



The Spirit of Caring:

**A Volunteer
Education Resource**

Module 4: The Spiritual Care Visit

**Developed by:
Provincial Spiritual Health Care Management Network**

Module 4 – Session Guide

The Spiritual Care Visit

Overview/outline:

TIME	ACTIVITY	RESOURCE	COMMENT
15-20 min	Round table introduction: one, two or three things about yourself that no one can see or guess by your appearance.	Participants' self-disclosure	Attention to the individuals in group Building trust
5 min	Why visiting?	Teacher focused: Visiting as opportunity for growth	Philosophical exploration
15 min	First dress in hospital gowns. What would you want in a visit?	Individual's ideas identified Collection of group's ideas	Identifying with the other
15 min possibly expanding to 30 min merging with next	Get practical about details of visit: Script for introduction – permission – dress code – name tag – touch – listening – action – documenting – follow-up	The group establishing boundaries and acceptable conduct in the light of the departments professional conduct responsibility.	Ethical code for spiritual care visits Courtesy & respect
	Handout summary (skim now; read later)	Print resource – like HSC, Wpg (Appendix 1)	Conclusion
10 min break (NOTE: During the break participants change back into private clothes)			
15 min	Responding to the other in a dynamic relationship. Friendly visit leads to a spiritual visit. Getting “below the surface”. Non-verbal communication. (Group shares life-experiences relating to visiting)	Teacher centered: Picture of Iceberg as a metaphor for visit/personhood/relationship (Appendix 2) + Maslow's hierarchy of needs. (Appendix 3)+ 1-10 list of topics + screening	Review of theoretical material on personality and interpersonal relationships
10 min	The previous talk may be summarized as a matrix for spiritual care	Diagram by Tracy Carr from research article (Appendix 4)	Repetition of above for emphasis. Review of article
Different ways to end the session:			
20 min Either Or	Role Play: two persons acting out a visit with the group observing and processing what they notice.	One or several scripts to choose from. OR Make your own	A different way to absorb the idea of spiritual visitation
	Listen and respond to a story.	Either: (Appendix 6) “The Prince who thought he was a Turkey” Or “The Wounded Healer”	
5 min	Participants share ONE thing they will take with them into this week		Debriefing

The Spiritual Care Visit:

Otto Christensen

Objectives:

Students will:

1. Reflect individually and cooperatively on what constitutes a “good” spiritual care visit for the purpose of their visiting in a health care setting.
2. Be able to identify the nature of the visit including: person’s spiritual comfort and wellbeing; mutuality; form and content; follow-up; dangers/hazards etc.

Opening activity:

Round table icebreaker/re-introduction:

Ask each participant to write two or three things about him/herself that no one can see or guess by appearance. (Hand out index cards if needed). Participants share their “secret” while others listen. No questions – just listening.

Why visiting?

Philosophy: A meeting between (two) people is full of potential. It may be uplifting, devastating, crucial, irrelevant, trivial, mundane, joyful, sad, or anything else. The meeting in itself is a sign of connectedness even if its potential remains just ‘a potential’. Therein lies its universal value. It is a fundamental human activity.

In health care it is carried out in a range of settings from the first contact in the waiting room to its formal practice as a spiritual care visit (soulful encounter); there are lots of variants in between which truly makes spiritual care visitation everybody’s business.

Eastern, western and traditional spiritual approaches all practice “visitation” as a forum for nurture, assurance, challenge, transition or transformation. It is the meeting-place where connections happen or not – where all can be found or lost. Where wisdom may emerge and learning flourish; also where harm can be inflicted and hopes crushed.

What would you want in a visit?

Exercise

- Hand out hospital gowns to participants. Ask that they change into the gown and come back in 2 minutes.
- Meanwhile write on the blackboard/a flip chart: *“This is how I would like to be approached by a spiritual care volunteer if I were hospitalized”*.
- When all are back ask each participant to make a list in response to the question - (2 minutes) ... then each person shares from his/her list while the facilitator writes it on the flip chart/blackboard. Make sure everything is up on the board. Should more than one person have the same suggestion indicate this on the board (15 min). The list may include words such as: respectful, friendly, sensitive, caring, open-minded, personable. Try to unpack each word with examples.

In the spirit of the just established “list” above continue to brain storm around the following topics. (Remembering that the guiding principles for spiritual care are hope, healing, diversity, and inclusivity.)

1. How to dress – What do you wear as a volunteer with Spiritual Health Services? Talk about jewelry, clothing, accessories, brochures/printed material.
2. Try to come up with a script for introducing yourself: Maybe something like: “Hello my name is XXX, I’m a volunteer for Spiritual Health Services. Would it be all right if I paid you a visit today? (get permission/contract)
3. How does (religious/spiritual) experience and belief fit into the visit? Whose agenda is this?
4. How do you conclude a spiritual care visit?

The brain storm can go on for a long time. However it is intended to just ‘scratch the surface’ and get students to think about themselves as visitors. After enough brain storming, introduce the RHA guidelines for spiritual health volunteer visiting (hand out a print version). You may also like to hand out one (or both) of the guidelines below.

Handout:

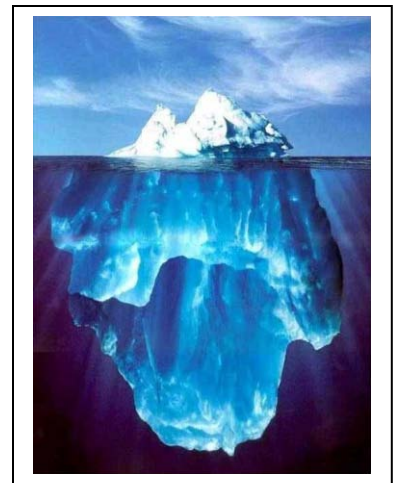
Winnipeg’s Health Sciences Centre: **SPIRITUAL HEALTH SERVICES VOLUNTEER VISITORS’ PROGRAM : SOME GUIDELINES AND SUGGESTIONS** (Appendix 1)

BREAK

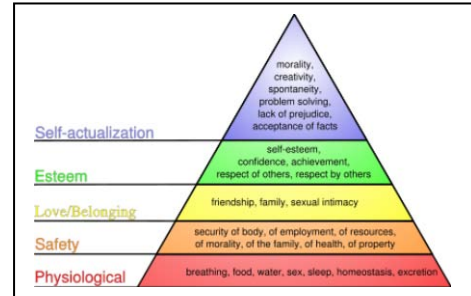
During the 10/15 min break students may change back to their own clothing.

