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Essay

A Graduated Approach to Spiritual Intervention in Health and Long-Term Care

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Abstract: Most professionals in health and long-term care know the importance of spirituality for well-being among older people; however, they are challenged to know how to approach the topic or what to do to enable the power of spirituality in their setting. This paper is based on an extensive search and content analysis of literature in the health and social sciences, and offers a step-wise approach to engaging with older adults on spiritual issues. The content analysis identified five levels of intervention. The first two levels require no special training (listening and acknowledging, referring). The next three levels—asking about spirituality, indirect, and direct interventions—each depend on a greater degree of preparation and expertise. All the levels offer the possibility of spiritual expression for clients/residents, and the opportunity for health and social service professionals to respond to these important issues.

Keywords: aging; health; intervention; long-term care; spirituality

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1. Introduction

Evidence is abundant for the impact of spiritual health on emotional well-being, coping, and resilience among older adults, particularly those with chronic conditions, disabilities, and life-limiting illnesses (Oz et al. 2022; McDonnell-Naughton et al. 2020; Jung et al. 2017; Curran et al. 2019; Kricke et al. 2019; Salman and Lee 2019). Some authors even state that the connection between spiritual health and overall well-being is so strong as to confer an ethical obligation to provide spiritual care to older adults in health and long-term care settings (Puchalski et al. 2020; Kruizinga et al. 2018). And yet it is frequently reported that spiritual issues are neglected (Selman et al. 2018). This is hardly surprising when we consider that qualified spiritual care providers are available in less than half of long-term care settings, and carry extraordinarily large caseloads when they are available (Kuepfer et al. 2022a).

Several authors acknowledge that other professionals besides professional chaplains can participate in spiritual care, particularly occupational therapy, nursing, and social work (DeFord 2011; Nelson-Becker et al. 2015; Hixson 2016; McColl 2016b). An integrated approach to the provision of spiritual care is recommended, where chaplains fulfill specialty roles, while other health professionals fulfill generalist roles (Puchalski et al. 2020). Various models of care are advanced for combining and integrating interprofessional approaches (Balboni et al. 2014).

However, individual practitioners state that they are at a loss to know how to engage with patients on spiritual issues, even how to talk about spirituality (McColl 2013). They invoke as reasons for avoiding spiritual care the pressure on their time to complete their primary roles, and their lack of training for roles in spiritual care.

2. Purpose and Methods

The purpose of this paper is to identify suitable roles in spiritual care for professionals in health and long-term care settings. Given that these individuals will have varying levels

of education and training in spiritual care, a graduated approach is proposed to provide guidance on roles appropriate to different levels of preparation.

For the purpose of this paper, I will subscribe to Puchalski's definition of spirituality: "Spirituality is the aspect of humanity that refers to the way individuals seek and express meaning and purpose, and the way they experience their connectedness to the moment, to self, to others, to nature, and to the significant or sacred" (Puchalski et al. 2009, p. 887).

A targeted review of the literature was undertaken with the following parameters. Peer-reviewed journal articles and books were searched using an electronic database designed for the health and social sciences, specifically the Cumulated Index of Nursing and Allied Health Literature (CINAHL). This database was chosen because it focuses on the health and long-term care context of this issue. The literature was searched for the years 2000–2022, using keywords from the following two sets: (aging, gerontology, geriatric, long-term care) and (spirituality, spiritual care, chaplain). A further hand-search was conducted for articles cited that did not appear in the original search.

Content analysis of the literature was undertaken to identify: (a) specific spiritual care interventions for older adults; and (b) the level of expertise required (health professional credential, spiritual care credential, neither, both; formal vs. informal preparation). A matrix of interventions and credentials led to the development of the graduated approach. Intervention approaches found in the literature were coded for the type of intervention (assessment, referral, indirect, direct) and level of expertise required (health vs. spiritual care professional; formal vs. informal credential). Interventions categorized within the matrix were then categorized for descriptive purposes.

