A resurgence of interest in spirituality is evident in postmodern culture. This interest has not been limited to popular culture alone; scientific interest in the effects of spirituality and religion on health has been gaining momentum since the 1980s. A search of the term “spiritual care” in the CINAHL database yielded only 293 articles for the period 1982 to 1994, and 1106 articles for the period 1995 to 2005. Taylor reported that a mid-2004 search of PubMed yielded 202 clinical trials in which religion was a study variable, 30,000 articles on religion, and 1500 articles on spirituality and that more than 12 nursing textbooks on spiritual care had been published since 1989.

A consensus is growing that religiosity and spirituality are significantly related to physical and psychological health and that the scientific study of spirituality and health is an important focus of nursing research. Concerns about the quality of the methods used in research on spirituality and religion are ongoing. Despite the resurgence of spirituality as a legitimate focus for nursing research, little data-based information specific to spirituality and critical care nursing practice is available.

In this article, I identify challenges of providing spiritual care in critical care settings, explain how the elements of the American Association of Critical-Care Nurses (AACN) Synergy Model for Patient Care address spirituality, and recommend nursing interventions based on the Synergy Model that are targeted to critically ill patients’ spiritual needs.

**What Is Spirituality?**

Scholars are seeking to clarify spirituality as a concept for use in the health sciences. Authors generally agree that the concept of spirituality is broader than the concept of religion. Religious beliefs and practices can be expressions of spirituality, but spirituality exists apart from religion. The consensus is that spirituality is defined as the manner by which persons seek meaning in their lives and experience transcendence—connectedness to that which is beyond the self—whereas religion is best understood as adherence to an accepted formalized system of belief and practices. Most nurse authors view spirituality as a universal phenomenon, for although all persons do not understand and accept the supernatural, all persons have needs for seeking meaning and acceptance in their lives.

Although spirituality is an abstract and multidimensional concept, 2 components of spirituality are widely described: vertical and horizontal. The vertical component describes that which is transcendent, the connections between a patient...
the body) and something outside of the patient: God, the divine, or a higher power (upward or out there somewhere). The horizontal component addresses the connections between persons. Connections between persons are generally understood as personal and social support that is embedded in the spiritual context and provided by religious settings and spiritual relationships.

Spiritual care is defined as the provision of interventions in the domain of spirituality and has long been the focus of hospital chaplains. Spiritual care also has been accepted as a legitimate focus of nursing practice. The North American Nursing Diagnosis Association has 2 accepted nursing diagnoses for spirituality: spiritual distress and readiness for enhanced spiritual well-being. The Nursing Outcomes Classification includes 20 indicators for spiritual health, and the Nursing Interventions Classification includes 4 specific interventions for spiritual care—religious ritual enhancement, spiritual support, spiritual growth facilitation, and forgiveness facilitation—and 2 more general interventions that are often used in spiritual care: bibliotherapy with sacred texts and presence.

Spiritual Nursing Care in Critical Care Settings

Critical care nursing is a demanding specialty that requires advanced knowledge of physiology and highly technological interventions. Nurses care for critically ill patients in intensive care units (ICUs) and progressive care units. Because the acuity of hospitalized patients has increased, some authors claim that all hospital nursing care has become critical care. Patients in critical care units are the most seriously ill and injured among all hospitalized patients.

ICUs house patients who are the sickest and in the most unstable condition, patients whose physiological needs predominate. The culture of critical care units is created by staff interaction around the competing demands of treating multiple life-threatening and complex problems in a fast-paced environment. Fontaine identifies the purpose of ICUs as places to provide monitoring of the sickest patients in the hospital and convincingly describes the difficulties of creating healing environments in ICU settings. The issue of environment is so important that the AACN has identified creating healing environments as a research priority. One of the 2 platforms of the new AACN standards on healthy work environments is that work and care environments must be safe, healing, and humane and respectful of the rights, responsibilities, needs, and contributions of patients, patients’ families, nurses, and all health professionals. Although critical care units are a challenging location for spiritual care, such care can be a way to enhance the healing and humanity of the highly technical, physiologically driven ICU environment.

