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Cultural and spiritual health assessment

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Learning objectives

- Define the term 'culture'.
- Discuss how cultural beliefs may influence a person's behaviour during an illness and describe how such behaviours may impact on the assessment process.
- Identify and discuss some of the reasons why the incidence of certain medical and mental health conditions is higher in some cultural groups than in others.
- Describe how the cultural needs of patients may be assessed.
- Define the terms 'spiritual' and 'spirituality'.
- Discuss some of the possible influences of spirituality on health and illness.
- Give an outline of how the spiritual needs of a patient could be assessed.

Cultural health assessment

Before we can explore appropriate mechanisms to assess the cultural needs of patients and clients, we need to think about why culture is important as part of the nursing process. Archer (1998: p1) suggests that culture is very difficult to describe and remains vague despite little dispute that it is a core concept. Shanahan & Bradshaw (1995: p457) would agree that: 'the culturally diverse person's health beliefs and practices are often not well understood and explored'. Archer

(1998: p1) suggests that culture is 'grasped' so what is this grasp that the nurse must have in the array of assessment skills they need to acquire?

Activity

Before we go on to explore this further, take a few minutes to reflect on what is in your mind just now. What picture do you hold in your mind when you think of culture? What are the factors that you initially think are important?

This picture will probably lead to the questions you think you need to ask patients and clients to ensure you have considered cultural needs and will also help to identify any knowledge gaps you may have. Within your sociology curriculum you will have debated such concepts of culture and have some understanding of how the predominant cultural environment of which an individual is part shapes beliefs and values. Leninger (1985: p450) describes the word 'culture' as the: 'learned, shared and transmitted values and beliefs, norms and lifestyle practices of a particular group that guide thinking, decisions and actions in patterned fashions'.

For the nurse, the challenge is to have sufficient understanding of an individual's uniqueness to be able to provide culturally sensitive care. The Nursing and Midwifery Council (2004) requires a registered nurse or midwife to be personally accountable for ensuring the promotion and protection of: 'the interests and dignity of patients and clients, irrespective of gender, age, race, ability . . . lifestyle, culture and religious or political beliefs'.

Within this statement from the NMC, culture and religious beliefs are linked together but this relationship, although sometimes very strong, should not be assumed. *The Code of Ethics for Nurses* (ICN, 2000) and the introduction of the Patient's Charter (DoH, 2001) placed a responsibility on healthcare professionals to show respect for the religious, spiritual and cultural needs of all who use the health service. Prior to that, the importance of improving access to services for all users had been emphasised in a number of government publications (DoH, 1998a,b, 1999). Therefore part of the aim of this chapter is to explore some of the cultural beliefs, values and practices that may influence the assessment process and the provision of care. Later on in the chapter, we will discuss some issues in relation to the assessment of patients' spiritual needs, which includes the assessment of religious needs.

Cultural frame

Culture is often referred to as 'the way we do things around here' and this may have an impact on health behaviours of different groups. For example, in some parts of England Friday night is 'fish and chip' night, associated with social interaction and the signalling of a rest from the week of work. This kind of subculture may have implications for health promotion activity and ensuring patients comply with treatment regimes to maintain a healthy lifestyle. Indeed, Archer (1998: pxvii) suggests that the: '... cultural system and sociocultural life do not exist or operate independently of one another; they overlap, intertwine and are mutually influential'.

According to Mazanec & Tyler (2003), values, beliefs and rules of conduct within cultural groups continually evolve; hence achieving cultural competence is a continual process. Everybody lives within a 'cultural' frame and for some it may be easier to fit in with the predominant culture where care is taking place but for others the potential for care to be compromised due to lack of thought or understanding on the part of healthcare individuals can be more problematic. So for nurses to be able to provide culturally and spiritually sensitive care, they need to be aware of how culture and spirituality are part of the fabric of both their own and their colleagues' lives and how their patients and clients view illness, health, the health system and the different cultural and religious practices.

Influence of culture on health, illness and assessment

Cultural background tends to inform many people's understanding of illness. Thus cultural beliefs could influence a person's behaviour following an illness. In Vietnamese culture, for example, it is disrespectful to ask a doctor a question (Shanahan & Bradshaw, 1995). Within that culture, it is also believed that individuals who do not complain of pain or discomfort are strong in character (Shanahan & Bradshaw, 1995; Wills & Wooton, 1999).