Reflexivity statement: I approach this topic from my perspective as an occupational therapy professor, a scholar in disability studies, and a qualified chaplain and grief counsellor. I also draw on my experience teaching and writing about spirituality for health professionals over the past 20 years. The current paper synthesizes content from a keynote address and invited workshop at the Canadian Association of Spiritual Care Conference (2022) and a presentation at the International Conference on Ageing and Spirituality (2022).

3. A Graduated Approach to Spiritual Care

A five-step graduated approach to spiritual care was developed through the literature search, with increasing expectations of personal and professional expertise and training with each successive step. The five steps are: (1) listen and acknowledge; (2) refer; (3) ask about spirituality; (4) indirect interventions; and (5) direct interventions. The approach begins with two levels that require no additional knowledge or skill beyond health professional training; it progresses to levels that are predicated on more knowledge and skill, and ultimately that require specific formal qualifications in spiritual care. This approach permits practitioners to choose the level at which they are comfortable and qualified for the role.

3.1. LEVEL 1: Listen and Acknowledge

The most basic way to engage with clients or residents at a spiritual level in health and long-term care is to listen and acknowledge that there is a spiritual component to their current situation. This compassionate presence includes the adoption of an "unknowing" stance (Ellington et al. 2015). It sounds easy, but it can be challenging for professionals in a busy environment. Mundle and Smith (2013) offer the concept of embodied listening that involves four qualities in the listener. *Being seated* is the first step in creating the kind of environment that suggests you can be trusted with intimate, personal thoughts, and that you are not in too much of a hurry. The second step in embodied listening is to *be still*—avoid fidgeting, shuffling papers, and attending to any of a number of distractions that shift the attention away from the speaker. The third aspect of embodied listening is *eye contact*: creating an interpersonal connection. And the fourth is *bodily expressiveness*, such as leaning in to the conversation, turning toward the speaker, nodding, and indicating your attentiveness.

Acknowledging is the other part of this approach—reflecting back what you have heard—both content and emotion. Show that you have grasped what has been said, and that you recognize that it may be difficult, frightening, shameful, sad, regretful, or any number of other expressions of emotion. Acknowledging requires that you recognize an expression of spiritual intent when one is proffered. Some clients will be explicit about their religious beliefs and convictions, their public or private faith practices, and their relationship with a higher power. Their expression may be overt—for example, "I think God must be angry with me." Alternatively, it may be more subtle, oblique, or covert. Indirect expressions might include displaying symbols of their faith, asking questions about issues, such as life after death, why things happen, searching for meaning, and losing hope or faith. In either case, it is important to be able to recognize the words, symbols, ideas, and themes that clients may use to raise a spiritual issue.

There are two difficulties that professionals typically encounter when clients raise spiritual issues. Either they do not have language or concepts to respond confidently and professionally to such an overture, or they are worried about imposing their own beliefs and values (McColl 2016a). Both are legitimate issues; however, both can be dealt with by simply acknowledging the depth and importance of the issue the person is raising, and asking if he or she would like to discuss it further. All that needs to be said is an acknowledgement that something profound and important is going on for the person. Spiritual issues are sufficiently sensitive in our culture that clients may be insecure about raising them. It would be a shame indeed if a care provider was unable to appreciate the depth and importance of a spiritual issue that a client or resident was trying to raise, and therefore left it unattended.

3.2. LEVEL 2: Refer

A second level of response to an expression of spiritual concern is an offer to help the person find someone to talk to who might be able to better address the issue at hand. This may be an officiant of the person's own faith tradition, or it may be an inter-faith chaplain, such as who works in many hospitals and long-term care facilities (Kuepfer et al. 2022b). Resources with specific expertise in spiritual issues might be:

- Spiritual health professionals or counsellors. Chaplains or other interfaith spiritual professionals are educated in theology at the graduate level, and have intensive training, typically in health or long-term care settings (Huth 2011);
- Community clergy from the appropriate faith community. Ministers, priests, rabbis, imams, and other spiritual leaders have training and expertise to equip them to help clients interpret their own faith;
- Lay experts in the community in various spiritual practices, such as meditation or counselling;
- Health professionals with explicit spiritual health credentials, such as Faith Community Nurses (Hixson 2016; Sessanna et al. 2021);
- Community groups that share the person's issues; or
- Print or electronic resources.

