concerns will be incorporated into treatment plans, but it may lead to a visit from a denominational chaplain to offer personal support.

The inability of a purely biomedical model to pursue matters of health, as contrasted with illness, was clearly indicated in the World Health Organization's 1948 definition of health as "a state of complete physical, mental and social well-being and not merely the absence of disease or infirmity".[3] However, a persuasive clinical expression of this expanded view of health did not appear until Engel's articulation of a biopsychosocial approach to care.[4] This model gives more attention to quality of life: for example, health becomes a possibility for people living with chronic illness. But, in this model, biology continues to dominate, psychology is largely applied to an individual's motivations and responses, and the social dimension is limited to the small-group relationships of family, friends or support groups, not the wider patterns of social influence that shape institutions and individuals. It is this model that is most often extended to incorporate spiritual care (a biopsychosocial–spiritual model).[5]

The biopsychosocial model uses psychological frameworks to understand health beliefs and behaviours. Unlike a classical biomedical approach, it takes seriously a connection between spirituality and health, but frequently confounds spirituality with individual psychology. Spiritual assessment focuses on a person's perceptions and beliefs, and the tools developed according to this model resemble psychological assessments.[6] Patients' answers to a series of standard questions contribute to an assessment of spiritual need. This process may be transparent to the professional caregivers but less so to the patient and family. Because interpretation is in the hands of the "expert", professional opinion may override that of the patient. In other words, the biopsychosocial model extended to spiritual care continues to assume that care is the responsibility of professionals. Spiritual care will be provided by the clinicians involved — usually nurses — or by adding a further professional to the team.

Social models of health[7] deal with broad patterns of health and illness within societies. Fundamental variables include occupational class, level of education, sex, ethnicity and age. These models more appropriately inform policy than treat illness, but they do identify targets for health promotion campaigns addressed to individuals. Spirituality is usually treated as an aspect of culture, and may be seen as an ally in reinforcing healthy behaviour.[8] This view of health is more likely to favour spiritual care provision by community and culture-specific groups than by health care agencies per se.

To summarise, in agencies organised according to biomedical priorities, spirituality is a personal coping mechanism that need not be incorporated into the health treatment plan. Integration is the patient's issue — patients must work out how to incorporate their experience of the biomedical system into the rest of their lives. Social perspectives that regard spirituality as a means of social support view spiritual care as the responsibility of the cultural and religious communities supporting the patient. Practitioners operating within a social model may be more intentional about involving these communities in care, but they still leave the decision to participate to the patient and family. In both these approaches, it is for patients to decide whether they will seek spiritual care alongside the health care being provided. However, spiritual care may be seen differently within a biopsychosocial framework. Here spirituality is related to quality of life and is thus one of the individual characteristics that shape health beliefs and motivations. It affects compliance and outcomes, and is thus legitimately an area of interest for clinicians.

Health as an aspect of spirituality

The interpretations of spirituality made within health frameworks do not do justice to the way spirituality is understood in society in general. It seems clear that most in our society would see health care as encompassed by spirituality, not spirituality encompassed by health care. That is, health care issues will be placed within the broader concerns of spirituality. For example, while from a health care perspective it may be vital to do everything possible to preserve a patient's life, from that patient's perspective the struggle to preserve life may be quenching his or her spirit. Much contemporary literature on illness experience demonstrates that a fundamental social role of spirituality is to resist professional discourses that might otherwise overwhelm personal life.[9] Spirituality supports individuals to maintain their identity where it is threatened by powerful others, to maintain relationships despite the disruption of professional care, and to hope in spite of professionals' lack of hope.[10] Spirituality demands that care be person-centred, attending to the concerns of the person receiving care.[11]

Herein lies a dilemma for spiritual care delivered within a biopsychosocial perspective. If, as social analysis indicates, spirituality preserves and enhances autonomy when much of a patient's life is being directed by experts, then delivering "spiritual care" as part of a total health care package may be counter-productive. Rather than enhancing a patient's sense of control, it may further undermine it: the experts will have taken over this aspect of life as well. In such instances, rather than giving the patient the capacity to transcend immediate physical and mental preoccupations, spirituality may be harnessed to those preoccupations. Clinical spiritual care, based on expert assessments, may be experienced as invasive and presumptuous or — worse — may immobilise patients by depriving them of a resource they need to cope or survive.

A further concern to be taken into account in a health-centred approach to spiritual care is the role illness and treatment may play in a person's spiritual journey. The worldview a person brings to illness may need to be reshaped in the light of this experience, but when and how this reshaping will be done is less clear. Frequently the burden of illness and treatment postpones reflective change until intensive treatment has been completed.[12] Spiritual care during treatment may thus need to be primarily supportive, foreshadowing further reflection to come, and ensuring that people become aware of resources they may call upon later to explore meaning and revise identity.