Activity

With reference to the above information on some Vietnamese individuals:

- What effect do you think such a belief might have on an individual's behaviour during illness?
- What impact is such behaviour likely to have on the health assessment process?

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Activity		
Country/ group	Examples of cultural belief/s	Possible behaviour when ill/impact on assessment and care planning
<ul style="list-style-type: none"> Some West Africans 	<ul style="list-style-type: none"> May believe that illness has come about as a result of juju; beliefs usually acceptable in such cultural groups 	
<ul style="list-style-type: none"> Asians 	<ul style="list-style-type: none"> Most Asians believe that the sick, postnatal women and those who have had surgery should stay in bed. The sick patient is expected to express suffering and anxiety openly. S/he is not expected to be active or cheerful 	
<ul style="list-style-type: none"> Muslims 	<ul style="list-style-type: none"> A central tenet of Islam is the concept of <i>hiya</i> (modesty). Nudity/nakedness is extremely offensive. Traditionally, except for their faces during the day, women are clothed from head to toe. Men are obliged to cover from the waist to knee (Maternity Alliance, 2004) 	
<ul style="list-style-type: none"> Filipino-Americans 	<ul style="list-style-type: none"> Belief in <i>bahalana</i>, i.e. one must endure great suffering because it is God's will (Villanueva & Lipat, 2000) 	
<ul style="list-style-type: none"> Japanese 	<ul style="list-style-type: none"> Eye contact is confrontational and adversarial (Lester, 1998) 	
<ul style="list-style-type: none"> Some tribes in Zimbabwe 	<ul style="list-style-type: none"> Making direct eye contact is considered disrespectful 	

The above activities indicate that cultural beliefs could influence how one reacts to an illness. Such reactions could in turn determine the outcome of the illness. In a comparative study of patients in India and the US who experience chronic malignant pain, for example, Kodiath & Kodiath (1995) found that soon after noticing any physical changes in their bodies, the Americans sought medical advice and help. They therefore experienced very little or no pain in connection with the condition. The Indians, on the other hand, experienced high levels of pain

and only sought help when it had become intolerable, because pain is viewed as part of a normal life.

Health status in different cultural groups

Certain conditions appear to be more prevalent in certain cultural groups. Dyson & Smaje (2001), for example, reported higher incidence of hypertension within Caribbean, Pakistani and Bangladeshi groups as compared to the white population. The incidence is, however, lower in the Chinese and Indian populations (Dyson & Smaje, 2001). African-Americans also have a higher incidence of stroke and stroke mortality than their white counterparts (Horner *et al.*, 2003).

Incidence of diabetes mellitus and the rate of death due to diabetes are also said to be high for all countries compared to England and Wales (Dyson & Smaje, 2001).

Inherited blood diseases such as sickle cell disorders tend to affect mainly, but not exclusively, people from Africa, the Caribbean, India, Mediterranean origin and Middle East (DoH, 2004; Dyson, 2001; Streetly, 2005). Beta-thalassaemia is another genetically inherited blood disorder which affects mainly, but not exclusively, people of Mediterranean origin, with particular reference to Cypriots, plus those from the Middle East, India, Pakistan and China (DoH, 2004; Dyson, 2001; Streetly, 2005).

The National Statistics (ONS, 2004) also reported that children from Bangladesh, India, Pakistan and China were less likely than other ethnic groups, or the general population, to report any form of acute illness. Afro-Caribbean and Pakistani young females were also more likely to be obese than those in the general population (Saxena *et al.*, 2004).

Whilst this information is significant, it is also of interest that these areas are receiving high-profile interest through the National Service Frameworks, as both the incidence and mortality and morbidity are on the increase in the UK. This is a phenomenon which relates to a number of factors, which can be attributed to both cultural and subcultural lifestyle influences.

The Reed Report (1994) and Iley & Nazroo (2001) suggest that the admission rate to mental health hospitals for Afro-Caribbean people is higher, with the likelihood of being diagnosed as suffering from psychotic illness, particularly cannabis psychosis and schizophrenia, 3–6 times higher than the white population. However, the incidence of depression seems significantly lower than the white population (Iley & Nazroo, 2001).