Spirituality and the AACN Synergy Model for Patient Care

The AACN Synergy Model (see Sidebar 1) is emerging as the accepted standard conceptual framework for acute care and critical care nursing. The first of the 5 assumptions underlying the model is that each patient is a whole person: body, mind, and spirit. This assumption means that each patient is more than the pressing physiological needs that caused hospitalization for the critical illness. Nursing care of the whole person, guided by the Synergy Model, addresses not only physiological care but also care in the psychosocial (care of the mind) and spiritual (care of the spirit) domains. The inclusion of spirit as a central aspect of the AACN Synergy Model makes this nursing model a particularly useful guideline for providing spiritual care in ICUs. Indeed, use of the Synergy Model may help nurses overcome some of the constraints to spiritual care in hospitals identified by Van Dover and Bacon: priority placed on physical health needs, multiple demands on nurses’ time, and varying expectations of nurses and healthcare institutions concerning the nurses’ role in giving spiritual care.
The Synergy Model identifies 8 characteristics of nurses and 8 characteristics of patients within the hospital environment. The key to care is the relationship between nurses and patients, so that nurses’ competencies coincide with patients’ needs. The model is termed the Synergy Model because it posits that by matching nurses’ competencies to complement patients’ characteristics, something more than the sum of the parts ensues and synergy occurs. Four areas of the model can be related to spiritual care: 2 characteristics of patients—resiliency and resource availability—and 2 characteristics of nurses—caring practices and response to diversity.

Patients’ Characteristics Related to Spirituality Resiliency

The characteristic of resiliency in patients is defined as the “capacity to return to a restorative level of functioning using compensatory coping mechanisms”6(p14); the ability to bounce back quickly after an injury. At the lowest level of resiliency (minimally resilient), a patient is unable to mount a response, has “failure of compensatory/coping mechanisms and minimal reserves, and is brittle; . . . at the highest level (highly resilient), the patient is able to mount and maintain a response and has intact compensatory/coping mechanisms, strong reserves, and endurance.”6(p14)

Interventions to strengthen a patient’s resiliency can be categorized as belonging to the vertical component of spirituality. Prayer is a communication used to make a connection between human beings and God and is recognized as a coping mechanism.21 Prayer is reported to be one of the most frequently used complementary and alternative medicine techniques.32-24 Studies of spirituality in hospitalized patients often have indicated that prayer is a coping mechanism.24-27 In a study of 100 patients hospitalized the night before open heart surgery, Saudia et al26 found that 96 of the patients prayed and 2 had others pray for them; only 2 had no prayer. Internal reserves are reserves that are available to be called on in times of need. These reserves can be of great depth, are often beyond rational explanation, and are available in time of need. For example, Arslanian-Engoren and Scott26 conducted a phenomenological study of 7 self-identified spiritual patients who had experienced tracheostomy for prolonged mechanical ventilation (mean length of stay 37 days, SD 14 days). All of the patients found comfort through religion and spent much time in daily prayer. The patients also derived reassurance and support from visions of dead relatives and angels; in these encounters the patients reported that they received guidance and encouragement.

Spirituality also can provide reserves that enhance endurance. In a qualitative research study of men hospitalized with prostate cancer, Walton and Sullivan27 applied the metaphor “men of prayer” because all of the patients identified the use of prayer as vitally important. The patients reported that prayer provided strength, assurance, comfort, and inner strength. Walton and Sullivan27 also identified 2 concepts, trusting and living day by day; meanings ascribed to the 2 concepts indicated endurance through difficult illness, treatments, and unknown outcomes.

Resource Availability

The characteristic of resource availability in patients is influenced by the “extent of resources brought to the situation by the patient, family, and community.”6(p34) Resources are technical, fiscal, personal, psychological, social, or supportive. At the lowest level, resources are few, personal/psychological support is minimal, and access to social systems is minimal. At the highest level, patients have access to many resources. The Synergy Model posits that the more resources, the greater is the potential for a positive outcome; with less resource availability, the potential exists for a more constrained recovery process.6(p34)

The horizontal component6-11 of spirituality, the direction symbolizing the connections between persons, contributes directly to a patient’s resource availability. Persons connected to a religious congregation may have the potential for greater resources. Both personal support and social support are often provided by fellow congregants. Personal support for patients who are congregants comes from the patients’ ongoing relationships with clergy, who provide formal pastoral care.12 Also, many congregations have parish nurses (recently renamed faith community nurses) who provide spiritual and other nursing care to ill congregants.28(pp200-202) Social support comes from congregations that function as de facto social service organizations. The tradition of service found in many faiths, the doing of good works for spiritual gains, can be extended to ill congregants.

