Editorial/Uvodnik

Spiritual and existential care in nursing homes

Duhovno-eksistencialna oskrba v domovih za starejše

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Spiritual-existential questions are defined as the fundamental questions of human life, e.g., what makes life worth living and how to cope with the finality of life. Difficulties in finding answers to such questions can result in existential suffering and distress (Grech & Marks, 2017). The European Association for Palliative Care (EAPC, 2022) defines spirituality as *"the dynamic dimension of human life that relates to the way persons (individual and community) experience, express and/or seek meaning, purpose and transcendence, and the way they connect to the moment, to self, to others, to nature, to the significant and/or the sacred"*. Accordingly, in the face of life-changing events (such as birth, trauma, ill health, loss, high age, serious illness) or sadness, spiritual care acknowledges and responds to the human spirit. It may include the need for meaning, for self-worth, for self-expression, for faith support, perhaps for rites, prayers or sacraments, or simply the need for an empathetic listener. Therefore, spiritual care begins with encouraging human contact through compassionate relationships and moves in the direction of what is needed (McSherry et al., 2020).

Nursing is based on a holistic understanding of human health which includes a physical, mental, social, and spiritual/existential dimension. Controlled by the brain, these different dimensions are in constant interaction and form an integrated whole of physical, mental, social, and spiritual/existential aspects (Seligman 2006, 2012). Accordingly, patients are unique and indivisible physical-psycho-social-spiritual entities in which the body, soul and spirit are integrated and constantly interact with each other. That is, human experiences, expectations, thoughts, and feelings are at the same time spiritual, emotional and physiological states or biochemical conditions in the body that affect the body and thereby also the entire person (Pace-Schotta, et al., 2019). Research shows that most diseases, ailments and suffering develop through interactions)between the spirit, the soul (the mind; our thoughts, feelings and experiences) and the body. Patients' emotions are biochemical bodily realities. Candace Pert (1999), an internationally renowned scholar in the field of stress, shows that the brain communicates with the immune system using "messenger cells", i.e., neuropeptides or transmitters. What is more, all our immune cells are immediately informed of how the brain interprets emotions (e.g., fear, anger, sadness). Several studies show that the count of a certain type of white blood cells termed "natural killer cells" increases during cognitive therapy and different methods of relaxation and visualisation (Haugan, 2021). This process has been described as "bits of the brain floating around the body" (Pert 1999). As explained by Haugan (2021), our emotions and thoughts "float around the body" in the form of protein molecules (peptides) through countless biochemical and physiological processes.

Therefore, rather than mere changes in mood, positive attitude and optimistic expectations are actual biological facts, and optimism has a significantly favourable effect on human health (Seligman, 2006;2012; Keyes 2002;2007;2014). Recent studies also show that the perception of meaning in life is essential for the maintenance of not only mental and emotional but also physical and functional well-being (Haugan 2014a, b; Mwilambwe-Tshilobo et al., 2019). One of such studies exploring human holistic existence shows that the perceptions of meaning and loneliness have a direct impact on the brain function in older adults (Mwilambwe-Tshilobo et al., 2019), thereby advancing our knowledge of the phenomena of meaning and loneliness. While operating through emotions and experiences, these phenomena also represent physical states that take place in the intrinsic network of the human brain (ibid.). Health-promoting interventions, adapted to the individual's needs and circumstances,

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Received/Prejeto: 7. 8. 2022
Accepted/Sprejeto: 18. 9. 2022

https://doi.org/10.14528/snr.2022.56.4.3196

therefore affect the entirety of the patient's being (body, mind and spirit). Consequently, phenomena such as anxiety, depression, pain, fatigue and nausea can also be affected through nursing care that addresses the human spirit.

We are currently facing a major transformation in the world's population, with many people around the world reaching very old age. While increased life expectancy is a positive development, it also means that many people have to live with functional and chronic comorbidities and various disabilities, and that many also require long-term care in a nursing home (NH). Moving into an NH is accompanied by numerous losses, illnesses, disabilities, loss of function and social relationships, and the inevitability of life's ending, all of which deepen one's vulnerability and distress. Loneliness and depression have been identified as risks to the emotional well-being of older people (Routsaldo et al., 2006; Savikko, 2008). the NH population is characterised by advanced age, frailty, concurrent diagnoses, mortality, disability, powerlessness, dependency, vulnerability, poor general health and high symptom burden (Haugan, 2014a; Rinnan et al., 2022), which implies a highly existential state of living (Hoben et al., 2016). Consequently, existential issues such as the finality of life, social isolation, loneliness and meaninglessness are indicative of existential suffering among NH residents (Sanderson & Scherbov, 2010; Drageset & Haugan, 2021). In general, NH residents face daily losses, disease, severe symptom and grief, and spend a lot of time in passive activities such as doing nothing, sleeping and waiting, which can lead to feelings of boredom, loneliness, meaninglessness, and indignity (Brownie & Horstmanshof, 2011; Slettebø et al., 2017). Moreover, the NH life is institutionalised and as such represents the loss of social relationships, privacy, meaning-in-life, and connectedness (Haugan, 2014b; Barca et al., 2009). Yet, the focus on palliation and spiritual/existential care in NHs has been scarce.