Socio-economic factors are said to contribute to disproportionately high levels of mental health symptoms nationally and internationally. For example, it has been shown that the likelihood of having a neurotic disorder or depression increases as household income falls (ONS,

2003). Also, in Lima-Costa *et al.*'s study (2003: p7), the poorer elderly in Bambui (a town in south eastern Brazil) were found to have reported more psychiatric symptoms compared to the 'better off'.

Different views about illness challenge professionals to provide treatment and care in a way that is meaningful (McGee, 2000: p33) and an awareness of different concepts of health is fundamental to providing this care. Current Western notions of health (McGee, 2000) encompass a range of states in which the individual responds and adapts to a number of factors such as age, social circumstances and the environment. This range of states can include the presence of disease or disability, meaning that individuals can describe themselves as 'healthy' even though they have an illness (Seedhouse, 1991). Helman (2000) refers to the Indian Ayurvedic system of medicine that is based on the concept of harmony and balance between various parts of the body; illness is a state of disharmony, meaning that health and illness cannot co-exist.

Assessment of cultural needs

Effective communication with all patients, clients and their families is an essential element of nursing practice and is essential in the assessment of cultural needs. Consequently, the fundamental questions of 'what?', 'when?' and 'how?' are of equal importance in the assessment of cultural needs.

Culturally competent care means being sensitive to the context in which questions are asked. For example, physical closeness and eye contact may be interpreted differently. How will you know what is the right stance to take? In many situations in the hospital environment, resources may be available to give you guidance but don't be afraid to ask patients, relatives or indeed an interpreter if custom related to body language is different from the context with which you are familiar. Cultural competence is also about respecting clients' wishes in how they are addressed and the appropriateness of using first names, etc. This will differ between age as well as cultural groups and should be considered as part of the process of gaining consent from the patient and carers.

Nurses also come from diverse cultural backgrounds themselves and this will influence their perception of the world around them. It may be helpful to reflect on a recent situation where you have made assumptions about people based on your own experience.

Within the healthcare system, diversity is strength within nursing and other healthcare professional teams. This means that role modelling is important behaviour and so care needs to be taken with the use of language which may be potentially disrespectful. For example, in the author's part of the country it is quite common for the terms 'me duck' and 'me love' to be heard in all environments where interaction

takes place. For nurses from overseas, copying the language but using it out of context can be a big problem. Any misunderstandings can have embarrassing and frustrating consequences. So being culturally sensitive applies just as much to work colleagues as it does to patients and clients.

Millon-Underwood (2000) highlighted some of the questions nurses in Britain need to ask to ensure they come to informed decisions about the appropriate care for patients. The example relates to breast cancer but could be supplemented in respect of any other condition. These questions are just the beginning to enable the nurse to achieve knowledge and skill in providing culturally competent care (Campinha-Bacote, 2002):

- What is the incidence of (breast cancer) among members of black or other ethnic minority groups?
- What do members of these different groups think (cancer) is?
- What beliefs about and attitudes towards (cancer) do members of these groups hold?
- How would you explain (cancer) and the importance of screening and early detection to a member of a black or other ethnic minority group? (Millon-Underwood, 2000)

McGee (2000) suggests that to provide care in a meaningful way means moving away from the 'recipe' approach of providing the right food, finding an interpreter and knowing what to do when someone dies, although these important factors need to be included.

For people to thrive spiritually, even in the context of life-threatening illness, requires skilled interpersonal effectiveness from nurses and carers, adding to the sense of meaning in the communication rather than detracting from it by failing to recognise the cultural needs of patients and their families. Asking questions is easier than listening to the responses; ask yourself if you actively listen to the clients with whom you interact. Watch body language; listen to what they are *not* saying as much as what they are saying; think through some of the emotional consequences which may be running alongside admitting they have an illness.

Assessing the needs of clients in a multicultural society is a partnership between the nurse and the patient. Often the assumption is made that the lived experience within the predominant culture is a positive one. We know very often this is not the case which is as significant for the person who has always been part of British society as for those from outside it.