Use the two pictures - images relating to the spiritual care conversation.

1. The Iceberg (Appendix 2). The Iceberg image is a reminder that only a small part of a person’s reality is visible to the observer (remember the opening activity?) Spirituality, spiritual resources and issues are often hidden below the ‘surface’ of a person’s life. The purpose of a spiritual care visit is to attend to the entirety of the person and invite reflection around the spiritual needs of the person. Invite participants to reflect on the iceberg image. The iceberg also relates well to Freud’s description of the Ego, Superego and Id. Maybe don’t go there but keep it in mind.



2. Maslow's Hierarchy of Needs (Appendix 3). Human beings are multifaceted. Maslow's Hierarchy of Needs is a classical example. In this context it provides a way to discuss the dynamics of a spiritual care visit. A visit may be superficial—not much more than a greeting or it may be deep and soulful. Sometimes a friendly visit may turn into a spiritual visit. The distinction between spiritual care and physical care is fluid (care/cure). Sometimes the day-to-day activities (in the hospital/PCH) done by a multidisciplinary team member may suddenly turn into deep personal sharing. Once trust is established sharing may become intimate/spiritual/soulful. Volunteers are sometimes endowed with trust because other health professionals have earned it for them. Volunteers always need to recognize they are in a position of trust – not necessarily earned by themselves – and certainly never to be breached in any way. NEVER talk to others about an encounter where the person can be identified in any way. Physical care and activities of daily living can be done more or less spiritually. The 'pyramid' implies different layers. In reality there are no boundaries; also the need for self-actualization may be the one that matters above all else (often in First Nation Spirituality)



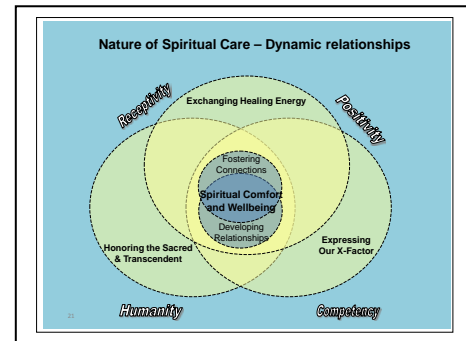
3. A scale from 1-10 of conversational topics moving from the superficial to the deep and soulful.
- Greeting – hello I'm Xxxx. I'm a spiritual health volunteer. Would you like me to visit you today?
 - Talking about coping and comfort
 - Revealing impersonal information such as like/dislike of weather, food.
 - Talk about clues in the room: cards, books, newspaper, flowers etc.
 - Home community, job etc.
 - Family matters, recreation.
 - Significant experiences
 - Personal life history – sharing of emotions
 - View of illness; motivations; fears
 - Hopes and dreams
4. An initial visit is often a screening for:
- further visiting or not.
 - a community (or other) referral.
 - spiritual health specialist/spiritual assessment/spiritual counseling.

Matrix for Spiritual Care¹

Introduce Tracy Carr's spiritual care matrix. Step by step – one through four. (power point slide- or on the board)

Discus each term – especially the "X-factor".

Tracy Carr: Our "X-factor" is a concept used by one of the participants that refers to the essence of who we are, our spirit or soul. It is our uniqueness—the total combination of our individual human qualities—which is intuitively known to us and others but remains something of a mystery. Expressing our X-factor thus involves a process of nurturing our special qualities and making it known that we are willing and able to share our unique self—our spirit—with another. According to participant accounts, our X-factor, or our spirit, is an important source of strength and energy that can serve as a healing resource within a person and between persons.



A summary of Tracy Carr's article is included. (Appendix 4)

Chose your ending to the unit:

Depending on how the lesson has progressed make a decision on how to end the lesson. Is the group more likely to act or to listen? Has it been very left or right brain? Are you in the mood for a story? You can also ask the group for input.

A) role play ending **OR** **B)** story ending (two options)

A: Role play: (one volunteer from the group acts the role of the patient. Another takes the role of the spiritual health volunteer; the rest of the group are observers. Afterwards all comment on the way the visit took place and review the scenario. There may be time for more than one role play. Or try the same role play with a patient impairment (hearing, vision, drug-induced hallucinations)

The case scenarios provided with the course form excellent role play opportunities. The group may like to make up its own or use the one below.

Diane Brady, Age 26, Breast Cancer

Diane Brady is a 26-year-old fourth year medical student who recently found a lump in her left breast. She comes to the primary care physician's office for a clinical exam. The exam reveals a palpable 2 cm. mass in the upper left quadrant. The physician orders a mammogram and schedules an appointment with a breast surgeon. The mammogram is suggestive of a malignancy, and an interventional radiologist does an immediate core

¹ Tracy Carr: **Mapping the Processes and Qualities of Spiritual Nursing Care.** (Quality Health Research Vol. 18, #5, May 2008, p 686-700)

biopsy. The pathology report states that the sample is positive for infiltrating ductile carcinoma. The breast surgeon explains the surgical options to Diane. Diane chooses to treat her lesion aggressively by opting for bilateral radical mastectomy and left auxiliary sentinel node biopsy. Reconstruction surgery will be postponed until after treatment. Diane and her fiancé are upset by the diagnosis and treatment alternatives.

Dianne requests a visit from spiritual care. The next day a volunteer comes to see Dianne. She is alone in the room.

B: Stories

Simply tell the story (or read it out) while students listen. Afterwards invite participants' reactions.

1. The Prince Who Thought He Was a Turkey (Appendix 7)
or
2. The Wounded Healer (Appendix 8)

Closing.... One Thing I Will Remember

Give participants 5 minutes to write (on index cards): One thing that I will remember from this session. Make a list on a flip chart for sharing the one thing.

What you need:

- Blackboard/flip chart
- Index cards/scrap paper + pencils
- Hospital gowns
- Printed handouts (see below)
- Power point – Computer + LED projector – can also be drawn on the board

List of Appendices:

1. Health Science Centre: Some Guidelines and Suggestions for Visitation
2. Iceberg picture – can also be drawn on board
3. Maslow's hierarchy of needs diagram – can be drawn on board
4. Matrix for spiritual care relationship (power point slide or step by step drawing on the board) – can be drawn
5. Summary of Tracy Carr article
6. Story: The Prince who Thought He Was a Turkey
7. Story: The Wounded Healer

**SPIRITUAL HEALTH SERVICES
VOLUNTEER VISITORS' PROGRAM****SOME GUIDELINES AND SUGGESTIONS***Principles and Core Values*

1. There are a number of principles and core values that guide our work.
 - a. These include:
 - i. Inclusivity
 - ii. Celebrating Diversity
 - iii. Hope
 - iv. Healing
 - b. Lean, learn, and practice into these values so that they inform everything you do and, over time, everything you are becoming.
 - c. Notice how these values implicitly guide everything else mentioned in this handout.