Spiritual care is about supporting a person's search and expression of what presently gives their life meaning and purpose. It is also about fostering their connectedness to self, others, nature, and, for some people, a transcendent being such as God. Such connectedness is seen as extremely important for the experience of joy, meaning of life and self-transcendence (Haugan, 2021). Studies show that a sense of belonging (connectedness) is central to the well-being of NH residents (Philips-Salami et al., 2012; Welsh et al., 2012; Prieto-Flores et al., 2011a,b), suggesting that "feelings of support and trust," "searching for meaning and finding answers," and "a perspective beyond death" are crucial to their spiritual well-being (Thauvoye et al., 2019). In NHs, spiritual care takes place through the interaction between the nurse and the patient, through relational qualities that support and strengthen the human spirit. The experience of being respected, understood, listened to and taken seriously, of being seen and acknowledged as the person you are, fosters a sense of trust and nourishes the resident's spirit and thus also their body, which in turn strengthens their health and well-being (Haugan, 2014b). Excellent nursing care can therefore be defined as the nurse being "present" with the older adult while performing nursing activities. Such nursing combines competence and attitude as inextricably linked aspects of care.

Through the use of structural equation modelling and the Nurse-Patient Interaction Scale (NPIS) (Haugan et al., 2012), recent studies have shown that the way NH residents perceive interactions with their nurses has a significant impact on their perceived levels of loneliness (Drageset & Haugan, 2021), joy-of-life (Haugan et al., 2020), meaning-in-life (Haugan 2014a,b), sense of coherence (Drageset et al., 2020), hope (Haugan, 2014c), self-transcendence (Haugan et al., 2012), and anxiety and depression (Haugan, Innstrand & Moksnes, 2013). Pleasant interactions which incorporate spirituality have shown a positive correlation in all these areas. In other words, nursing care characterised by being present and respectful, sincere, friendly, sensitive, and responsive to NH residents' feelings of vulnerability, care that shows understanding for patients' needs, that is compassionate to different types of suffering, and that provides emotional support and affirmation (Tejero & Marie, 2012; Rchaidia et al., 2009; Nåden & Eriksson, 2004; Moss 2009; Cartter 2009) nurtures residents' spirit and consequently also their health and well-being. A qualitatively positive nurse–patient interaction helps patients to feel a sense of trust, safety, comfort, affirmation, value, dignity, and enhanced well-being (ibid).

Spiritual care or spiritual nurse-patient interaction, is based on nurses' listening skills and their ability to establish rapport, i.e., to recognise and nurture the true essence of the resident's experience. In any nurse–patient relationship, nurses rely on their ability to pay attention. They need to pay attention to clearly evaluate the situation and to competently and ethically assist the resident. Nurses need to be attentive to minor indications that may provide valuable information, which is also the case when dealing with various physical conditions, such as dressing wounds or dealing with pain, urinary infections or pneumonia. Hence, spiritual care is not additional care, something extra or added to the general nursing care, but care which attends to the patient's spirit while being present with the patient. In short, it is "being in doing" (Baldacchino, 2010).

Slovenian translation/Prevod v slovenščino

Duhovno-eksistencialna vprašanja so temeljna vprašanja človekovega obstoja, npr. kaj daje življenju

smisel in kako se soočiti z njegovo končnostjo. Težave pri iskanju odgovorov na tovrstna vprašanja lahko povzročijo eksistencialno trpljenje in stisko (Grech & Marks, 2017). Evropsko združenje za paliativno oskrbo (EAPC, 2022) opredeljuje duhovnost kot dinamično razsežnost človekovega življenja, ki je povezana z doživljanjem, izražanjem in/ali iskanjem pomena, namena in preseganja ter načinom doživljanja trenutka, sebe, drugih, narave, pomembnega in/ali svetega. Skladno s tem se duhovna oskrba ob ključnih življenjskih dogodkih (kot so rojstvo, travma, bolezen, izguba, visoka starost, resna bolezen) datakne človeškega duha in se nanj odzove. Tovrstna nega odgovarja na potrebo po pomenu, po lastni vrednosti, po samoizražanju, po veri, morda po obredih, molitvah ali zakramentih, ali preprosto na potrebo po empatičnem poslušalcu. Duhovna oskrba se zato prične z navezovanjem človeškega stika skozi sočutne odnose in se razvija v smeri tega, kar je v danem trenutku potrebno (McSherry et al., 2020).