Evidence suggests higher levels of self-reported ill health amongst immigrants, which might be linked to poorly paid jobs in deprived environments (Dyson & Smaje, 2001). One group that may have significant psychological needs are refugees or asylum seekers. McGee (2002) reports on a Foundation of Nursing Studies seminar which

focused on 'meeting the needs of refugees in hospital'. It was noted that many refugees suffer poor health as a result of their experiences both before and after arrival in the UK. At least 134 countries are known to routinely use torture and abuse as a means of punishment, repression and maintaining control. This is most likely to be sexual and psychological. In assessing such patients, four key issues need to be addressed:

- **Communication.** Careful and clear explanations of interventions are essential. Interpreters should be selected with care to avoid the revelation of distressing information linked with repressive regimes.
- **Consent.** Consent must never be assumed, even for minor interventions.
- **Compliance.** Recognise that compliance with healthcare regimes may not always be a priority for those struggling with the complexity of new social situations.
- **Procedures.** Recognise that some interventions, e.g. catheterisation, may be very similar to past experiences of torture. Be sensitive to patients' past experiences and believe what they tell you.

The above seminar was held under the auspices of the Transcultural Nursing and Healthcare Association, set up in the UK in 1998 to promote knowledge and understanding of cultural issues to help healthcare professionals provide the best care to all their patients.

Spirituality and spiritual needs

Spirituality as a subject and the need to address patients' spiritual needs are issues which are sometimes not addressed by nurses. Research findings do, however, suggest that where spiritual needs are identified and care interventions take place, there is a sense of well-being amongst nurses and patients feel 'comfortable and supported' and 'appear peaceful, relaxed, calm and grateful' (Narayanasamy & Owens, 2001: p453).

Literature suggests (Mickley & Cowles, 2001; Sherwood, 2000; Thompson, 2002) that humans have four spiritual necessities in sickness and in health. These are the need:

- for meaning and purpose in life
- to give hope and receive love
- for creativity
- for forgiveness.

Other needs that have been identified by other authors include faith, connectedness and the need for the right relationship with self, others

and 'God'/deity (Narayanasamy *et al.*, 2004; Sherwood, 2000; Tanyi, 2002).

Providing meaningful care includes care that meets the spiritual needs of patients. It is not possible for nurses and midwives to meet such health needs unless they are spiritually aware and have some knowledge of how their clients view illness, health, the health system and the different spiritual and religious practices. To provide good spiritual care, healthcare professionals need to be able to carry out a thorough assessment of the patient's spiritual/religious needs. Before they can do so, however, they also need to have some idea of what is meant by the terms 'spiritual' and 'spirituality' and to be self-aware of their own beliefs and values. So prior to reading the rest of this chapter, it would be useful to spend a few minutes reflecting on the terms 'spiritual' and 'spirituality'.

Activity

- Now jot down on a piece of paper what the terms mean to you.
- Do you feel that you have any spiritual needs? If so, what are they?
- If you do not have any spiritual needs, why do you think that is?
- Now compare your answers with that of your colleagues.

You will probably notice that you had some difficulty in arriving at any answers. If you did manage to get any answers, they are probably quite different from those of your colleagues. You may also find that unlike the term 'culture', the terms 'spiritual' and 'spirituality' are elusive concepts (McSherry, 2004; Narayanasamy & Owens, 2001; Tanyi, 2002).

Definitions of spirituality

Search for meaning and purpose

Some authors view the spiritual dimension as a search for meaning (Frankl, 2004; Watkinson, 2002). Narayanasamy (2000) suggests that clients with mental health illness often struggle to find meaning and purpose in their lives. It has also been suggested that the spiritual dimension strives for answers about the infinite and comes into focus during health crises, with particular reference to death (Narayanasamy *et al.*, 2004; Russell, 2002).

Spiritual distress could occur due to a total inability to invest life with meaning (Burnard, 1987). It may be characterised by spiritual pain, guilt, anger, anxiety, loss and despair (Thompson, 2002). Apart from emotional, mental and physical pain, for instance, spiritual wrestling is often triggered when a life-threatening diagnosis such as

cancer is given (Sumner, 1998). Cancer patients and their families also tend to give more thought than before to spiritual questions; they could, for example, become preoccupied with issues about death, the purpose of life, life after death and the existence of God (Kuupelomaki, 2000, 2002). Mazanec & Tyler (2003) advocate that patients could be helped to recognise meaning and purpose in their lives if encouraged to tell their life stories.