Entering the Patient's Room

2. Remember that the patient's room and bed are their personal space while they are in the hospital.
 - a. Whenever possible, knock before entering the room or, even, on the wall near the bed before crossing the line of a curtain that defines that patient's particular area.
 - i. If the curtain is completely drawn around the bed, speak outside the curtain and be sure you have the patient's/family's permission before stepping inside the curtained-off area.

- b. Announce yourself by name, department, and role and ask if it is OK to come in.
 - i. E.G. *“Hello, my name is XX, I am a volunteer with Spiritual Health Services here in the hospital. Would it be OK if I come in for a moment?”*
- c. Respect for the humanity, privacy, and situation of each patient and the patient’s circle of Health are essential to what we do.

Positioning Yourself in the Patient’s Room

- 3. Position yourself in a sensitive manner.
 - a. Examples, depending upon patient and situation:
 - i. If the patient is at all physically exposed because of gown, equipment, etc, try to find a spot near the bed that is as discreet as possible.
 - ii. Perhaps the patient is hard of hearing; position yourself and speak clearly to maximize the patient’s ability to hear you and/or read your lips.
 - iii. Perhaps the patient has a sight deficiency; position yourself accordingly and use your voice and/or touch to ensure the patient knows you are there and that you have identified yourself, as the patient may not otherwise be able to recognize you from a previous visit.
 - iv. Sit in a chair, if possible, so that you are eye-level with the patient; however, do not immediately sit, because that might signal to the patient that you intend to stay for awhile – make sure you have determined with the patient/family that an extended visit at that time is appropriate and welcomed. (Do not sit on the bed.)

If the Patient Indicates He/She Does Not Wish a Visit

- 4. Do not stay if the patient does not wish a visit.
 - a. We *do* take “no” for an answer!
 - b. If you can, take a bit of time to clarify the patient’s ‘no’.

- i. Ask if they would like you to come back at another time and when a good time might be.
 - ii. Ask if they would like another volunteer or Spiritual Health Specialist to come back later, if your own schedule does not allow you to make a timely return visit.
 - iii. Ask if they have specific needs that will help determine to whom you might pass on the referral – to a priest, or Elder, or Complementary Therapist, or a woman, or a man, etc.
 - iv. Ask if they would prefer that we wait for them to request a visit and explain to them how to contact us (by asking the Nurse or Unit Clerk to call us on their behalf, is the easiest way).
- c. You might want to leave a Spiritual Health Services brochure with them for further information and later contact.

Touch

5. Be cautious with physical touching.
- a. It is often natural for us to want to touch a patient:
 - i. To hold hands or place a hand on the head, for example, while praying;
 - ii. To lay a hand on an arm or shoulder as an expression of comfort or reassurance.
 - b. However, touch can be a “touchy subject”.
 - i. The patient may be in physical pain that even a little pressure might exacerbate.
 - ii. The patient’s personal history and/or personal temperament may make touch unwelcome or threatening.
 - iii. The patient may misunderstand the intent of the touch, especially if their condition in any way decreases their understanding and perception.
 - c. Whenever possible, if you wish to touch a patient, ask the patient’s permission first.
 - d.

What We Do and Don't Do

6. Remember, we emphasize listening.
 - a. Our first concern, always, is simply TO BE WITH patients/families.
 - i. To listen.
 - ii. To let them lead any conversation where they want/need it to go.
 - iii. To be a quiet presence, if that is what is needed and possible.
 - b. We seldom or never:
 - i. Give advice.
 - ii. Try to convince anyone of anything.
 - iii. Proselytize (try to win converts to our religious beliefs and communities) – this one is a NEVER.

7. We sometimes pray with patients/families.
 - a. We will pray:
 - i. If they request it.
 - ii. If they agree to our suggestion/offer to pray.
 - iii. After clarifying if they want us to pray *with* them, then and there, or *for* them, in our own time, perhaps back in the sanctuary.
 - iv. After clarifying what prayer means to them and what style of prayer is appropriate for them. (We do not assume prayer using a particular religious form or language, unless it is clear from the patient/family that is what they want and expect and if we ourselves are comfortable with that kind of prayer.)
 - b. A prayer/blessing we often use is this: (with variations)

*“The light of God (or The Creator/Heart of Universe, etc ...) surrounds you.
The love of (God) enfolds you.
The power of (God) protects you.
The presence of (God) watches over you.
Wherever you are, (God) is.
And (God) is love and all is well.*

8. We sometimes provide other rituals and ceremonies, appropriate to the patient's/family's situation and background.
 - a. Some examples include:
 - i. Communion – either in Protestant or Catholic fashion
 - ii. Confession
 - iii. The Sacrament of the Sick
 - iv. Smudging
 - v. Baptism for patients at risk and usually actively dying
 - vi. Blessings for newborns
 - vii. Clearing rituals by a bed, in a room, on a unit ...following a death and before another patient moves into the room
 - viii. Rituals for dying patients, or for family members around a dead loved one.
 - b. You can suggest such rituals to ensure the patient/family knows they are available, but be cautious of assuming they want it or that you are seen as pushing them.
 - c. Clarify for yourself and them exactly what the ritual is that they wish.
 - d. Speak with the volunteer coordinator if you want to offer the ritual yourself, if you are qualified and comfortable to provide it, OR determine who is the appropriate person on our staff (or in the community) to provide that ritual and make a referral.
9. We do occasionally provide other religious materials, upon request and according to availability.
 - a. Examples include rosaries, bibles, other sacred writings, spiritual literature, etc.
 - i. There is a limited supply of such items in the Spiritual Health Department main office area.
10. Depending upon your time and style, you can do other things that arise naturally out of the relationship.