Connection to a religious congregation is not required, however, for enhancing the availability of spiritual
resources. Many spiritual persons are not members of religious groups but do have ongoing, long-term spiritual companions who provide guidance for spiritual growth.29 Spiritual companions is a newer iteration of the traditional “spiritual director,” a more mature person who takes on the responsibility for the formation of spirituality. This relationship is a formal one in which the focus is spiritual growth. These spiritual relationships provide excellent sources of personal and social support in times of crisis.

**Nurses’ Characteristics Related to Spirituality**

**Caring Practices**

The purpose of caring practices is to promote comfort and healing and prevent unnecessary suffering.6,p71 Caring cannot occur without respect for each patient as a person who has unique needs. Nursing interventions embedded in caring promote a healing environment. Caring practices acknowledge the give and take between nurses and patients, in which mutuality is part of the relationship.

Caring for the entire patient as a person includes care of the spirit. In a study of 10 critical care nurses, Kociszewski30 identified a “mutual knowing” between patients and the nurses that led to what she called “a bridge” for spiritual assessment. This mutual knowing began with the nurses’ personal spirituality and built on the nurses’ knowledge of spiritual care. Over time, the nurses explored the spiritual needs of the critically ill patients and the patients’ families and looked for overt and covert cues. These cues were often subtle and included photos, artifacts, a visitor praying with a patient, and so on.

The connections between the nurses and the patients became bridge building for effective spiritual assessment.

Nowhere in nursing is caring more evident than in end-of-life care, which has emerged as an area of concern in the ICU. In a recent study, the Robert Wood Johnson Foundation convened a critical care end-of-life peer work group and added to the scholarly group 15 physician-nurse teams who worked together in 15 ICUs across the United States. Spiritual support for patients and patients’ families emerged as one of the identified interventions. The working group31 identified 3 actions as indicators of the quality of spiritual support:

1. assess and document spiritual needs of patients and patients’ families on an ongoing basis;
2. encourage access to spiritual resources; and
3. elicit and facilitate spiritual and cultural practices that patients and their families find comforting.

These quality indicators were identified specifically for end-of-life care, but they also are appropriate caring practices for all patients in critical care units.

**Response to Diversity**

The characteristic of response to diversity in nurses is defined as the sensitivity to “recognize, appreciate, and incorporate differences (in patients) into the provision of care.”6,p8 The Synergy Model identifies spiritual beliefs as one of the differences to be addressed. Development of sensitivity among nurses is an important aspect of this characteristic. In 2002, the AACP practice analysis task force expanded the initial 5 assumptions underlying the Synergy Model by adding “the nurse brings his or her background to each situation, including various levels of education/knowledge and skills/experience.”6,p8 This assumption is demonstrated by nurses who bring their own spirituality to the nurse-patient relationship. In an exploration of the attributes of spiritual care in nursing practice, Sawatzky and Pesut32 provided a definition of spiritual nursing care that simultaneously highlights this assumption and focuses on patients’ diversity: “Spiritual nursing care is the intuitive, interpersonal, altruistic, and integrative expression that rests on the nurse's awareness of the transcendent dimension yet reflects the patient’s reality.”32(p123)

Kociszewski identified the concept of “the spiritual nurse,”33(p136) a label she gave to nurses who had developed a “spiritual self.” These nurses indicated that they were on a spiritual journey or pilgrimage and that “being spiritual was the first step in giving spiritual care.”31(pp136-137) The idea that nurses with self-awareness of the spiritual realm are better prepared to provide spiritual care than are nurses without such awareness is well supported.23,34,35 A spiritual nurse brings the experience and knowledge of the spiritual self into the critical care setting and is particularly adept at meeting patients’ spiritual needs.

It is not expected that every nurse is or should be a spiritual nurse. Studies13,16 of hospital nurses have identified 2 types of nurses: those who think that it is not within the purview of nursing to provide spiritual care and those who lack education in spirituality. Specialized education in spirituality can help ensure that nurses are aware that spiritual care is within the purview of nursing and can prepare all nurses to deliver an appro-
appropriate level of spiritual care to patients. The following suggestions for nursing interventions provide guidelines for appropriate spiritual nursing care.

