# August 2013 Article of the Month

This month's article selection is by Chaplain John Ehman,
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Taylor, E. J. and Mamier, I. "**Nurse responses to patient expressions of spiritual distress**." *Holistic Nursing Practice* 27, no. 4 (July/August 2013): 217-224.

**SUMMARY and COMMENT:** The authors of our featured article this month open with a practical observation about nurses being the health care professionals most physically present to patients: "Even when spiritual care experts are available, the urgency of the situation, the existing rapport in the nurse-patient relationship, or a patient's resistance toward meeting with spiritual care experts may mean that it is only the nurse who will deliver spiritual care" [p. 215]. While some previous studies have offered descriptions of spiritual care by nurses, "This study breaks ground by offering a quantitative method for analyzing nurse empathic response to spiritual distress and a description of what nurses may in actuality say to patients" [p. 423]. Chaplains -- including CPE supervisors -- should be interested not only in the findings about nurses but in the method used here for measuring empathic responses.

Data from mailed questionnaires were gathered from 200 practicing registered and student nurses from 6 institutions across the US -- religious and non-religious -- over a 7-month period in 2006. Three vignettes of patient spiritual distress (regarding abandonment by friends, inability to ascribe meaning to suffering, and doubt regarding strength of personal faith [--see p. 219]) were part of a larger study. Participants were asked to write out verbatim what they thought would be the "the most spiritually healing response" to the immediate words of the hypothetical patient in each vignette. Nurses' responses were then assessed using a 5-item Response Empathy Scale [--see Table 3, p. 220]:

- Accuracy (of feeling family and intensity): Does the respondent recognize the deeper feelings expressed by the patient?
- Here and Now: Does the respondent refer to what the patient is experiencing at the current moment?
- Topic Centrality: Does the respondent refer to what is most important to the patient? Does the nurses' response relate to the client's basic complaint or problem?
- Choice of Words: Does the respondent use rich, vivid, or metaphorical language in a way consistent with the client's discourse?
- Exploratory Manner: Does the respondent communicate a sense that he/she and the client are working together in a process of exploration? (e.g., phrases responses tentatively, asks open questions or brings to awareness current concern, shows respect and sensitivity)

The authors give good illustrations of the types of responses that were rated on the Response Empathy Scale as low, high, and at the mean. The examples for low empathy and high empathy make clear the full range of responses that patients may receive from nurses, and the fact that there is such a range seems itself significant. However, the responses at the *mean* of the RES are especially telling and are cause for "apprehension," because

these "average" responses from the nurses show marked limitations. For instance: "What do you mean --nobody cares?" and "Okay, let's pray to God together, would you like to do that?" [p. 222].

Further, Taylor and Mamier found that the ability to respond empathically to spiritual distress did not vary appreciably by "age, gender, religiosity (of the participant or the participant's work or study environment), and length of time working in health care" [p. 222]. There was some variance by ethnicity, but this finding is described as "weak" [p. 224] and "should be considered cautiously" [p. 223]; nevertheless, it does "intimate...that culture must be considered in future research" [p. 223].

The authors focus on the consistency of the findings across demographic variables that one might have suspected would be influential, such as work experience, and they speculate on deficiencies in nursing education around interpersonal skills and the role of a nurse's own "faith development, spiritual maturity and awareness" [p. 223]. Chaplains might extrapolate from such findings and informed conjectuure that there could be opportunity for greater chaplaincy involvement in nursing education, which may at present give more attention to recognizing spiritual distress than to being skilled in speaking empathically when patients express their distress.

However, the aspect of the article most intriguing to clinical chaplains, research chaplains, and CPE supervisors may be the methodology in measuring empathic responses. The Response Empathy Scale is an adaptation of a measure "originally developed to allow an independent rater to evaluate the responses of a therapist providing counseling to a client" [p. 219]. Here it is shortened/modified to allow for evaluation of written responses in such a way that it could have application within CPE to verbatim analysis as well as to studies of pastoral care. [For more on the RES, see Items of Related Interest, §I (below)]. One note of an error in the printing of the article: the adapted Response Empathy Scale is described in the text has having only 4 items [p. 219] instead of the actual 5 items listed in Table 2 [p. 220].

The lead author, by the way, has completed 2 units of CPE, and chaplain readers may discover in the article a kindred emphasis on the nature and importance of interpersonal skills. Taylor and Mamier have together put forward work that could be a valuable stepping-stone for chaplains' research and collaboration with nurse researchers on spiritual care and professional education.