- a. For example: reading to a patient, playing a game or doing a puzzle, going to the cafeteria for coffee, taking a patient in a wheelchair for a walk, going to a hospital activity together (in Rehab activity area, e.g.)
11. We are sometimes asked to do things that are outside of the mandate of Spiritual Health.
- a. Examples might include questions related to housing needs (Social Work), forms of counseling (Psych Liaison), or translation for an aboriginal person (Aboriginal Health Services).
 - i. We pass these requests on to the appropriate person or department (probably by speaking to the patient's nurse or other unit staff or by consulting with the Spiritual Health Volunteer Coordinator)
EVEN IF WE ARE ABLE TO PROVIDE THE SERVICE OURSELVES.
12. It is the policy of the Spiritual Health Department not to respond to requests from anyone for money or food, etc.
- a. We do keep a list of community resources in the Spiritual Health Staff Room that we can use to try to find an appropriate referral for such a need.
13. We are not a transport service so that taking a patient to the hairdresser and waiting for them to come back (as an example) is not a service we provide.
- a. Some patients can try to take advantage of our good intentions and ask from us things that are outside of our responsibility and comfort zone.
 - b. We might transport or accompany a patient if it is to a Spiritual Health Services program. With permission from patient's nurse.

Infection Control Concerns

14. Be aware of infection control signs and procedures.
15. Wash your hands frequently –whenever arriving and leaving a unit and before and after each patient visit.
- a. If hands are soiled, use soap and water.

- i. If not, use the alcohol-based product available in bottles on each unit, often on the wall and sometimes on tables or counters.
- b. It is important to wash hands thoroughly, including fronts and backs of hands, wrist areas, between fingers, and into fingernail areas.

<i>Areas Outside of Volunteer Scope of Practice</i>
<p>1. If there are further precautions required with particular patients, these instructions are clearly posted on the door to a patient room.</p> <p style="padding-left: 40px;">***This may include all or some of gowning, masking, wearing gloves, and keeping door closed.</p>
<p>2. Note that isolation areas restrict what materials can be taken in and out of a room and how they are to be handled – notebooks, pens, etc. may need to be sterilized before leaving a room if they are brought in and exposed to the air.</p> <p style="padding-left: 40px;">***From time to time, it is prudent to use an antibacterial-decontaminating substance to wipe down personal items such as pens, glasses, and notebooks.</p>
<p>3. Familiarize yourself with the signage, equipment, and procedures you may encounter in regard to these various precautions.</p> <p style="padding-left: 40px;">***Please enquire with the Spiritual Health Services volunteer coordinator. If you have not been trained yet, regarding these routine procedures.</p>

16. If you have a cold, cough, etc, do not visit patients.
- a. If you are unsure whether your contagious period is over, for added protection, you can wear a mask when making patient visits

Reports and Referrals

17. Here are some things to be aware of regarding reports and referrals.
- a. When writing reports, be succinct and write/print clearly.
 - i. The primary purpose of these reports is to record information that others might need in order to do follow up.
 - ii. Consider keeping a journal to write more extensive accounts after a visit, perhaps for your own learning and/or to share with the Volunteer Coordinator for further reflection and debriefing. No information identifying patients should be written outside of the

volunteer notebook. Kept in the volunteer office in Spiritual Health Services.

- b. Especially if follow-up is needed quickly, make out a referral slip (copies in the staff room and supply cupboard) and pass it on to the Admin Assistant to refer to appropriate Spiritual Health staff.
 - c. If follow-up is more routine and not immediately urgent, simply make a referral to the Spiritual Health Specialist assigned to the patient's unit.
 - i. Normally the Spiritual Health Specialist assigned to that unit will do any follow-up.
 - ii. Sometimes a person providing a particular service may do the follow-up: as examples, when Communion or Healing Touch treatments are being given on an on-going basis. (If unsure, pass referral to Admin Assistant.)
18. Note: Volunteer Visitors, including those providing Complementary Therapies, do not have access to patient charts.
- a. If you think something from your visit should be charted, ask the patient's nurse to do the charting or let the Volunteer Coordinator or a Spiritual Health Specialist assigned to that particular unit know.

Promoting Inclusivity and Diversity

19. Wearing of religious symbols.
- a. Because inclusivity is one of our core values and is basic to our approach, we do not outwardly wear any symbols related to our own particular religious convictions or affiliations.
20. If a patient asks about our own religious connections and/or background, it is OK to answer the question briefly and directly.
- a. Stress that, as a member of the Spiritual Health Services, we do not represent any particular religious group.
 - b. That having been said, it is OK to let the person know your own faith tradition and association – briefly.
 - c. Avoid getting into “discussions” about different faiths, beliefs, and practices.

- i. Occasionally these discussions can be stimulating and informative for both visitor and patient/family;
- ii. But often, these discussions can become debates that do not promote peace, harmony, healing, and hope.

Use of Staff Room and Adjacent Areas

21. You are welcome to use the student/volunteer room located in Spiritual Health, 2nd floor General Hospital Room GF-214.
- a. There are coat closets and lockers in the area for your use.
 - b. You may use the phone in the staff room but check with the Admin Assistant before making a call, please keep calls to less than 2 minutes.
 - c. You are welcome to use the volunteer room for coffee breaks, lunch, preparing your lists, reporting, etc.
 - d. We respectfully ask that students and volunteers do not use the staff room as we have a large staff and the staff room can become quite crowded, as it is a small space.
 - e. Please feel free to use the hope room and/or sanctuary if you need a place to reflect/relax. Also feel welcome to join any sessions/services that you wish.
 - f. The general supplies and equipment – photocopier, etc – are available for your use as it pertains to your role and responsibilities. (See Admin. Assistant.)