3.3. LEVEL 3: Ask about Spiritual Issues

The two previous strategies do not require any specific personal training or expertise to be able to engage. This next approach, while not dependent on a particular credential, does depend on the ability of the person to marshal the words to be able to ask about spiritual issues. This is the first step in any spirituality-based practice—finding language that is comfortable, authentic, and credible. Asking about spirituality has been repeatedly confirmed to be a key element of quality care (Williams et al. 2022).

One option for asking about spiritual issues is to use a recognized measure, thereby overcoming the need to craft original language. Both qualitative and quantitative measures are available. Quantitative measurement of spirituality is somewhat controversial. However, two measures that are frequently cited in the literature are: the Spiritual

Well-Being scale; and the Multidimensional Measure of Religiousness and Spirituality (Harrington 2016; McColl 2011).

Qualitative measures tend to be identified by acronyms, such as FICA (Faith, Importance, Connections, Action), HOPE (Hope, Organized religion, Personal practices, Effects), and FAITH (Faith, Apply, Involved, Treatment, Help) (LaRocca-Pitts 2012). A qualitative approach based on research with participants with disabilities includes five themes that arise in the context of a health or existential crisis: awareness, intimacy, trust, vulnerability, and purpose (McColl et al. 2000a, 2000b). These themes can form the basis of questions that permit older clients or residents to express their spiritual concerns (see Box 1).

Box 1. Assessment questions arising from research on spirituality and disability.

- AWARENESS—Do you feel aware of your place in the world? Of the presence of a supreme being? Is that awareness positive or negative?
- INTIMACY/CONNECTION—Do you feel a connection with [insert deity/higher power if person has mentioned it]? With others? With disenfranchised groups? With the world/the cosmos?
- TRUST—Do you feel like the world is a good and safe place? Like others can be trusted? That [God/higher power] can be trusted?
- MORTALITY/VULNERABILITY—Do you feel a sense of the arc of your life? Do you think about where you are in your life? How do you feel about time and what it means for your life? Do you believe in any sort of existence after death? Is that belief a comfort or an anxiety?
- PURPOSE/MEANING—Do you sense that there is a larger cosmic purpose to life? Do you feel that you have a mission relative to others, or a sense of calling? Are you aware of the presence of a divine will? Do you feel there is a plan for your life?

3.4. LEVEL 4: Indirect Interventions

Indirect spiritual interventions refer to a set of therapeutic practices that offer the opportunity of a spiritual experience or discussion, but that are not inherently spiritual or religious. A review of the literature revealed six modalities that may be used in dealing with spiritual issues among older adults (McColl 2011). These modalities, detailed below, can be used by professionals even if they are not spiritual or religious themselves. Furthermore, they can be used with both individuals or groups (Coyle 2014; Wong et al. 2019).

- *Narrative*—The process of creating and relating narratives has received considerable attention in the gerontology literature (Stevens 2018; Coyle 2014). Narratives are vehicles for spiritual exploration and growth. They enable the narrator to create meaning, to connect to spiritual themes (such as hope, healing, and redemption), and to make connections across the past, present, and future (Bruner 1990). The power of narrative lies in its potential to relate an individual's story to the story of the whole cosmos. Links may be created to stories of other people, of the natural world, or of a supreme power. Particularly in older people, the process of life reminiscence may be a powerful tool for spiritual expression and exploration. Several interesting examples include: telling stories of transcendence (Coyle 2014); relating spiritual paths over the lifespan (Garthwait et al. 2020); and stories told repeatedly to transmit values and beliefs (McColl 2022).
- *Ritual*—Rituals refer to ordinary activities that are invested with symbolic meaning when performed to celebrate, commemorate, or sanctify important events or ideas (Niven 2008; MacKinlay 2008; Thibeault 2011). They have the power to mark passages, transitions, and milestones. They allow individuals to transcend the ordinariness of the activity and to reach a new level of understanding of their place in their own lives, in their relationships, and in the world. Rituals may include symbols, actions, practices, devotions, or ceremonies.
- *Appreciation of nature*—The appreciation of nature as a therapeutic activity has the potential to promote spiritual growth and discovery (Unruh 2011). Experiences in the natural world can dissolve the boundaries between the self and the world, and make