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## Suggestions for the Use of the Article for Student Discussion:

This month's article would lend itself especially well to an exercise prior to the assigned reading: students could be asked to respond in writing to the three vignettes used in the study [--see Table 1, p. 219], though with the wording slightly edited to omit the nurse-specific elements. This would give students a personal point of comparison when they read the research --and might even turn up some insights about students' own empathic communication. The subject of empathy often comes up in discussions of pastoral care, but are students really clear about what it is and how it might be assessed? The general topic could be explored in light of the article, and particularly around the Empirical and Theoretical Background section [pp. 217-218]. Also, what do students make of the finding that most demographic variables one might assume would affect a provider's capacity for empathic communication did not seem to have an impact? What aspects of chaplaincy training do students believe have had the greatest effect on their own capacity for empathic communication?

## Related Items of Interest:

**I.** The Response Empathy Scale (RES) used in our featured study is a 5-item adaptation of the 9-item Response Empathy Rating Scale first presented in Eliott, R., Filipovich, H., Harrigan, L., Gaynor, J., Reimschuessel, C. and Zapadka, J. K., "**Measuring response empathy: the development of a multicomponent rating scale**," *Journal of Counseling Psychology* 29, no. 4 (July 1982): 379-387. That measure by Elliott, et al., was itself a refinement and expansion [with an added item for accuracy-plausibility] of a scale by James L. Lister, Professor and Chairman in the Department of Counselor Education at the University of Florida in 1970. Elliott and his co-authors make reference to the Lister Empathy Scale and cite for it two sources by David S. Hargrove: a 1973 dissertation and a 1974 short notice in the *Journal of Consulting and Clinical Psychology* [vol. 42, No. 2, p. 305]: "**Verbal interaction analysis of empathic and nonempathic responses of therapists**." Hargrove himself only lists the original scale as: Lister, J. L., A scale for the measurement of empathic understanding. Unpublished manuscript, University of Florida, 1970. Nevertheless, for further reading about the background to Taylor & Mamier's Response Empathy Scale, the best source would likely be the 1982 article by Elliott, et al. (esp. pp. 381-382).

For more on measuring empathy in research, two reviews were published in 2009: Pedersen, R., "**Empirical research on empathy in medicine -- a critical review**," *Patient Education and Counseling* 76, no. 3 (September 2009): 307-322; and Yu, J. and Kirk, M. "**Evaluation of empathy measurement tools in nursing: systematic review**," *Journal of Advanced Nursing* 65, no. 9 (September 2009): 1790-1806. Readers may also be interested in an older review: Duan, C. and Hill, C. E., "**The current state of empathy research**," *Journal of Counseling Psychology* 43, no. 3 (July 1996): 261-274.

**II.** Taylor and Mamier note that their research was "influenced by the theoretical and empirical work of [the late Brant W.] Burleson who has written extensively about how lay and professional people converse to alleviate emotional distress" [p. 218]. They go on to say:

> Burleson and colleagues contend that distressed persons' emotional reactions reflect their appraisals, responses that show how they interpret and evaluate events. Thus, helpful responses include verbal strategies that allow distressed persons to hear themselves and reappraise the event with satisfying meaning. Aspects of "sophisticated" comforting messages include (a) focusing on the distressed other (vs the helper), (b) maintaining neutral or nonjudgmental stance to the distressed person, (c) centering responses to target feelings (instead of focusing on thoughts and ideas), (d) accepting and legitimizing the other's experience, and (e) explaining from a cognitively oriented perspective the distressed other's feelings.... [p. 218]

Chaplains may hear in this a good bit that resonates with Clinical Pastoral Education. For more on Burleson's theoretical and empirical work, see the following, cited in our featured article.

> Burleson, B. R. "**Comforting messages: features, functions, and outcomes**." In Daly, J. A. and Wiemann, J. M., eds. *Strategic Interpersonal Communication*. Hillsdale, NJ: Lawrence Erlbaum, 1994. Pp. 135-161.
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> Burleson, B. R. and Goldsmith, D. J. "**How the comforting process works: alleviating emotional distress through conversationally induced reappraisals**." In Anderson, P. A. and Guerrero, L. K., eds. *Handbook of Communication and Emotion: Research, Theory, Applications, and Contexts*. San Diego, CA: Academic Press, 1998. Pp. 245-280.
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> Burleson, B. R. "**Emotional support skill**." In Greene, J. and Burleson, B. R., eds. *Handbook of Communication and Social Interaction Skills*. Mahwah, NJ: Lawrence Erlbaum, 2003. Pp. 551-570.