**Patient Lists*

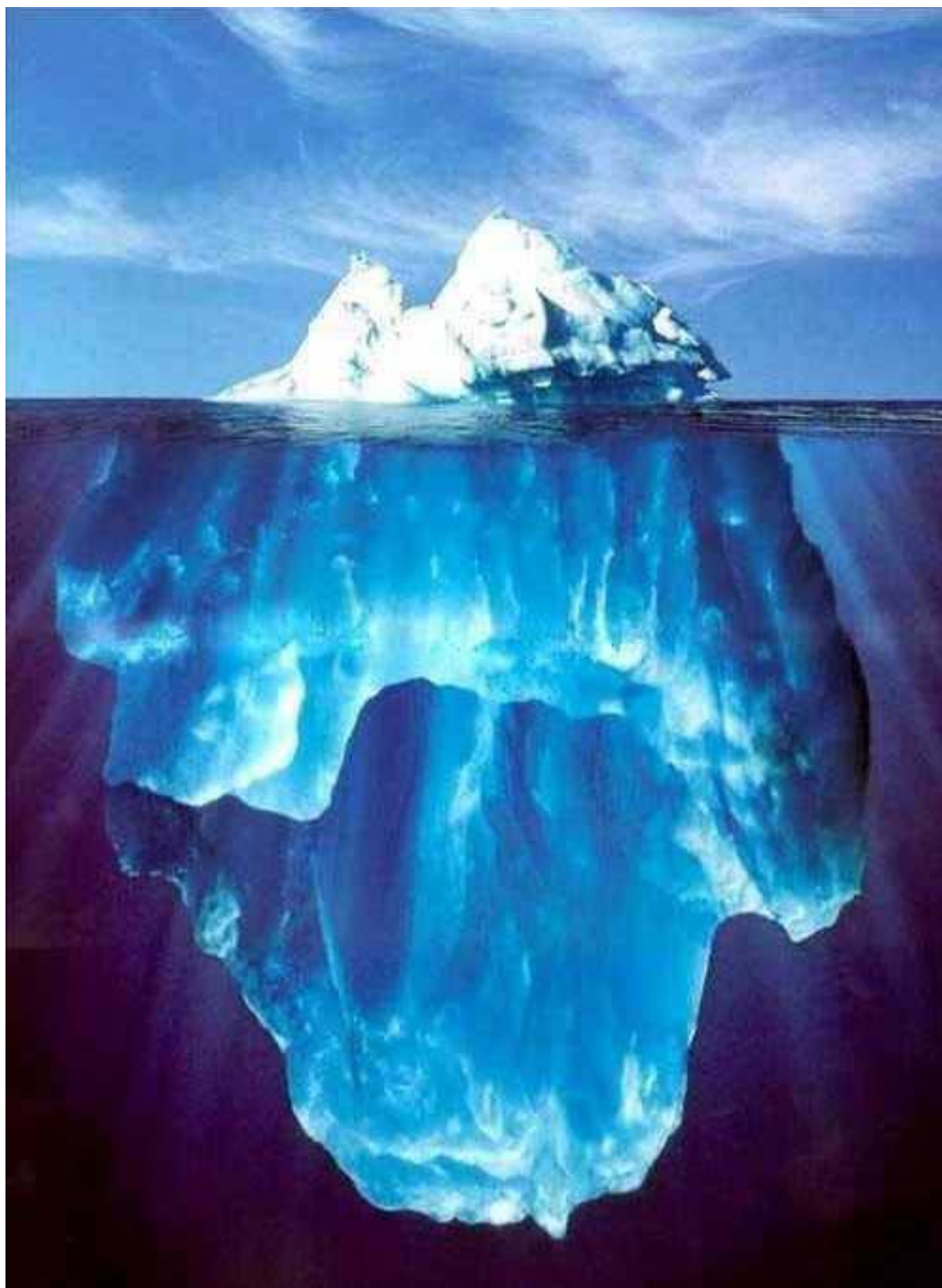
22. Because of PHIA guidelines, you have access only to those patient lists pertinent to your area of responsibility.
- a. The Volunteer Coordinator will clarify for you which list(s) you have access to.
 - b. All lists, photocopies of lists, notes you make using information from these lists, and any notes you make about your visits are confidential.
 - i. They should be destroyed after use by putting them through the departmental shredder. (Place confidential information in the recycling box located in the Admin. Office.)

- c. You have all had briefing regarding PHIA and have signed a pledge of confidentiality.
 - i. Please respect and adhere to those guidelines and your pledge in all your dealings within and beyond HSC.

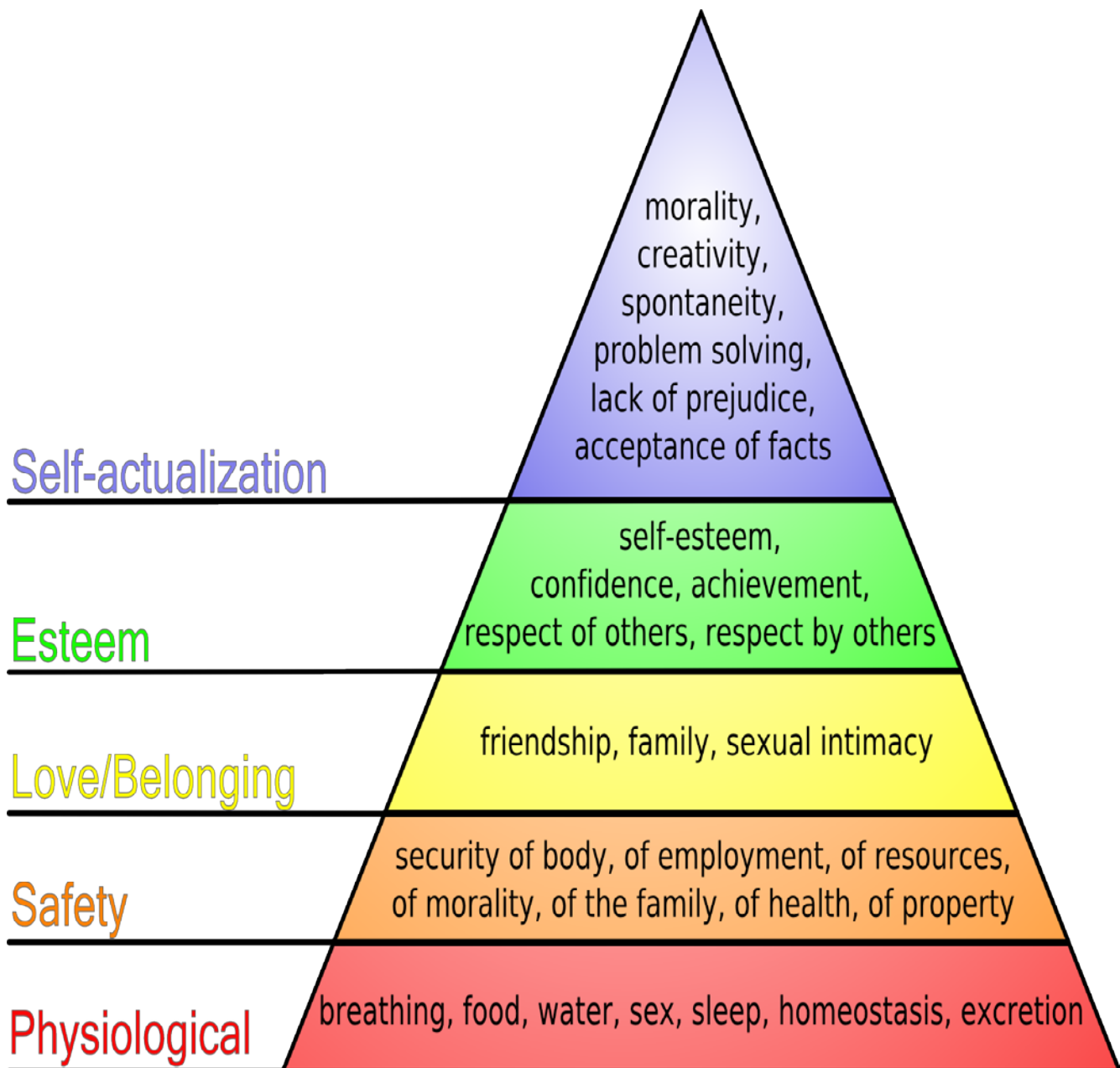
Morning Reflections/ Afternoon Debriefing

