What do we mean by "Spiritual Need?"

A brief reflection on evidence

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Introduction

Spiritual need is a frequently used term in the context of holistic patient care; but it is not tightly defined. Consequently, when two or more practitioners refer to spiritual need, caution must be exercised to ensure each is talking about the same thing. A century ago there would have been little problem: *spirituality* in England would have meant *Christian* spirituality, though disagreement about its Catholicity or Protestantism might have been likely. Spiritual *need* would have meant that intangible "cure of the soul" commonly entrusted to a priest, minister or member of a religious community. Today we live in a society where spirituality can be interpreted in a multiplicity of ways and where faith allegiance is fluid and, for many, nominal. Yet the requirement to meet patients' spiritual need remains enshrined in NHS legislation. This raises a question: What do we mean by "spiritual need?" Unless we have some idea, carers - not least members of the Trust's chaplaincy team - might be offering a service that is inappropriate or irrelevant

As part of a recent MA project, I undertook a reflection on evidence to see if an answer to the question could be found. By considering University Hospital of North Durham (UHND) Chaplains' Visit Logs from Summer 2010 and Winter 2010-2011 together with prayer requests written between Summer 2008 and Summer 2010, in the light of extant NHS and other healthcare related publications on Spirituality, I believe I have perhaps the beginning of an answer.

Visit logs

Essentially confidential records of chaplaincy activity, visit logs are a relatively recent development reflecting modern expectations that Chaplains' activity must, increasingly, be quantifiable in terms of cost effectiveness. Their statistical element indicates the number of patients with whom chaplains have had a 'significant encounter', the number of visits made to a particular individual during an inpatient episode and the "religious/spiritual-care interventions" made by chaplains. Logs also contain a reflective element in which chaplains note matters of importance raised during their conversations with patients. Taken together both elements comprise a comprehensive picture of chaplaincy activity.

During both periods studied, the number of individual patient visits and the frequency of prayer and sacramental intervention show consistency. Visit log evidence suggests almost 50% of those we worked with asked for prayers whilst 20-25% received sacramental care, usually in the form of Holy Communion. Bearing in mind contemporary statistics[1] suggesting only 15% of the population have any regular church connection, log-evidence suggests that, nevertheless, for a considerable number of patients a relationship with God still matters. More interesting is the range and frequency of conversation themes encountered during chaplain-patient interventions; these are presented in the tables below. It is in the frequency of faith, family, loss, reminiscence, separation and change as conversation material that we find pointers to understanding the *nature* of spiritual need.

In reality, much of the chaplains' time is spent simply 'being there' with patients. In common with most UK hospitals, the majority of our patients are elderly. These are drawn from the generation most likely to have had some faith or church contact during their lifetime; consequently they are at least aware that chaplains are people with whom they can talk openly. Of course we meet, chat with and

Chaplain-patient conversations by theme

Conversation theme	Occurrence Summer n	as % of Summer conversation themes	Occurrence: Winter n	as % of Winter conversation themes
Faith/church	31	14.2	20	9.9
Family	26	11.9	26	12.8
Progress of healing	24	11	17	8.4
Reminiscence/story	17	7.8	18	8.9
Sense of place now	17	7.8	5	2.5
Life/lifestyle	15	6.9	18	8.9
Distress at hospitalization	13	6.0	8	3.9
Loss/widowhood	11	5.0	9	4.4
Separation from home/ own space	9	4.1	11	5.4
Need reassurance	9	4.1	6	3.0
Hope/fear/anxiety Facing future	9	4.1	18	8.9
Change	7	3.2	6	3.0
End of life	6	2.75	4	2.0
Confusion	5	2.3	3	1.5
Tiredness	4	1.8	1	0.5
Importance of prayer	4	1.8	3	1.5
Love	2	0.9	1	0.5
World situation	2	0.9	0	0
Self worth	2	0.9	0	0
Disability	1	0.5	0	0
Guilt	1	0.5	0	0
Need to chat/be heard			22	10.8
Total	218	100	203	100

minister to younger patients too, some of whom are surprised to learn we are people with whom they can discuss anything knowing whatever may be disclosed will go no further.