**Suggestions for Interventions**

The Synergy Model can be used to organize and guide 5 nursing interventions.

**Caring Practices: Accurately Identify Spiritual Needs**

Being listened to and cared for are basic needs of all patients and their families in the environment of the ICU. When performing nursing assessments, nurses should identify cues specific to the spiritual realm and should collect data to identify spiritual needs. Ongoing assessment is essential, because spiritual concerns can arise during hospitalization. In-service training or continuing education and support are needed if staff nurses are to develop expertise in spiritual assessment. The Joint Commission on Accreditation of Healthcare Organizations has established that as a minimum, each hospitalized patient’s denomination, beliefs, and spiritual practices should be assessed and has made suggestions for additional questions to be used in a spiritual assessment (see Sidebar 2). Two especially detailed and comprehensive nursing guides for spiritual care texts by O’Brien and Taylor. Assessing spiritual needs includes identifying patients who do not want any spiritual care, a step that is important inasmuch as studies of hospitalized patients indicate that one third of patients do not desire spiritual care while hospitalized.

**Response to Diversity: Make Congruent Matches**

Using the Synergy Model to assign patients to nurses ensures that congruent matches will be sought. Once a patient and the patient’s family have been identified as needing and desiring spiritual care, a match can be sought with a nurse who is known for attending to spirituality. Ideally, the nurses with spiritual expertise are as well known on the unit as are nurses with expertise in weaning, handling a new trauma patient, or dealing with a difficult family. Making these assignments on the basis of spirituality will become just as routine as looking for good fits in physiological and psychosocial areas of the model.

**Support Resiliency: Make Appropriate Referrals**

For critical care nurses, the pressing priority is physiological care; spiritual care often happens in-between and while delivering other nursing care. Consultation and referral to the hospital chaplain and/or a patient’s own clergy or spiritual companion and making space and time for the patient and the chaplain, clergyperson, or companion to be together privately helps support the vertical component of the patient’s spirituality.

**Support Resiliency: Make Space and Time for Group and Individual Religious Rituals and Spiritual Practices**

An appreciation for the practices of a patient’s faith is actualized by prioritizing time and providing space for sacred ritual in the hospital environment. A patient may need to have uninterrupted time for spiritual reading or prayer; a church group may need to offer a sacred song or a blessing. In some faiths, a patient may need a connection with nature, such as being able to look out a window or see the sun rise or set. This nursing intervention is a simple but important one that cannot be overemphasized.

**Support Resource Availability: Make Connections Between Patients and Their Spiritual Support Systems**

If appropriate, critical care visitation can be extended to the members of a patient’s congregation. When fellow congregants cannot

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**Sidebar 2**

**Suggestions for Spiritual Assessment**

- **Initial screening questions**
  - Are there any religious or spiritual practices that would be helpful to you while you are here?
  - Would you like to see a chaplain?

- **Additional screening questions**
  - What can I do to support your faith or religious commitment?
  - Are there aspects of your spirituality that you would like to discuss?
  - Would you like to discuss the spiritual or religious implications of your hospitalization?

- **Other questions**
  - Who or what provides you with strength and hope?
  - Do you use prayer in your life?
  - How do you express your spirituality?
  - What type of religious/spiritual support do you desire?
  - What role does the church/synagogue/mosque in your life?
  - How does your faith help you cope with illness?

*Based on the nursing assessment form at the Brigham and Women’s Hospital, Boston, Mass.† As suggested by Clark et al.‡ As suggested by the Joint Commission on Accreditation of Healthcare Organizations.

http://ccn.aacnjournals.org/
visit patients, the congregants can often visit the patients’ families in the waiting room and support the families. Many congregations have videotapes of worship services; opportunities and equipment for patients to watch tapes can be provided. Flower delivery by congregants is the traditional mark of religious visitation; when flowers are not permitted, small symbolic religious gifts may be brought. Other ways to make connections can be individualized to meet patients’ needs.

Specific spiritual nursing interventions are presented in the 2 case studies. Case 1 focuses on supporting resiliency by making space and time. Case 2 focuses on caring practices when a spiritual nurse is able to accurately identify a spiritual need.