Relationship with self, others and/or things of world

It is worth noting that not everyone has faith in God. An atheist, for instance, denies the existence of God and an agnostic is unsure of God's existence; hence their spirituality might be focused on 'strong beliefs in significant relationships, self-chosen values and goals instead of a belief in God' (Burnard, 1988; Stoll, 1989; Tanyi, 2002: p503). This means that some people explore spirituality through connection with others; Buddhists, for example, explore their spirituality through connection with Siddhartha Gautama (the Awakened One, the Buddha) through lighting candles, burning incense and meditating in the presence of his statue (BBC, 2004). For the Buddhists, their main goal in life is to reach enlightenment, a state that goes beyond suffering by enabling the mind to be at peace through meditation (BBC, 2004). So the Buddhist who practises such beliefs is perhaps more likely to be hopeful for an escape from suffering than those who do not.

Also, in a study of women with breast cancer, Moch (1998) found that meaning and purpose in their lives were identified through connectedness with the environment, self and others. The sample studied by Moch was small but the findings suggest that for some people, spirituality may not be related to a connection with or belief in deity but in people or things around them and they may consider the search for meaning as a spiritual journey. Hence, their needs will probably be more related to the search for the right relationship with the self and with others (Narayanasamy *et al.*, 2004), as well as for the meaning and purpose in life. Coyle (2002: p4) refers to such dimensions of spirituality as the 'value guidance approach'.

Relationship/connectedness with God/deity

The word 'spirituality' has also been defined as 'one's relationship with God/Deity, Supreme Being' (Mattis, 2000). This implies a sense of connectedness with God and may be expressed through prayers, meditation (Black, 2003; Dossey, 2002), presence, physical touch (Kendrick & Robinson, 2000) or an appreciation of spiritual music. It is important to note that people's perceptions of who or what God is differ. Muslims, for example, believe in one God (Maternity Alliance, 2004), referred to as Allah (Rasool, 2000). Many Christians also believe in one God, referred to as the Lord God (Jesus Christ). Mattis' study (2000) highlighted the need for participants to feel connectedness with God or a

higher power, which contributed to their health. This suggests that the sense of connectedness appears to be beneficial to health, which will be discussed later on.

Stoll (1989) also referred to spirituality as her being, the inner person, expressed through her thought, body, judgement and what she does. It is through spirituality that she appreciates God and the things around her. She is also motivated to worship and communicate with God. This means her relationship with God is expressed through her beliefs, nature and interactions with herself and with others. It also means it is the spirituality within her that gives her God-consciousness and increased self-awareness. People who express spirituality in this way are probably more likely to search for the right relationship with God/deity and for forgiveness in time of health crisis or death (Mickley & Cowles, 2001; Narayanasmy *et al.*, 2004).

Vital principle of man or breath of life

Schofield (1986) explained that it is the spirit part of a person which allies them to the spiritual creation and gives them God-consciousness. This implies that the spirit links human beings to and helps them to interact with the spiritual realm. Since the word 'spirit' means 'air in motion', 'wind or breath' or 'breath of a man or woman', Stoter (1995: p3) sees spirituality as 'the vital principle of man or breath of life, which gives life to the physical organism'. This also means that spirituality is an integral component of humans (Narayanasmy, 2000; Wright, 2000) and that the body without the spirit is dead. This in turn implies that 'spirituality' is the presence of the divine (God) in human lives, as Black (2003) suggests. Coyle (2002: p4) refers to definitions of spirituality which appear to highlight God/deity as an essential feature as the 'transcendence approach'.

In a study of patient's religiosity and spirituality Woods & Ironson (1999) found that the patient's beliefs and connectedness to a higher power, self or others promoted a sense of hope. This means that a patient's sense of hope is likely to be promoted especially at point of death, irrespective of who they perceive deity to be and has implications for practice in the assessment of one's spirituality.

Spirituality and religion

Some authors draw distinctions between spirituality and religion (McSherry, 2004; McSherry & Ross, 2002) but others seem to have difficulty in separating the two. Barnes *et al.* (2000), for example, suggest that in connection to children, the two concepts are best understood as highly related, with blurred boundaries in everyday life. Likewise, for many Christians spirituality is directly related to religion (Kuupelomaki, 2002).

The word 'religion' has been defined as 'an organised system of worship' by Kozier *et al.* (2003), examples of which include Buddhism,

Hinduism, Islam, Judaism, Jehovah's Witnesses (Arianism), Mormons, Rastafarianism, Sikhism and the Christian religion, examples of which are Baptist, Church of England, Roman Catholicism, Methodism, Pentecostalism, Presbyterianism and Seventh Day Adventists.