Common to conversations across the generations is the sense that, no matter how brief, the hospital experience is a dislocating one. Hospital removes patients from their usual environment, immersing them in one which, whilst necessarily clean and clinical, is both impersonal and public. Outpatient areas are public places of anxiety as the individual waits his or her turn to be called into the consultant's office. For those hospitalised, 'my space' becomes the bed, the chair, the locker top, the table - a space easily violated by clinicians, care workers and wandering fellow patients who 'enter before knocking' simply because the space has no defined boundary. It is also a transitory space – patients may be moved between several wards during their stay. This physical dislocation provides the backdrop against which emotional and spiritual dislocation is played out as patients ask Big Questions concerning themselves, their future, and God. A couple of examples will illustrate this:

Chaplain-patient conversation themes, by genre

Patient conversation themes:	Occurrence: Summer n	as % of Summer conversation themes	Occurrence: Winter n	as % of Winter conversation themes
"Faith" related (Faith, church, prayer)	35	16	23	11.4
"Personal story" related (family, reminiscence, lifestyle, work, love)	63	28.9	70	34.7
"Hospitalisation" related (progress, distress, anxiety, tiredness, separation, place)	76	34.9	60	29.7
"Change" related (change, self worth, reassurance, confusion, guilt, world)	26	11.9	15	7.4
"Loss" related (widowhood, EOL, disability)	18	8.26	13	6.4
General need to chat	0	0	22	10.9
Total	218	100	203	100

• An elderly lady, let's call her Agatha, is admitted with a hip injury following a fall at home. It's not an uncommon scenario. What we find in conversation with Agatha is that her husband died three years ago; her grown-up family and their children live down south. Agatha has been coping alone since her husband's death. As she spends time recovering from her injury she reflects on the precariousness of her lifestyle. She's going to need support which will involve making changes to her home and allowing someone she doesn't know to come in to help her. Her social activities – church and bingo with her friends, her annual holiday at her son's will have to be done differently. As she reminisces on life Agatha realises that her life is in its latter years, if not actually drawing to its close; and she asks some very searching questions of God.

• A young man, let's call him Zak, is admitted following a suspected heart incident. Zak lives with his partner and their 18 month old daughter. He's a lorry driver and, in his spare time, enjoys a game of five-a-side football with his mates from the club. For Zak, being in hospital undergoing a range of very necessary tests raises financial questions: he's not earning while he's hospitalised and wonders whether he will be able to drive again for a living? How will he and his partner manage if he cannot? It raises questions about his social life: What about his football? Will he be able to play again? Will he be fit for the big match next Sunday? And, as tests reveal the potential implications of condition, he begins to ask "Why?" and "Why me?"

For Agatha and Zak these inner 'wrestlings' are compounded by separation from family, friends, work colleagues and the social circles within

which they fine meaningful self expression. True, those folks may visit, but visiting hours are closely prescribed, adherence to which may impose great inconvenience on those visiting. Furthermore the environment is alien to that in which those relationships are usually experienced and expressed. Consequently, conversation that would flow freely in the usual (outside) setting can become artificial and almost surreal.

Prayer requests

Written in a notebook on a table in the hospital chapel entrance, most are anonymous although chaplains sometimes encounter an individual writing a request or, having had a conversation with a patient, family or staff member invite them to write a request. Reading the prayers and considering both the nature and tone of the requests highlights several common themes which can be grouped into four overarching genres. These are summarised as follows:

Prayer requests according to theme: Family focussed, death related

Death related themes	Requests n	% Death related requests
Anniversary of death	135	52.7
Following recent bereavement/ loss	70	27.3
Following specifically baby loss	28	10.9
For a good death	19	7.4
For loved one's death to be delayed	4	1.5
Total death related prayers	256	38% of all prayers

Prayer requests according to theme: Family focussed, healing /condition related

Prayer themes	Requests n	% Healing/ Condition related requests
Non specific healing or strength	47	37.3
For peace/healing	16	12.6
For N to be made well again	16	12.6
Freedom from pain	14	11.1
Safe delivery of a baby	12	9.5
Keep safe/look after N	8	6.4
Healing from specific illness	7	5.5
For N to be brought home safely	6	4.7
Delivery from addiction	1	0.7
Victims of abuse	1	0.7
Total healing/ condition related prayers	126	19% of all prayers

Prayer requests according to theme: Family focussed, but unconnected with death/ healing/ condition

Prayer themes	Requests n	% Family related requests
Family specific general prayers	6	31.5
Love to be reciprocated	3	15.7
Family member taking exams	3	15.7
Family guidance	2	10.5
For family members serving in the military	2	10.5
Visa to stay be granted	2	10.5
Wedding Day prayer	1	5.2
Total family related prayers	19	3% of all prayers