**III.** Lead author Elizabeth Johnston Taylor, PhD, RN, Associate Professor, School of Nursing, Loma Linda University, has written primarily for nurses, but a good many of her publications may be of special interest to

chaplains, including:

Pesut, B., Fowler, M., Reimer-Kirkham, S., Taylor, E. J. and Sawatzky, R. "**Particularizing spirituality in points of tension: enriching the discourse**." *Nursing Inquiry* 16, no. 4 (December 2009): 337-346. [(Abstract:) The tremendous growth in nursing literature about spirituality has garnered proportionately little critique. Part of the reason may be that the broad generalizing claims typical of this literature have not been sufficiently explicated so that their particular implications for a practice discipline could be evaluated. Further, conceptualizations that attempt to encompass all possible views are difficult to challenge outside of a particular location. However, once one assumes a particular location in relation to spirituality, then the question becomes how one resolves the tension between what are essentially theological or philosophical commitments and professional commitments. In this study, we discuss the tension between these perspectives using the idea of a responsible nursing response to spiritual pluralism. We then problematize three claims about spirituality in nursing discourse based upon our location as scholars influenced by Christian theological understandings: (i) the claim that all individuals are spiritual; (ii) the claim that human spirituality can be assessed and evaluated; and (iii) the claim that spirituality is a proper domain of nursing's concern and intervention. We conclude by suggesting that the widely shared values of social justice, compassion and human dignity may well serve as a grounding for the critique of spiritual discourses in nursing across particularized positions.]

Pesut, B., Fowler, M., Taylor, E. J., Reimer-Kirkham, S. and Sawatzky, R. "**Conceptualising spirituality and religion for healthcare**." *Journal of Clinical Nursing* 17, no. 21 (November 2008): 2803-2810. [AIMS: To discuss some of the challenges of conceptualising spirituality and religion for healthcare practice. BACKGROUND: With the growing interest in spirituality in healthcare, has come the inevitable task of trying to conceptualise spirituality, a daunting task given the amorphous nature of spirituality, the changing understandings of spirituality among individuals and the diverse globalised society within which this task is taking place. Spirituality's relationship to religion is a particularly challenging point of debate. DESIGN: Critical review. CONCLUSIONS: Three social and historical conditions - located in the context of Western thought - have contributed to current conceptualisations of spirituality and religion: the diminishment of the social authority of religion as a result of the Enlightenment focus on reason, the rise of a postmodern spirituality emphasising spiritual experience and current tensions over the ideological and political roles of religion in society. The trend to minimise the social influence of religion is a particular Western bias that seems to ignore the global megatrend of the resurgence of religion. Current conceptualisations are critiqued on the following grounds: that they tend to be ungrounded from a rich history of theological and philosophical thought, that a particular form of elitist spirituality is emerging and that the individualistic emphasis in recent conceptualisations of spirituality diminishes the potential for societal critique and transformation while opening the door for economic and political self interest. RELEVANCE TO CLINICAL PRACTICE: Constructing adequate conceptualisations of spirituality and religion for clinical practice entails grounding them in the wealth of centuries of philosophical and theological thinking, ensuring that they represent the diverse society that nursing serves and anchoring them within a moral view of practice.]

Taylor, E. J. "**Client perspectives about nurse requisites for spiritual caregiving**." *Applied Nursing Research* 20, no. 1 (February 2007): 44-46. [(Abstract:) Some patients welcome nurse-provided spiritual care, while others do not. This pilot study addressed the question: What characteristics does a client look for in a nurse before welcoming spiritual care from that nurse? This cross-sectional, correlational study allowed 156 cancer patients and 68 family caregivers to complete paper-and-pencil questionnaires including the 7-item Nurse Requisites Scale (NRS). Findings suggest relationship is a salient requisite, and that religiosity is directly related to how important it is to a client that these requisites be met prior to spiritual care.]

Taylor, E. J. "**Prayer's clinical issues and implications**." *Holistic Nursing Practice* 17, no. 4 (July-August 2003): 179-188. [(Abstract:) Because prayer frequently sustains coping and brings comfort,

it is an important resource for nurses to support or offer. How shall nurses incorporate prayer in nursing practice? This article explores practical aspects of including prayer in bedside nursing care, including suggestions for assessment, supporting patients when beliefs about prayer challenge, discussing prayer with clients for whom prayer may be harmful, overcoming nursing barriers to prayer, and more.]