Zdravstvena nega temelji na celostnem razumevanju človekovega zdravja, ki vključuje telesno, duševno, socialno in duhovno/eksistencialno razsežnost. Te različne dimenzije, ki jih nadzirajo možgani, so v nenehni interakciji in tvorijo integrirano celoto fizičnih, mentalnih, socialnih in duhovnih/eksistencialnih vidikov (Seligman 2006, 2012). V skladu s tem se tudi paciente dojema kot edinstvene in nedeljive fizično-psiho-socialno-duhovne entitete, znotraj katerih se odvija nenehna medsebojna interakcija med telesom, dušo in duhom. To pomeni, da so posemeznikove izkušnje, pričakovanja, misli in občutki hkrati duhovna, čustvena in fiziološka oziroma biokemična stanja v telesu, ki vplivajo na telo in posledično na celotno osebo (Pace-Schotta, et al., 2019). Raziskave kažejo, da do večine bolezni, tegob in trpljenja pride skozi medsebojno delovanje duha, duše (uma; naših misli, občutkov in izkušenj) in telesa. Čustva pacientov so biokemični procesi, ki lahko potekajo le znotraj telesa. Candace Pert (1999), mednarodno priznana raziskovalka na področju stresa, pojasnjuje, da možgani komunicirajo z imunskim sistemom s pomočjo »kurirskih celic« (*messenger cells*), tj. nevropeptidov ali živčnih prenašalcev. Čim možgani interpretirajo neko čustvo (npr. strah, jezo, žalost), so o tej interpretaciji obveščene vse imunske celice v telesu. Študije potrjujejo, da se med kognitivno terapijo in različnimi metodami sproščanja in vizualizacije poveča število belih krvničk, imenovanih tudi »naravne celice ubijalke« (Haugan, 2021). Pert (1999) ta proces opisuje kot potovanje delčkov možganov po telesu (Pert 1999). Podobno tudi Haugan (2021) pojasnjuje, da naša čustva in misli potujejo po telesu v obliki beljakovinskih molekul (peptidov) v sklopu številnih biokemičnih in fizioloških procesov.

Optimistična naravnanost in pozitivna pričakovanja so torej stvarna biološka dejstva, saj ima optimizem dokazano izjemno ugoden vpliv na zdravje (Seligman, 2006; 2012; Keyes 2002; 2007; 2014). Nedavne študije tudi dokazujejo, da je dojemanje življenjskega smisla bistvenega pomena za vzdrževanje ne le duševnega in čustvenega, ampak tudi fizičnega in funkcionalnega dobrega počutja (Haugan 2014a,b; Mwilambwe-Tshilobo et al., 2019). Ena od študij, ki se posvečajo celostnemu obstoju človeka, kaže, da na delovanje možganov starejših oseb močno vplivata dojemanje smisla življenja in osamljenost (Mwilambwe-Tshilobo et al., 2019). Študija s tem pomembno poglablja naše poznavanje konceptov življenjskega smisla in osamljenosti. Ta pojava se izražata ne le skozi čustva in izkušnje, ampak tudi skozi fizična stanja znotraj kompleksnega omrežja človeških možganov (ibid.). Ukrepi za krepitev zdravja, ki so prilagojeni posamezniku in okoliščinam, v katerih se nahaja, torej pomembno vplivajo na celotno pacientovo bitje (na telo, um in duha). Posledično lahko na pojave, kot so anksioznost, depresija, bolečina, utrujenost in slabost, pozitivno vpliva tudi zdravstvena nega, ki nagovarja človekovega duha.