one more aware of the mystery and connectedness of all things. The sense of awe and wonder that often accompanies experiences in nature can evoke thoughts and feelings about beauty, creation, and the divine (Sturm et al. 2022). The appreciation of nature may be accomplished with outdoor activities, art or photography, gardening, or pet therapy.

- *Creativity*—A fourth type of indirect spiritual intervention is creative activity. Creative activity affords an opportunity for unconstrained expression of the spirit and communication of universal truths (Miner and Dowson 2017). Often spiritual concepts defy expression through language, and instead are more effectively communicated through the universally accessible media of imagery, poetry, music, or visual arts (Corry et al. 2014).
- *Work*—Work is a medium that offers individuals an opportunity for service and contribution, for participation in a shared mission, for the dignity associated with a job well done, and for the rhythm of work and the orderliness of time structured by work routines. The workplace, whether it be at home, at school, community service, voluntary work, or remunerative work, affords a sense of belonging and achievement; in addition, it reinforces the individual's place in the world (Baptiste 2011). Any task that entails a degree of obligation and expectation may be broadly considered as work.
- *Movement*—Movement can evoke spiritual remembrance of our physical connection to the earth, to our bodies, and to each other. Embodiment is a fundamental aspect of what it means to be human, even when the body is physically limited or constrained. The frailty of the body, particularly among older people, emphasizes the transition from the material to the spiritual, and reminds us of the finite nature of our lives. Movement may be achieved through dance, exercise, sport, yoga, tai chi, stretching, drumming, or even vicarious movement (Salman and Lee 2019).

3.5. LEVEL 5: Direct Interventions

Direct spiritual intervention refers to specific faith practices, such as prayer, meditation, worship, or spiritual counselling. These practices may enhance the cultural relevance of treatment for those patients who have a faith tradition (Hamilton et al. 2020; Sessanna et al. 2021). Direct interventions require additional training and qualifications to be able to administer with integrity and expertise. Most health professionals do not feel that they are within their professional scope of practice, unless they have obtained some specialty certification. McColl and Farah (2011) offer guidelines for the use of direct spiritual interventions. They suggest that if a health professional can answer positively to the following four questions, then it may be appropriate to undertake a direct spiritual intervention:

- Is the client's problem inherently spiritual in nature?
- Is the client receptive to spiritual intervention?
- Is the therapist qualified to offer the spiritual intervention?
- Would the therapist's employer support him or her in offering this type of intervention?

If the answer to all four questions is "yes", then it is possible to consider offering to pray, meditate, worship, or engage in other spiritual practices with a patient. If not, it probably makes more sense to refer the individual to someone with whom they can undertake these direct spiritual practices. There are a number of cautions, such as the need for a secure therapeutic relationship, the necessity for the practice to be genuine, and the assurance that it is in no way forced or imposed.