Taylor, E. J. "**Prevalence and associated factors of spiritual needs among patients with cancer and family caregivers**." *Oncology Nursing Forum* 33, no. 4 (July 2006): 729-735. [(Abstract:) PURPOSE/OBJECTIVES: To measure the prevalence of spiritual needs and identify factors associated with spiritual needs among patients with cancer and family caregivers. DESIGN: Descriptive, cross-sectional, quantitative. SETTING: Inpatients and outpatients at a university medical center in the southwestern United States. SAMPLE: 156 patients with cancer and 68 family caregivers who were primarily white and Christian and mostly perceived their cancer as not life threatening. METHODS: Self-report questionnaires, including the Spiritual Interests Related to Illness Tool and Information About You. Statistical analysis involved analyses of variance, correlations, and factor analysis. MAIN RESEARCH VARIABLES: Spiritual needs and desire for nursing help with spiritual needs. FINDINGS: The most important spiritual needs included being positive, loving others, finding meaning, and relating to God. The least important were needing to ask "why" questions and preparing for dying. Desire for nursing assistance with spiritual needs was moderate and varied. Variables correlated with spiritual needs and desire for nurse help included religiosity, being an inpatient, and perceiving the cancer as incurable. Desire for nurse help and importance of spiritual needs were directly correlated. CONCLUSIONS: Distressing spiritual needs were reported least frequently. Certain factors appear to be associated with how much spiritual need is perceived and how much nurse help with those needs is wanted. IMPLICATIONS FOR NURSING: Patients with cancer and family caregivers have similar spiritual needs that may require care. Spiritual assessment and therapeutics can target specific types of spiritual needs. A nurse's help with spiritual needs, however, is not always wanted.]

Taylor, E. J. ***Religion: A Clinical Guide for Nurses***. New York: Springer, 2012. [For details about this new work, which includes contributions from 21 theologians/clergy, see the publisher's website.]

Taylor, E. J. ***Spiritual Care: Nursing Theory, Research, and Practice***. Upper Saddle River, NJ: Prentice Hall, 2002. [(Description from the book's back cover:) Innate and deeply personal, spirituality is an integral part of each of us. It affects every aspect of life-including one's health. For this reason, spirituality is becoming an increasingly important issue within the nursing community. Nursing the whole patient includes nurturing the spirit. *Spiritual Care: Nursing Theory, Research, and Practice* is the only text written to address the depth of this subject matter. Written from a universal standpoint, it details the "how-to's" of spiritual caregiving including spiritual assessment, planning care, documentation, ethical concerns, and numerous approaches to nurturing the spirit.]

Taylor, E. J. "**Spiritual complementary therapies in cancer care**." *Seminars in Oncology Nursing* 21, no. 3 (August 2003): 159-163. [(Abstract:) OBJECTIVES: To review literature documenting the frequency of use and efficacy of spiritual complementary therapies. Implications for clinical practice and research that reflect this literature are offered. DATA SOURCES: Data based research on complementary therapy usage and clinical articles about selected mind/body therapies. CONCLUSION: Spiritual complementary therapies are among the most frequently used. Prayer, spiritual healing, and meditation are the most frequently used spiritual therapies. Equivocal evidence supports their efficacy. IMPLICATIONS FOR NURSING PRACTICE: Although spiritual practices may not be considered a "therapy," clinicians should assess and support these practices. Clinicians should only pray with patients when observing ethical guidelines.]

Taylor, E. J. "**Spiritual pain**." *Advance for Nurses* 9, no. 21 (September 24, 2007): 15. [This brief overview for nurses is available online from the journal.]

Taylor, E. J. ***What do I Say? Talking With Patients About Spirituality***. Philadelphia, PA: Templeton, 2007. [(From the publisher's description:) Health care professionals, clergy, chaplains, social workers, and others who counsel people in medical crisis often find themselves faced with deeply painful questions: "Why is this happening to me? Am I dying? Why should I live? I'm just a burden to others." Here is a workbook that suggests healing verbal responses to such expressions of spiritual pain. The accompanying DVD helps reinforce the lessons and exercises that integrate psychology, psychiatry, pastoral counseling, nursing, chaplaincy, and spiritual direction for whole person care. The author, an internationally recognized expert in spiritual caregiving, points out that wanting to help is one motivation for learning these skills, but there are also evidence-based reasons: helping patients express their innermost feelings promotes spiritual healing; spiritual health is related to physical and emotional health; spiritual coping helps patients accept and deal with their illness; and patients tend to want their health care professionals to know about their spirituality. Lessons, tips, and exercises teach how to listen effectively, with guidelines for detecting and understanding the spiritual needs embedded in patients' conversations. Suggestions are provided for verbal responses to patients who express spiritual distress, including tips for building rapport, using self-disclosure, and praying with patients. A FAQ section deals with frequently asked questions and miscellaneous information.... By practicing and using these healing techniques, Taylor explains, healthcare professionals will be able to provide patients responses to their questions that allow them to become intellectually, emotionally, and physically aware of their spirituality so they can experience life more fully.]