Conclusions and Summation

A key feature identified by the Synergy Model is the relationship between nurses and patients, so that nurses’ competencies coincide with patients’ needs. Assigning nurses with expertise in spiritual care to patients who have spiritual needs results in synergy. Also important are appropriate referrals, because nurses often cannot provide all of the spiritual care that is needed. Making time and space for the practice of religious rituals at the bedside is important and is often overlooked as a nursing intervention.

Using the Synergy Model as a basis for research on spiritual care in the critical care setting is needed, especially monitoring the frequency and quality of spiritual assessments. Synergy can be studied by examining assignments of patients to nurses and patients’ outcomes. Referrals can

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**Case 1: Supporting Resiliency by Collaborating With a Chaplain and Making Time and Space for Religious Ritual**

I was working the evening shift on the medical intermediate care unit at a large urban hospital, where I have been a per diem staff nurse for more than 10 years. I was caring for an elderly man with end-stage lung disease who was critically ill with a severe pneumonia, had borderline values on arterial blood gas analysis, and was chronically on the verge of needing intubation. The on-call hospital chaplain, an ordained Protestant woman, was following up on the patient’s request from earlier in the day to receive the “sacrament of the sick.” She asked if the priest had visited. This question was the first I knew of the request and the first indicator I had of the patient’s Roman Catholic faith. Although I had cared for the patient the day before, his room had had no visual cues that indicated a faith commitment, and I had been so busy caring for his physiological needs that I did not even think about his spiritual needs. The chaplain and I determined that the priest had not yet visited, and she went to find him.

When the priest arrived, I was in the middle of a critical physiological procedure. My previous practice would be to ask the priest to “go away and come back at a more convenient time.” But, because I had recently begun to understand what a sacrament meant to a patient of this faith, I asked the priest to wait a few minutes, and I prioritized making arrangements for the space, time, and privacy for the sacrament to occur between priest and patient. The patient was visibly less anxious after the religious ritual, and his tachypnea and oxygen saturation values were stable for the rest of the shift. Indeed, he recovered from his pneumonia without needing intubation.

This appreciation for the practices of another’s faith can be generalized to all faiths.

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**Case 2: Caring Practices, or an Intensive Care Unit Patient Needs a “Spiritual Nurse”**

It was shortly after morning report, and I was checking on a student caring for an elderly widow, a postoperative patient in the surgical intensive care unit. I was a clinical instructor teaching seniors in a large teaching hospital in Southern California, and I had 8 students spread out over 4 critical care units. The student told me, “I don’t understand what is going on with my patient; in report they said she had delirium, and she is constantly mumbling and won’t open her eyes when I try to speak to her.”

I entered the room and found the patient with the usual postoperative invasive catheters, monitoring equipment, and drainage tubes. She was lying on her back with her eyes closed, and she had her hands clasped against her chest. She was mumbling, and did not appear to hear me when I spoke to her. I touched her arm and bent down to listen, and I heard her reciting the words of the 23rd Psalm, using the old English words of the King James Version: “Yea though I walk through the valley of death, I shall fear no evil, for Thou art with me . . .” I joined in her recitation: “Thy rod and thy staff they comfort me . . .”

We finished reciting the Psalm together, and she opened her eyes and looked at me expectantly. I said, “Sometimes it really helps to say the words aloud,” and she said “I’ve been praying and praying, but I feel all alone here.”

We went on to have a conversation about her surgery and her perceptions of the intensive care unit. I stayed with her for several minutes and was able to ascertain that she was without family and was scared. She had been reciting the words of the Psalm in an effort to prove to herself that she was not alone. I was able to make arrangements for the hospital chaplain to visit. The hospital chaplain, in addition to being present and giving spiritual care, was able to contact the patient’s pastor and church friends, who came in and lent their support.

This situation was one in which personal knowledge of the King James Version of the Bible led to the ability to recognize what the patient was doing and to connect with her by reciting the Psalm together. This activity led to the identification of her isolation. Although this experience was based in Christianity, the learning is applicable for other situations. I am now more sensitive to a cue of a recited prayer or sacred text passage. For example, if I had a Muslim patient reciting the Koran in Arabic, I might not recognize it and would not be able to join in. But because of the experience described here, I would suspect the potential use of prayer and sacred text and ask a Muslim chaplain or colleague to assess the situation.
References