- 23. Monday through Friday at 8:30am, the staff gathers – usually in the Hope Room – for about 15 minutes of prayer and reflection, led by that day’s On-Call Spiritual Health Specialist.
 - a. You are always welcome to join in this circle if the timing is convenient to you.
 - b. The daily staff debriefing sessions, from 4:00 – 4:45 pm are confidential and volunteers, students, etc, are unable to attend or be present during these sessions.

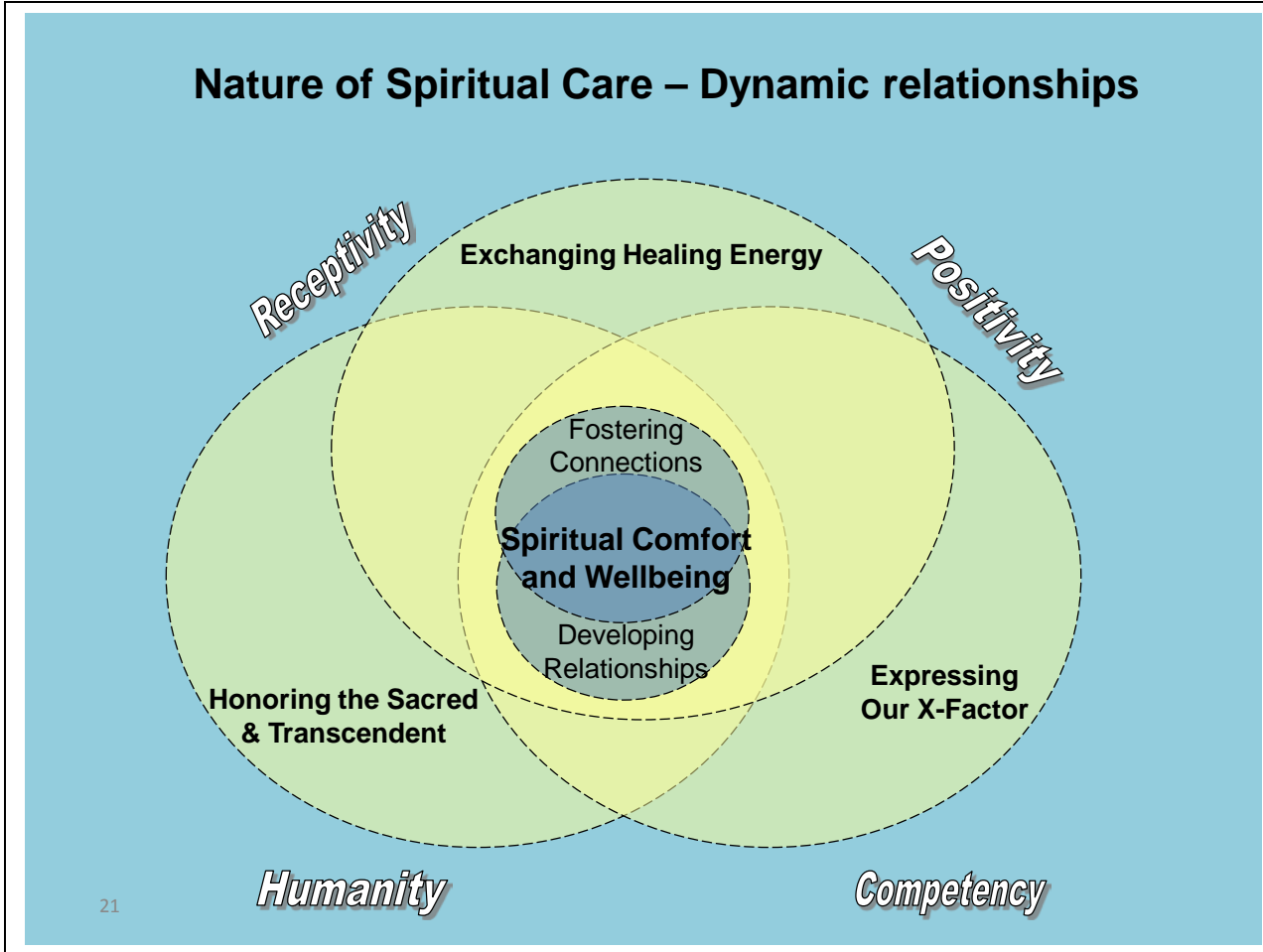
**** Please let the Volunteer Coordinator know of other information to add to this document that would be useful for you and your volunteer colleagues. ****



Maslow's Hierarchy of Needs



Consider turning Maslow's hierarchy of needs upside down as a means of understanding how to deepen a spiritual care visit!



Summary

Mapping the Processes and Qualities of Spiritual Nursing Care,
Tracy Carr, U of NB, Canada²

Tracy Carr's article is focused on Spiritual Nursing Care. How do nurses do it? However it is the universally held ideal of caring for a (suffering) person that is the real focus and thus her findings are relevant to all caring profession(al)s. Her premise is that while nursing theory recognizes the importance of 'spiritual care'—even regards it as its core—research shows that a significant number of nurses do not view themselves as skilled in this dimension of care. Her research is an attempt to get behind this seeming contradiction.

Using phenomenological research and drawing on other research she shows that spirituality and spiritual care increasingly is understood as founded on relationships—with self, others, the world around, and for some God and the universe. From this central perspective those in the study described spirituality as broadly infiltrating all aspects of life and spiritual care as infiltrating all aspects of their nursing care. Consequently, they explained that it is not always possible to isolate the spiritual impact, because the spiritual dimension infiltrates all other dimensions. As a result all nurses experienced problems in documenting their patient's spiritual needs in their care plans—such needs could not be isolated. Tracy Carr says: "If nurses have difficulty documenting spiritual care in patients' charts, they may very likely have the same difficulty when completing research questionnaires. Consequently some doubt is cast on the common conclusion made by earlier researches that nurses rarely attend to the spiritual dimension of their patients."