Taylor, E. J. "**What is spiritual care in nursing? Findings from an exercise in content validity**." *Holistic Nursing Practice* 22, no. 3 (May-June 2008): 154-159. [(Abstract:) The scope and nature of what is spiritual care in nursing are poorly defined. This article explores what is nursing spiritual care using data collected from a panel of 9 experts for the purposes of establishing content validity for an instrument to measure frequency of nurse-provided spiritual care therapeutics.]

Taylor, E. J. and Outlaw, F. H. "**Use of prayer among persons with cancer**." *Holistic Nursing Practice* 16, no. 3 (April 2002): 46-60. [(Abstract:) This study explored how persons use prayer to cope with cancer. Employing phenomenologic methods, 30 informants were interviewed in depth about why, when, and how they prayed, as well as what they prayed for and the outcomes expected. Findings detail how patients use prayer to ease the physical, emotional, and spiritual distresses of illness. A range of approaches to prayer and topics for prayer was observed, often determined by illness circumstances. The article provides a discussion that begins to suggest how these data can inform clinical practice and future research.]

Taylor, E. J. and Mamier, I. "**Spiritual care nursing: what cancer patients and family caregivers want**." *Journal of Advanced Nursing* 49, no. 3 (February 2005): 260-267. [(Abstract:) AIM: This paper presents findings from a study that was designed to understand, from the perspective of cancer patients and their family caregivers, what spiritual care is wanted from nurses. BACKGROUND: Distressing and transformative spiritual responses to living with cancer have been documented. Although there is momentum for providing spiritual care, previous research provides scanty and conflicting evidence about what are the clients' wishes or preferences with regard to receiving spiritual care from nurses. METHODS: A convenience sample of 156 adult cancer patients and 68 primary family caregivers, most of whom were Christians, independently completed the Spiritual Interests Related to Illness Scale and a demographic form, both of which were self-completed questionnaires. RESULTS: A variation in responses to items about nurses providing spiritual care therapeutics was observed; means and medians for these items mostly fell between 2 (disagree) and 3 (agree) on a scale of 1-4. Generally, therapeutics that were less intimate, commonly used, and not overtly religious were most welcomed. No significant differences were found between patient and caregiver preferences. A modest, direct correlation was observed between frequency of attendance at religious services and increased preference for nurse spiritual care. CONCLUSION: For both patients and caregivers, nurses must be sensitive to providing spiritual nurture in ways that are welcomed.]

Taylor, E. J., Mamier, I., Bahjri, K., Anton, T. and Petersen, F. "**Efficacy of a self-study programme to teach spiritual care**." *Journal of Clinical Nursing* 18, no. 8 (April 2009): 1131-1140. [(Abstract:) AIM AND OBJECTIVES: This study investigated the efficacy of a self study programme designed to teach nurses about how to talk with patients about spirituality, and to identify factors predicting this learning. Furthermore, the study investigated whether there were differences in learning between students and practicing clinicians, and between those in a religious or non-religious institution. BACKGROUND: Although USA and UK accrediting bodies mandate nurses learn how to assess and support patient spiritual health, there is a paucity of evidence to guide educators regarding how to teach spiritual care to nurses. Indeed, it is unknown if aspects of spiritual care can be taught using formal approaches. DESIGN: A pretest-posttest pre-experimental design was used to study how attitude toward spiritual care, ability to create empathic verbal responses to expressed spiritual pain, personal spiritual experience, and knowledge about communication for spiritual caregiving changed from before to after programme completion. METHODS: Study participants, 201 nursing students and RNs, independently completed the mailed self-study programme (i.e. workbook with supplemental DVD) and self-report study instruments (i.e. Daily Spiritual Experience Scale, Spiritual Care Perspective Scale-Revised, Response Empathy Scale, Communicating for Spiritual Care Test, and Information about You form). RESULTS: Significant differences were seen between the before and after scores measuring attitude, ability, spiritual experience, and knowledge. An interaction effect of time between students and registered nurses for both spiritual care attitude and personal spiritual experience was observed. CONCLUSIONS: Findings suggest learning occurred for both students and RNs, regardless of whether they were at a religious institution or not. Relevance to clinical practice. These data indicate that this self-study programme was an effective approach to teach nurses about how to converse with patients about spirituality.]

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