Benefits of spirituality/religiosity

Being spiritual and/or having faith in some form of belief system have been associated with certain benefits and the concepts of connectedness, self-transcendence and inner strength components all appear to add to the meaning of spirituality. Having faith or some form of belief system, for example, appears to generate inner strength and peace. Religiosity has also been linked to better cognitive function, greater social support, fewer depressive symptoms and greater co-operativeness (Koenig *et al.*, 2004) and to health-related physiological processes including cardiovascular, neuroendocrine and immune function (Seeman *et al.*, 2003). Barnes *et al.* (2000) also reported lower levels of drug misuse in religious children, as well as better decision making and well-being, with less violence and fewer behavioural problems in adolescents. Barnes *et al.* also suggested that a child's sense of spirituality or involvement in religious activities in a community may provide a structure for positive coping strategies. Low religiosity, on the other hand, has been associated with higher rates of drug misuse, smoking, teenage pregnancy and drinking (Borowski *et al.*, 1997). Such findings suggest that one's spirituality could influence how one behaves in society and one's health-related behaviours and have implications for practice.

Possible influence of spirituality on behaviour during an illness

One's spirituality may also influence how one responds to an illness. Asser & Swan's study (1998), for example, revealed that some parents in America decided not to resort to medical treatment since doing so may have been seen as a lack of faith. The parents believed that prayer could substitute for conventional treatment of children with medical conditions. Some parents may also not have their children immunised and this could lead to increased morbidity and mortality in their children (Rodgers *et al.*, 1998).

Research findings also suggest that spiritual beliefs could influence how people perceive the cause of an illness. Some Chinese patients, for example, believe that suffering before death is a way of reparation for any sins committed so if they do not suffer whilst alive, they will do so later (Mazanec & Tyler, 2003). There may also be some cultural aspects to such beliefs. This does, however, mean that the patient might not express pain to the health professional during health assessment. Such patients may also refuse pain-relieving agents. This suggests that

behaviour during an illness could affect the assessment process as well as impact on the care planning for and with the patient.

The points listed in the activity below are not comprehensive but are examples to provoke some thought. It is important to be aware that members of particular cultural groups will react differently to difficult situations or to an illness. Lack of acceptance and understanding of such individuals could lead to stereotyping. Stockwell (1984), for example, described how a patient was labelled as 'unpopular' and antagonistic because she detached herself from other people and used very limited forms of communication after experiencing a major loss. Such labelling and the consequent stereotyping should be avoided.

Activity		
Religious or cultural group	Examples of spiritual/religious beliefs	How are they likely to behave during an illness or on admission to hospital?
<ul style="list-style-type: none"> • Apostolic (oneness Pentecostals) 	<ul style="list-style-type: none"> • Belief in repentance and baptism by complete immersion in water in Jesus' name for the remission of sin, the receiving of the Holy Spirit and living in accordance with scripture teaching (<i>Acts 2:38; 10:43-8</i>) 	
<ul style="list-style-type: none"> • Buddhist 	<ul style="list-style-type: none"> • Need to practise <i>lamrim</i> (a set of 21 meditations) daily (BBC, 2004) 	
<ul style="list-style-type: none"> • Church of England 	<ul style="list-style-type: none"> • Sacraments (these include baptism and Holy Communion) are important (Green, 1992a) 	
<ul style="list-style-type: none"> • Hindus 	<ul style="list-style-type: none"> • Women wear nuptial thread around neck. Men wear sacred thread around arm, which indicates adult religious status attainment. Religious customs must be adhered to ensure good quality of one's next life 	
<ul style="list-style-type: none"> • Jehovah's Witnesses 	<ul style="list-style-type: none"> • Blood represents life itself; based on Bible teaching that refers to blood as the soul of the flesh (<i>Gen 9: 3-4, Acts 15: 20, 28-9, 21: 25</i>) 	
<ul style="list-style-type: none"> • Jewish (orthodox) 	<ul style="list-style-type: none"> • Need to observe the Sabbath as per Bible teaching to keep it holy and treat it as a day of rest (<i>Exodus 16: 22-9, 20: 8-11</i>) 	