Tracy Carr's research focuses on the phenomenon of spiritual care: the social processes and the relationships that are at work in the communication matrix between the carer and the person cared for.

"Clearly, consistently, and in their own words participants in the study explained that at its most basic level, spiritual nursing care is," says Tracy Carr, "two core processes—developing caring relationships and fostering connections—and one desired outcome: spiritual comfort and well-being." She goes on to say: "There are three sub-processes: expressing our X-factor, exchanging healing energy, and honoring the sacred and the transcendent. Finally for all this to work" she says, "the nurse must embody four essential human qualities: receptivity, humanity, competency, and positivity."

Developing relationships:

In the study Tracy Carr asked the participants if they and their family sought spiritual care from nurses. Interestingly the participants did not answer with a narrow religious definition of spiritual care but with a broad perspective of developing a caring relationship. "Thus, taking into account their broad perspective on the meaning of spiritual care, participants agreed that almost always, patients and their families do in some way seek spiritual care from nurses. This seeking, however, is most often not conscious or planned. It is simply a way of

² The article is an abbreviated version of Tracy Carr's doctoral dissertation (2006) titled: **From Ideals to Realities: Exploring the Meaning of Spiritual Nursing Care in the Context of a Contemporary Western Healthcare System.**

being human. Human beings desire to be cared for; they desire connectedness, and they desire to be recognized and affirmed as persons with a past, present, and future” concludes Tracy Carr.

Nurses are often sought out as the ones with whom patients in a subtle way explore issues and scenarios that they do not even discuss with family members and friends. Nurses are perceived to be ‘safe’ for conversation about intimate/ultimate concerns.

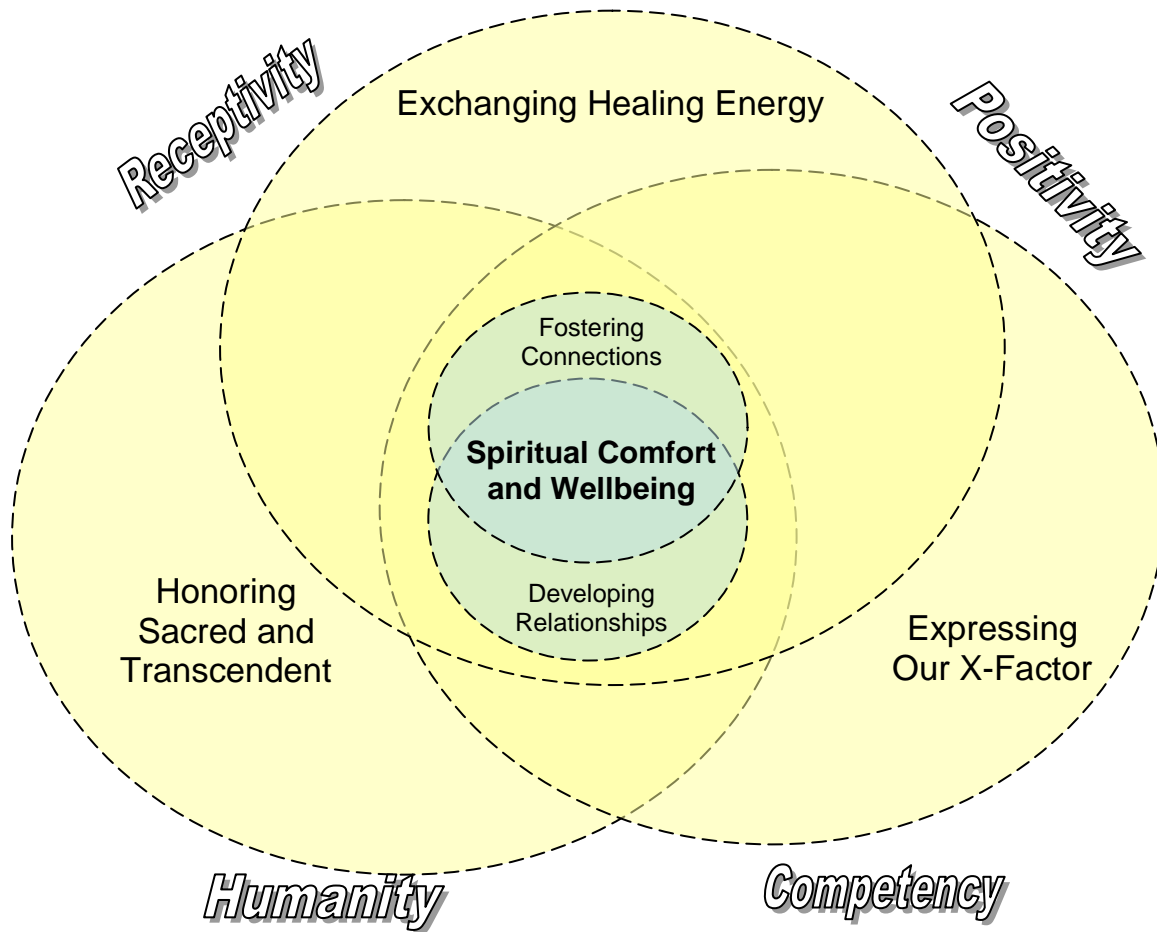
Fostering connections:

The unique, intimate relationship between nurse and cared for that occurs during life’s most important moments can lead to spiritually significant interactions and the development of caring relationships. However the connections that people have in their lives are multidimensional and interrelated. They can include family, friends, co-workers, those in support groups, a God or a higher power, the environment or nature, one’s work or central life interest, religious beliefs, and practices, and so forth. The importance of these other connections in the life of the cared for must also be recognized, respected and fostered. Spiritual care, then, involves the process of being a connection and fostering other meaningful connections for the cared for.

The processes of developing relationships and fostering connections interact with and are influenced by three sub-processes: expressing our x-factor, exchanging healing energy, and honoring the sacred and transcendent. (1) The term “x-factor” was used by a participant to describe “the essence of who we are, our spirit or soul”. It is our uniqueness—the total combination of our individual human qualities—which is intuitively known to us and others but remains something of a mystery. Expressing our x-factor thus involves a process of nurturing our special qualities and making it known that we are willing and able to share our unique self—our spirit—with another. (2) Exchanging healing energy is about transferring our healing energy from ourselves to others via caring connections. This is most often reciprocal. One nurse explains: “I become enlivened. It is life giving. Yet, it’s a dichotomy, because you can also be depleted of your physical resources. Sometimes I do get very tired, but there is that energizing aspect. I guess it is living in its fullest sense. It’s that ongoing thing between you and most patients. And for me it is soul nourishment.” (3) The process of honoring and exploring the sacred and the transcendent is about demonstrating respect for and exploring, when appropriate, these beliefs, practices, and experiences of the cared for. What constitutes the sacred for the person in care can often be inferred by keen listening on the part of the nurse (or other team member).

