ASSUMPTIONS AND PRINCIPLES OF SPIRITUAL CARE

Developed by the Spiritual Care Work Group
of the International Work Group on
Death, Dying and Bereavement

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Introduction

In those areas of the world where medical care has been shaped by sophisticated technologies and complicated health care delivery systems, efforts to humanize patient care are essential if the integrity of the human being is not to be obscured by the system. This is especially needed for individuals with chronic maladies or those who are in the process of dying.

Dying is more than a biological occurrence. It is a human, social and spiritual event. Too often the spiritual dimension of patients is neglected. The challenge to the health care provider is to recognize the spiritual component of patient care and to make resources available for those individuals who wish them and in the form desired.

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Spirituality is concerned with the transcendental, inspirational and existential way to live one's life as well as, in a fundamental and profound sense, with the person as a human being. The search for spirituality may be heightened as one confronts death. This uniquely human concern is expressed in a variety of ways both formal and informal. Those who provide care for dying persons must respect each person's spiritual beliefs and preferences and develop the resources necessary to meet the spiritual needs of patients, family members and staff. These resources and associated support should be offered as necessary throughout the bereavement period.

While the modern hospice movement has arisen within Western Society with its particular cultural, social and spiritual milieu, the following principles may be applicable in and adapted to other countries and cultures. Ultimately the Assumptions and Principles of Spiritual Care should influence other aspects of health care and be integrated into the larger system. Their need and manner of implementation, however, will be shaped by the spiritual life of a given individual and society.

General

1. A. Each person has a spiritual dimension.
   P. In the total care of a person, his or her spiritual nature must be considered along with the mental, emotional and physical dimensions.
2. A. A spiritual orientation influences mental, emotional and physical responses to dying and bereavement.
   P. Caregivers working with dying and bereaved persons should be sensitive to this interrelationship.
3. A. Although difficult, facing terminal illness, death, and bereavement can be a stimulus for spiritual growth.
   P. Persons involved in these circumstances may wish to give spiritual questions time and attention.
4. A. In a multicultural society a person's spiritual nature is expressed in religious and philosophical beliefs and practices which differ widely depending upon one's race, sex, class, religion, ethnic heritage and experience.
   P. No single approach to spiritual care is satisfactory for all in

a multicultural society; many kinds of resources are needed.

5. A. Spirituality has many facets. It is expressed and enhanced in a variety of ways both formal and informal, religious and secular, including, but not limited to: symbols, rituals, practices, patterns and gestures, art forms, prayers and meditation.
   P. A broad range of opportunities for expressing and enhancing one's spirituality should be available and accessible.
6. A. The environment shapes and can enhance or diminish one's spirituality.
   P. Care should be taken to offer settings which will accommodate individual preference as well as communal experience.
7. A. Spiritual concerns often have a low priority in health care systems.
   P. Health care systems presuming to offer total care should plan for and include spiritual care as reflected in a written statement of philosophy, and resources of time, money and staff.
8. A. Spiritual needs can arise at any time of the day or night, any day of the week.
   P. A caring environment should be in place to enhance and promote spiritual work at any time, not just at designated times.
9. A. Joy is part of the human spirit. Humor is a leaven needed even, or especially, in times of adversity or despair.
   P. Caregivers, patients and family members should feel free to express humor and to laugh.

Individual and Family (Natural and Acquired)

10. A. Human beings have diverse beliefs, understandings and levels of development in spiritual matters.
    P. Caregivers should be encouraged to understand various belief systems and their symbols; as well as to seek to understand an individual's particular interpretation of them.
11. A. Individuals and their families may have divergent spiritual

insights and beliefs. They may not be aware of these differences.

P. Caregivers should be aware of differences in spirituality within a family or close relationship and be alert to any difficulties which might ensue.

12. A. The degree to which the patient and family wish to examine and share spiritual matters is highly individual.

P. Caregivers must be nonintrusive and sensitive to individual desires.

13. A. Health care institutions and professionals may presume they understand, or may ignore, the spiritual needs of dying persons.

P. Spiritual needs can only be determined through a thoughtful review of spiritual assumptions, beliefs, practices, experiences, goals and perceived needs with the patient, or family and friends.

14. A. People are not always aware of, nor are able, nor wish to articulate spiritual issues.

P. (1) Caregivers should be aware of individual desires and sensitive to unexpressed spiritual issues.

(2) Individuals need access to resources and to people who are committed to deepened exploration of and communication about spiritual issues.

15. A. Much healing and spiritual growth can occur in an individual without assistance. Many people do not desire or need professional assistance in their spiritual development.

P. Acknowledgment and support, listening to and affirming an individual's beliefs or spiritual concerns should be offered and may be all that is needed.