4. Discussion

In summary, the paper has presented a graduated approach to spiritual intervention with older adults in health and long-term care settings. It offers a discussion of five levels of intervention for spiritual care. The most basic levels require no special training or credentials—listening and acknowledging, and referring to someone with spiritual expertise. Of greatest importance is the ability to recognize spiritual themes when clients express them and find ways of responding to those overtures. Those responses should

be compatible with the therapist or provider's level of comfort and expertise, should be authentic, and should not foreclose on the conversation about spirituality. The evidence is clear that spiritual factors can positively affect health, well-being, and mental health among older adults. Themes that consistently arise in discussions of later-life spirituality among older adults include: emphasis on the spiritual rather than the material world; on being rather than doing; transcendence of the self and the ego in favor of a more universal perspective; acceptance of paradox and ambiguity and relinquishing the ideal of coherence; adoption of a cosmic perspective on issues of life and death, space and time; a sense of belonging (vs. isolation); and a selectivity about roles and relationships (McColl 2016b; MacKinlay 2008).

The third level—asking about spirituality—requires a basic level of comfort with language used to express spiritual concepts. It may also involve initiating a discussion which might range outside of one's expertise or scope of practice. The fourth level is indirect interventions. These are often part of the scope of practice of a number of health professions. They are not inherently spiritual or religious in nature; however, they can be used to explore spiritual themes. They include: narrative, creativity, ritual, appreciation of nature, work, and movement. The paper expands on these six indirect interventions that afford an opportunity for spiritual expression and exploration, and offers examples of activities within each. Level 5 includes the most direct interventions—prayer, meditation, worship, and counselling. These are typically offered by spiritual health professionals or others who have undertaken special training.

There are a number of reasons why health and caring professionals may be hesitant to engage in spiritual exploration with clients or residents. One is a cohort effect. Older adults today grew up in a world where religious participation was common and religious interpretations were normative. Religious organizations were at the center of communities and public life. Older adults typically grew up with religious habits, such as prayer, worship, and participation in a faith community. They have more natural access to language for describing spiritual experiences (albeit religious language). They are more inclined to interpret events large and small through a religious lens (Kuepfer 2020).

Health and social service professionals, on the other hand, grew up in a world suspicious of religion and religious organizations. Many health professionals are from a generation without formal religious traditions. Instead, if they are inclined toward spirituality at all, it tends to be an individualistic, intuitive, and secular form (Kroeker 2011). Not only that, but they often work in public-sector organizations that insist on the absence of religious symbols or expressions. Our cultural mosaic requires that public services do not privilege (or appear to privilege) any ethnic or religious group in the delivery of service (McColl 2011).

Another explanation for the emphasis on spirituality in later life, and the potential gap between providers and patients, is life stage and developmental issues. Some theorists believe that a major stimulus for spiritual or religious searching is the fear of death. As a species, when humans became capable of contemplating their own mortality, a need arose to alleviate the fear associated with death and non-being (McColl 2016a). The solution to this need was to try to explain what lay beyond the limits of the material world. Aging raises questions of a profoundly spiritual nature, such as: What happens to me when I leave this life? Where do I go? What does it mean to be human? Is my humanity compromised by age or illness? Is the world a fair and just place? Who is in control of my life? What is the plan for my life? Is there a force for retribution or punishment at work in the world?

5. Conclusions and Future Directions

The spiritual tasks of elders have been characterized as the search for meaning in daily activities, in the life trajectory, and in the world as a whole; the need to transcend ill health and other losses; the desire for continuity of identity and values; the need to reconcile past hurts and to reinforce connections; and the need to prepare for death (Yeh and McColl 2019; McColl 2016b). Health professionals have a duty, and indeed the privilege, of contributing

to this important role at whatever level they feel prepared and authentic. Recognizing that service providers will have varying levels of comfort and preparation around spiritual issues, this paper offers a step-wise approach to engaging with the spiritual issues inevitably encountered with their patients or clients. Future research on a number of propositions raised in this paper would be beneficial in ensuring that the necessary expertise is available in health and long-term care settings. There is a challenge to educators, supervisors, and preceptors to evaluate the preparedness of their staff and students, and to discern what can best be done to ensure that spiritual issues do not go unattended in health and long-term care settings. This paper shows that it is possible for all involved to respond at some level to these important issues.

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