In a persuasive overview that draws upon a range of empirical studies, Wright indicates the scope of spirituality.[13] He emphasises the dynamic nature and breadth of the concept by mapping the spiritual domain onto horizontal and vertical axes, each representing a polarity across the domain. Vertically, the tension is between self-actualisation and belonging to community; horizontally, the tension is between becoming oneself and being transcended. The qualities of identity, community, meaning, connectedness and transcendence, listed in many reviews of spirituality, are placed in dynamic relationship by this map.[14] Wright identifies three key questions, the answers to which locate people within the domain: Who am I? Who are we? and Why are we here? While many people may not be able to articulate immediate answers to these questions, everyone, in practice, lives according to provisional answers. These answers are then frequently subject to revision in the face of life-changing events, such as an encounter with serious illness. Detailed answers will be unique to each person — the map is simply a guide for uncovering these details. As Damasio suggests, "the spiritual is an index of the organising scheme behind a life that is well-balanced, well-tempered, and well-intended".[15] Others similarly suggest that spirituality provides coherence to quality-of-life decisions.[16,17]

Wright's model can accommodate a range of ideas about spirituality, from a focus principally on the human spirit to a focus largely on transcendence, from the idea of spirituality as an individual quest to that of spirituality as a communal commitment. Further, it makes clear the integrative nature of the concept: spirituality connects a range of experiences and concerns that are normally addressed separately by contemporary caring disciplines. Spiritual assessment tools anchored in particular practice disciplines almost inevitably select certain aspects of the spiritual domain, but fail to encompass its entirety. The map reinforces the need for flexibility and inclusiveness in conceptualising spirituality, and emphasises that only a person-centred approach can encompass the breadth of interests involved.

Criteria for appropriate spiritual assessment

Spiritual assessment should thus not impose a view, let alone a definition, of spirituality, but should seek to elicit the thoughts, memories and experiences that give coherence to a person's life. This implies taking seriously the idea that spirituality preserves identity and sense of self, particularly in professionalised environments, and ensuring that professional practice assessments are made within a framework that matters to the patient. This means identifying spiritual needs and resources in ways that

- Respect patients' perspectives and do not infringe privacy;
- Involve all members of the interdisciplinary team to the extent that they are able and willing to contribute;
- Permit clear documentation of needs, strategic responses to these needs, resources required, and outcomes;
- Integrate strategies into an overall care plan in ways that are readily understood by all members of the interdisciplinary team;
- Provide a shared framework for continuity of care between community agencies and inpatient services; and
- Provide a place for religious care but do not conflate spiritual issues with religious practice. While spiritual care in general may be provided by a team, specific religious care is best provided by a person from the same faith community, preferably one willing to participate in the team.

Appropriate process for spiritual assessment

Spiritual assessment must be a process, not merely an event, as it needs to take account of emergent insights and accommodate the patient's exploration of particular issues if he or she so chooses. The discussion here applies to health care contexts in which process is possible (such as general medical practice, community health or residential care), rather than the brief encounters of day surgery or the emergency room.

The process should begin with a form of screening, preferably one that maps significant relationships within the domain of spirituality. This screening can be carried out descriptively, noting connections as they emerge in taking patient histories and in general clinical and informal encounters by all members of the team. Collating these observations will produce a map of the significant connections that hold a person's sense of self, commu-

nity and purpose (Who am I? Who are we? Why are we here?). As well as identifying these resources, it will indicate some of the significant connections that have been fractured or are under threat as a result of the illness experience. The guiding concept here is that spirituality — the practices that connect belief and action — can be inferred from the key events of a person's life.

On the basis of screening, a spiritual care plan can be developed, preferably guided by a team member with designated responsibility for monitoring the pattern of connections and identifying strategic implications (eg, a pastoral care worker or health care chaplain). Team members may then proceed to offer some observations or make enquiries as to whether a patient wants to follow up particular issues that have been raised or shared with them. Some patients may choose to do so, but others will not. Some will welcome the opportunity as part of their treatment, while others will wish to keep spiritual issues separate in order to retain that treatment in perspective. Some will be happy to name this process of exploration "spiritual care"; others will shy away from the term, preferring perhaps to use "quality of life" language. In this phase of active engagement, various modes of enquiry, including some of the research assessment tools already available,[18,19] might be used. There is no shortage of tools — as Gorsuch and Miller remark, the problem is that we need to learn to use the tools we already have rather than develop new ones.[20] The issue is not the need for new or better tools so much as the need for proper conceptualisation of the process.

A project that implements and evaluates the use of a screening and assessment tool consistent with these guidelines has begun in three Victorian palliative care services. The tool adopts a relational approach to spirituality, mapping the significant connections with places and things, with ourselves, with significant others and with groups and communities, as well as any allegiance to formal belief systems.[21,22] Mapping (screening) is carried out descriptively, and can on its own provide a basis for developing spiritual care strategies. If a patient is willing and able to explore through reflection and discussion some of the issues identified through mapping, a further phase of assessment can be introduced, usually by a pastoral care worker. The tool takes seriously the connections with local communities that sustain the spirit of many patients. Strategies for spiritual care may thus draw upon community resources and in turn build community capacity for spiritual and pastoral care.

Competing interests

None identified.

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