These processes that describe spiritual nursing care come together in a natural way of being human with another. It is often only after the fact (if ever) that the spiritual nature of the caring interaction is recognized—the cared for may be unknowing seekers and the nurses may be unknowing providers. This is not to say that the naturalness comes naturally to everybody. The ability to connect with and care for another is not equally present in all people. It requires a special blend of human qualities of which there are many. Four emerged as being critical for spiritual care: receptivity, humanity, competency, and positivity. (1) Receptivity: “Spiritual nursing care is about being there” – not only physically but being fully present with the person

– emotionally, socially, holistically and a sense of solidarity. (2) Humanity: “Spiritual Nursing care is about humanity meeting humanity”. Caring for the total personhood or the totality of who we are—that we are a mother, daughter, sister, father, son, brother; that we each have a unique past, present, and future; that we each have unique beliefs, practices, values, and characteristics. Respecting the autonomy of the cared for. (3) Competency: In nursing care it is important that a proper balance be found between caring for the spirit and the body. If a nurse doesn’t do the basic nursing procedures properly it leads to distrust in general and certainly the whole area of spiritual competency will become discredited. (4) Positivity: Caring for the spirit of another involves approaching such care with positivity, which again is a way of being that emanates from a person (x-factor) and is noticed by others. It includes embodiment of hope and determination; someone who can appreciate humor and laugh; one who is encouraging and honors and fosters creativity in others.



Tracy Carr’s findings are congruent with other recent phenomenological studies thus providing all careers with a helpful map for understanding the spiritual aspect of care. However what is particular to this study is participants’ description of spiritual nursing care as a whole and natural experience, which is often unplanned and sometimes even unrecognized by either the nurse or the cared for. “Perhaps”, says Tracy Carr, “under these circumstances spiritual nursing care can be understood simply as a way of being.” As such this would be labeled as an “existential approach” rather than a “scientific approach” to nursing care. Tracy Carr’s study shows that broadly understood nurses do attend to the spiritual dimension of care through the

development of a dynamic relationship with the cared for and through fostering connection. For many nurses this simply is a natural way of being.

Teaching spiritual nursing care becomes an issue as for some naturalness does not come naturally. What then? Along the same line it raises the question of how to teach spiritual care giving to other health care workers and volunteers.

Respectfully summarized by

Otto Christensen

The Prince Who Thought He Was a Turkey³

There was once a prince who took ill and decided he was a turkey. Stripping off his clothes, he crouched naked under the royal table, refusing to eat anything but crumbs which had fallen to the ground. The king was greatly upset. Many doctors were called to the palace to examine the prince but none could offer a cure.

One day a wise man came to the king and said, "Let me live in your home that I might befriend your son. Be patient and I will make him well again." Immediately the sage approached the royal table, stripped off his clothes and sat down naked next to the prince.

"Who are you and what are you?" demanded the king's son.

"I am your friend, a turkey like yourself," the wise man replied. "I thought you might be lonely and decided to come and live with you for a while."

Some weeks passed. The "turkeys" grew accustomed to each other and soon became good friends. They ate crumbs, drank from tin plates and discussed the advantages of being domesticated birds rather than men.

One night, when the royal family was having dinner, the wise man signaled to the king, whose servants brought two silk robes and cautiously placed them under the table. The sage quickly donned one of the robes and before the king's son could utter a word proudly announced, "There are some dumb turkeys who are so insecure that they believe putting on a silk robe might endanger their identity." The prince thought for a moment, nodded his head and began to clothe himself.

Some days later the wise man once again signaled the king. Broiled beef, baked potatoes, and fresh green vegetables were brought and placed on the ground near the sage. Looking quite pleased with himself, the wise man bit into his food and exclaimed, "Absolutely delicious! It's good to be a turkey sophisticated enough to enjoy the food of men." The prince readily agreed and hungrily ate his fill.

Eventually, the wise man called for some silverware and asked to be served from the king's good china. "After all," he explained to the prince, "why shouldn't intelligent turkeys want the best for themselves?"

Finally, after many months the sage came and sat by the table. While eating and drinking with the royal family, he called down to the prince and said, "Come join me. The food is the same but the chairs make an appreciable difference. Besides we turkeys have a lot to offer. Why should we restrict ourselves by remaining aloof? Certainly our ideas can benefit the minds of men."

The king's son came and sat by the table. It was only a matter of time until he was cured.

³ **Solomon and the Ant** by Sheldon Oberman (page 111-114) The story may also be found on the internet: www.hasidicstories.com/Stories/Nachman_of.../turkey.html

(2)The Wounded Healer⁴

A well known story among the Hebrew people concerns

A Rabbi who came across the prophet Elijah and said to him: “Tell me—when will the Messiah come?”

Elijah replied, “Go and ask him yourself.”

“Where is he?” said the Rabbi.

“He’s sitting at the gates of the city,” said Elijah.

“But how will I know which one is he?”

The Prophet said, “He is sitting among the poor, covered with wounds. The others unbind all their wounds at the same time and bind them up again, but he unbinds only one at a time and binds them up again, saying to himself, “Perhaps I shall be needed; if so, I must always be ready so as not to delay for a moment.”

⁴ *Doorways to the Soul. 52 wisdom tales from around the world* / edited by Elisa Davy Pearmain (page 107-108). (The source is listed as: **Before the Gates of Rome** in *A Jewish Reader: In Time and Eternity* ed. Nahum N Glatzer, Schocken Books, Inc.) The story originated in Greek mythology.

Another version: <http://storiesforspeakers.blogspot.com/2007/06/henri-nouwen-wounded-healer.html> Henri Nouwen’s book entitled ‘The Wounded Healer’, draws its inspiration from this story.

Henri Nouwen ends the story with: “What I find impressive in this story are these two things: first, the faithful tending of one’s own woundedness and second, the willingness to move to the aid of other people and to make the fruits of our own woundedness available to others.” (Henri Nouwen, [The Wounded Healer](#) (New York: Image, Doubleday, 1979)