16. A. Patients may have already provided for their spiritual needs in a manner satisfactory to themselves.

P. The patient's chosen way of meeting spiritual needs should be honored by the caregivers.

17. A. The spiritual needs of dying persons and their families may vary during the course of the illness and fluctuate with changes in physical symptoms.

P. Caregivers need to be alert to the varying spiritual concerns that may be expressed directly or indirectly during different phases of illness.

18. A. Patients and their families are particularly vulnerable at the time of impending death.
    P. Caregivers should guard against proselytising for particular types of beliefs and practices.
19. A. As death approaches, spiritual concerns may arise which may be new or still unresolved.
    P. (1) Caregivers should be prepared to work with new concerns and insights, as well as those which are long standing.
    (2) Caregivers must recognize that not all spiritual problems can be resolved.
20. A. The spiritual care of the family may affect the dying person.
    P. Spiritual care of family and friends is an essential component of total care for the dying.
21. A. The family's need for spiritual care does not end with the death of the patient.
    P. Spiritual care may include involvement by caregivers in the funeral and should be available throughout the bereavement period.

Caregivers

22. A. Caregivers, like patients, may have or represent different beliefs as well as different spiritual or religious backgrounds and insights.
    P. Caregivers have the right to expect respect for their belief systems.
23. A. Many health care workers may be unprepared or have limited personal development in spiritual matters.
    P. (1) Staff members should be offered skillfully designed opportunities for exploration of values and attitudes about life and death, their meaning and purpose.
    (2) Caregivers need to recognize their limitations and make appropriate referrals when the demands for spiritual care exceed their abilities or resources.
24. A. The clergy is usually seen as having primary responsibility for the spiritual care of the dying.

P. Caregivers should be aware that they each have the potential for providing spiritual care, as do all human beings, and should be encouraged to offer spiritual care to dying patients and their families as needed.

25. A. Caregivers may set goals for the patient, the family and themselves which are inflexible and unrealistic. This may inhibit spontaneity and impede the development of a sensitive spiritual relationship.

P. Caregivers and health care institutions should temper spiritual goals with realism.

26. A. Ongoing involvement with dying and bereaved persons may cause a severe drain of energy and uncover old and new spiritual issues for the caregiver.

P. Ongoing spiritual education, growth, and renewal should be a part of a staff support program, as well as a personal priority for each caregiver.

Community Coordination

27. A. Spiritual resources are available within the community and can make a valuable contribution to the care of the dying patient.

P. Spiritual counselors from the community should be integral members of the caregiving team.

28. A. No one caregiver can be expected to understand or address all the spiritual concerns of patients and families.

P. Staff members addressing the needs of patients and families should utilize spiritual resources and caregivers available in the community.

Education and Research

29. A. Contemporary education for health care professionals often lacks reference to the spiritual dimension of care.

P. Health care curricula should foster an awareness of the spiritual dimension in the clinical setting.

30. A. Education in spiritual care is impeded by a lack of fundamental research.

P. Research about spiritual care is needed to create a foundation of knowledge which will enhance education and enrich and increase the spiritual aspect of the provision of health care.

31. A. Freedom from bias is a problem in the conduct of research into spiritual care.

P. Research should be carried out into the development and application of valid and reliable measures of evaluation.

Glossary[1]

Assumption: The act of taking for granted.

Principle: A general or fundamental truth, a governing law of conduct.

Acquired Family: Friends who have a special relationship, share the same household but are not related by blood and/or marriage.[2]

Bereavement: Loss of loved one by death.

Care: To provide for or attend to needs.

Caregiver: One that gives care.

Clergy: A body of religious officials of functionaries prepared and authorized to conduct religious services and attend to other religious duties.

Existential: Based on the experience of existence: empirical as contrasted with theoretical.

Grief: Emotional suffering as caused by bereavement.

Integrity: The quality or state of being complete or undivided: material, spiritual or aesthetic wholeness.

Need: A want of something requisite, desirable or useful.

Proselytize: To (wittingly)[3] convert from one belief, attitude or party to another.

Religion: The personal commitment to and serving of God or a god (transcendental power)[4] with worshipful devotion, conduct in accord with divine commands especially as found in accepted sacred writings or declared by authoritative teachers.

Spiritual: Relating to the nature of the spirit rather than the material.

Spiritual Dimension: Sensitivity or attachment to religious values and things of the spirit rather than material or worldly interests.

[1]It was recommended that an international dictionary be utilized to define the terms contained in the glossary of a document propounded by an international body of scholars and clinicians.

[2]Definition developed by Work Group Members.

[3]Modified to incorporate notion of intentionality.

[4]Modified to amplify concept of deity.

Source: Webster's Third New International Dictionary of the English Language, Unabridged. Springfield, MA: G. and C. Merriam Co., 1981.