Continued

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Religious or cultural group	Examples of spiritual/religious beliefs	How are they likely to behave during an illness or on admission to hospital?
<ul style="list-style-type: none"> Lakota people 	<ul style="list-style-type: none"> Believe in spiritual healers; herbs, songs and prayers can cure illness or disease (Pickrell, 2001) 	
<ul style="list-style-type: none"> Muslims 	<ul style="list-style-type: none"> Need to pray 5 times daily facing Mecca. Fasting during daylight hours is important during Ramadan. Forbids ingestion of pork and meat that is not halal (Rasool, 2000) 	
<ul style="list-style-type: none"> Rastafarians 	<ul style="list-style-type: none"> Fear of contamination of the body (Green, 1992b) 	
<ul style="list-style-type: none"> Roman Catholics 	<ul style="list-style-type: none"> A sacrament for the sick is a symbol of Christ's healing. Belief in the last rite, i.e. need to confess sins (Green, 1992a: p28) 	
<ul style="list-style-type: none"> Sikh 	<ul style="list-style-type: none"> Have 5 traditional symbolic marks for men: long hair, comb to keep hair in place, a steel bangle on the right wrist, a sword, and a pair of shorts to symbolise spiritual freedom. Sikhs also use in holy water from the Gurdwara 	

Activity

Work individually or in groups.

- Can you think of other individuals, cultural or religious groups of people who have spiritual beliefs and practices that are different from the examples given in the activity above?
- How could their needs be met?

Spiritual assessment: questions to consider

A thorough spiritual assessment will help you identify the spiritual needs of a patient as well as helping you to plan and implement good spiritual care. The use of appropriate and relevant questions could facilitate spiritual assessment and allow the patients to explore their

feelings, fears and beliefs. Such exploration requires time, skills and sensitivity (McSherry & Ross, 2002) and has implications for nursing practice. In their research, Narayanasamy *et al.* (2004) found that listening plays a very important part in the identification and assessment of the spiritual needs of patients. Mickley & Cowles (2002) and Narayanasamy *et al.* (2004), also found that following a diagnosis of cancer, some patients use forgiveness to clarify personal values and help eliminate negative feelings from inflicted hurt. When assessing spiritual needs, the patient should therefore not only be observed but also be listened to very carefully.

The following are questions/points to consider when assessing spirituality:

- What is your source of hope and strength?
- What gives your life meaning? (Dossey, 1998: p46)
- Do you have a sense of purpose in life? (Dossey, 1998: p46)
- What is your concept of God/deity?
- Do you participate in any religious activities? (Dossey, 1998: p46)
- Who are the significant people in your life?
- How does spirituality impact on your state of health?
- To whom do you turn when you are ill or distressed?
- What has bothered you most about being ill (or what is happening to you)? (McSherry, 2000: p78)

Observation

Observe the patient closely for clues including possession and/or use of:

- Holy Bible, Torah, Koran or other religious/spiritual books
- necklace with a cross on the chain
- prayer beads/rosary/mat
- star of David
- musical equipment for meditation
- bracelets/rings
- special tattoos.

Also, note what TV programmes your patient prefers to watch and whether they observe the Sabbath, e.g. Jewish religion.

Listening

- Listen carefully to expressed concerns about the patient's relationship with God, deity or higher power.
- Listen carefully for expressions such as 'speaking in tongues', especially when the patient is distressed or in pain or when praying (Pentecostal faith).
- Listen carefully to patients expressing the need to forgive or be forgiven.

- Listen carefully to the patient expressing the need to see certain people or relatives.

Summary

From the above discussion, we note that everyone lives within a 'cultural' frame; this may be the predominant culture within the region or country where care is taking place. Spirituality is also a concept that is difficult to define and is unique to each individual irrespective of belief or religious orientation. Care could be compromised due to lack of thought or understanding on the part of healthcare individuals. Nurses need to be aware of how culture and spirituality are part of the fabric of individuals and how their clients view illness, health, the health system and the different cultural and religious practices, to help provide culturally and spiritually sensitive care.

Please complete the following activity after reading this chapter.

Activity

Spend a few minutes alone. Think about an incident or an event that involved cultural/spiritual issues and then try and address the following questions.

- What happened, how did you act and why?
- How did you feel about it at the time? How do you feel about it now?
- Could your reaction/actions have been different and if so, how?
- What have you learnt about yourself from this situation?

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