Prayer requests according to theme: Non specific "God" related

Non specific, "God" related theme	Requests n	% generally "God" related requests
Non specific prayers for named individuals	201	76.1
Thanksgiving to God	46	17.4
God's blessing on/ prayer for the hospital	6	2.2
Invocation of saints	5	2.0
To know Jesus	2	0.6
Peace in the world	1	0.3
"Why?"	1	0.3
God's will be done	1	0.3
Specifically Islamic Prayer	1	0.3
Total non specific, "God" related	264	40% of all prayer requests

Whilst the data records the range of prayer-request topics and the frequency with which they recur, what it fails to record is the heartfelt emotion contained within those requests. Prayers earnestly petition on behalf of named individuals, restating the love and affection in which the prayed-for one is held and asking God to watch over them. Following bereavement prayers commonly express hope that the deceased friend or relative will be held safe by God and reunited with others gone before. Although perceptions vary, overwhelmingly God is viewed not as disembodied spirit but as a (male) being of substance with whom humanity continues to have contact. To some He is powerful, loving, caring and aware of His people's needs; others perceive Him as wilful - depriving families of loved ones taken to fulfil some particular (though unknown) purpose, or else indifferent to the needs of suffering individuals. Common to all is a sense of dislocation and disruption caused by illness or loss, and the need for reconnection either with those who have died or with God who holds the situation in his hands.

Recent Publications

Several NHS focussed publications exploring spirituality and spiritual care have appeared in recent years. Without exception they consistently focus on *characteristics* of spirituality, the importance of carers being *aware* of patients' spirituality, and on the *efficacy* of offering spiritual care. They are strong on equality and diversity, stressing the importance of providing spiritual care for people of all faiths and stress the importance of chaplaincy services. Whilst some offer pointers to spotting spiritual distress their emphasis is always spirituality not spiritual need. Thus, in the most recent material on spirituality and religion from NHS Scotland we can read *"Spirituality is a slippery word these days, involving anything from monasticism to wind chimes..."*[1] *and 'Spirituality enables us to not only connect and relate to other people, but also experience some "higher" or "other" state in relating to humanity and the rest of the world...'*[2]. This is potentially problematic: in discussing the spiritual needs of service users the risk is that *spirituality* without absolute definition in faith terms is promoted. Spirituality thus becomes a quality that strives to inspire the individual, stirring within them reverence, awe, meaning and purpose as they engage with the Big Questions of life; spiritual need becomes whatever an individual needs to give them this meaning and purpose. This calls for a word of caution: not all that gives an individual meaning and purpose is necessarily good or positive either to themselves or to others.

Conclusion

Drawing together the themes portrayed in NHS material and the evidence from both visit logs and prayer requests, I believe we can define spiritual need:

The need to be reconnected with significant

others in and with whom one feels a sense of wholeness or completeness when that connection has become dislocated or broken.

Although there will always be exceptions, humans are essentially social creatures deriving our sense of identity from relationships with others. John Donne, onetime Dean of St Paul's Cathedral and a man much acquainted with illness, summarised this: *"No man is an island entire unto himself."*[3] Similarly, in Genesis[4], God's seeking out a helpmate for Adam, culminating in the creation of Eve, points to this. Whether an individual's significant others are family, friends, workmates, pets or God, whenever those relationships are dislocated or broken – spiritual need, manifested as spiritual distress and the asking of ultimate or existential questions, results. Illness, injury and hospitalisation – no matter how brief – are dislocating experiences.

Recognising spiritual need as essentially relational has implications for all involved in patient care. Although ours is a secular institution we should never be ashamed to offer spiritual care; it is integral to good holistic healthcare. Within this ethos, all carers should assure patients (and their families) of their value as unique individuals; take seriously their relationship needs and, as far as possible, ensure that pre-existing relationships are not unnecessarily compromised by the hospital stay. These simple practices will go some way to meeting spiritual needs – and thereby to alleviating spiritual distress. In addition, just as specialists bring their particular curative or palliative skills into play, chaplains too have specialist skills and experiences, and faith-resources upon which to draw in using them to encourage and strengthen relationships, particularly –but not exclusively – relationships with God. Don't be afraid to use them.

References:

1. **http://www.whychurch.org.uk/trends.php**
2. Spiritual Care Matters, (NHS Scotland 2009) p.6
3. Religion and Belief Matter, (NHS Scotland 2009) p.16
4. Donne, John 1572-1631; (Dean of St Pauls 1621-31) Meditation 12
5. Genesis 2:18-24