Svetovno prebivalstvo trenutno doživlja velike spremembe in številni ljudje po vsem svetu dočakajo zelo visoko starost. Daljšanje pričakovane življenjske dobe je samo po sebi sicer pozitivno, vendar pomeni tudi, da mora vse več ljudi živeti s funkcionalnimi in kroničnimi pridruženimi boleznimi ter različnimi telesnimi okvarami ter da mnogi potrebujejo tudi dolgotrajno oskrbo v domovih za starejše občane (DSO). Selitev v DSO spremljajo številne izgube, bolezen, invalidnost, izguba funkcij in socialnih odnosov ter soočenje z neizogibnostjo konca življenja, kar povečuje posameznikovo ranljivost in stisko. V literaturi sta osamljenost in depresija opredeljeni kot faktorja tveganja, ki lahko ogrozita čustveno počutje starejših (Routsaldo et al., 2006; Savikko, 2008). Populacija DSO se sooča z visoko starostjo, šibkostjo, pridruženimi boleznimi, umrljivostjo, invalidnostjo, nemočjo, odvisnostjo, ranljivostjo, slabšim splošnim zdravjem in visokim simptomatskim bremenom (Haugan, 2014a; Rinnan et al., 2022), kar vodi v bivanje na zgolj preživetveni ravni (Hoben et al., 2016). Eksistencialno trpljenje stanovalcev DSO se odraža tudi v prisotnosti eksistencialnih vprašanj, kot so dokončnost življenja, socialna izolacija, osamljenost in pomanjkanje smisla (Sanderson & Scherbov, 2010; Drageset & Haugan, 2021). Na splošno se stanovalci DSO vsakodnevno soočajo z izgubo, boleznijo, hudimi simptomi in žalostjo ter preživijo veliko časa v pasivnih dejavnostih, kot so mirovanje, spanje in čakanje, ki vodijo v občutke zdolgočasenosti, osamljenosti, nesmiselnosti in pomanjkanja dostojanstva (Brownie & Horstmanshof, 2011; Slettebø et al., 2017). Poleg tega je življenje v DSO institucionalizirano in kot tako predstavlja tudi izgubo družbenih odnosov, zasebnosti, smisla življenja in povezanosti (Haugan, 2014b; Barca et al., 2009). Kljub temu se paliativni in duhovni/eksistencialni oskrbi v DSO posveča vse premalo pozornosti.

Duhovna oskrba pomeni podporo človekovemu iskanju in izražanju tega, kar trenutno daje njegovemu življenju smisel in namen. Gre tudi za spodbujanje posameznikove povezanosti s samim seboj, drugimi, naravo in pri nekaterih tudi z nadčutnim (bogom). Takšna povezanost je izjemno pomembna za doseganje občutka veselja in smisla življenja ter samopreseganja (Haugan, 2021). Številne raziskave potrjujejo, da je občutek pripadnosti (povezanosti) osrednjega pomena za dobro počutje stanovalcev DSO (Philips-Salami et al., 2012; Welsh et al., 2012; Prieto-Flores et al., 2011a, b), kar nakazuje, da so občutki podpore in zaupanja, iskanje smisla in odgovorov na eksistencialna vprašanja ter pogled onkraj smrti ključnega pomena za posameznikovo duhovno dobrobit (Thauvoye et al., 2019). V DSO se duhovna oskrba odvija skozi interakcijo med medicinsko sestro in pacientom, skozi odnosne kvalitete, ki podpirajo in krepijo človekovega duha. Izkušnja biti spoštovan, razumljen, slišan in jeman resno, biti viden in priznan takšen, kakršen si, krepi zaupanje stanovalcev in neguje njihovega duha in telo, kar pa posledično krepi tudi njihovo zdravje in počutje (Haugan, 2014b). Odlično zdravstveno nego lahko torej definiramo kot »polno prisotnost« medicinske sestre ob starejši osebi med izvajanjem nege. Tovrstna zdravstvena nega združuje strokovno usposobljenost in negovanje odnosa kot neločljivo povezana vidika nege.

Novejše raziskave na podlagi modeliranja strukturnih enačb in vprašalnika o interakcijah med medicinsko sestro in pacientom Nurse-Patient Interaction Scale (NPIS) (Haugan et al., 2012) kažejo, da način, na katerega stanovalci DSO dojemajo interakcijo z medicinskimi sestrami, pomembno vpliva na samooceno njihove stopnje osamljenosti (Drageset & Haugan, 2021), veselja do življenja (Haugan et al., 2020), smisla življenja (Haugan 2014a,b), občutka skladnosti (Drageset et al., 2020), upanja (Haugan, 2014c), samopreseganja (Haugan et al., 2012) ter anksioznosti in depresije (Haugan, Innstrand & Moksnes, 2013). Pozitivna komunikacija, ki vključuje duhovno komponento, kaže pozitivno korelacijo na vseh teh področjih. Z drugimi besedami: zdravstvena nega, za katero je značilna polna prisotnost v trenutku, spoštljivost, iskrenost, prijaznost, občutljivost in odzivnost na občutke ranljivosti ostarelih; nega, ki izraža razumevanje za njihove potrebe in sočutje do različnih vrst trpljenja in ki zagotavlja čustveno podporo in potrditev (Tejero & Marie, 2012; Rchaidia et al., 2009; Nåden & Eriksson, 2004; Moss 2009; Cartter 2009), neguje duha ostarelih in s tem tudi krepi njihovo zdravje in dobro počutje. Pozitivna interakcija z medicinsko sestro pacientom pomaga občutiti zaupanje, varnost, ugodje, potrditev, vrednost, dostojanstvo in boljše počutje (ibid).

Duhovna oskrba, izražena skozi interakcijo med medicinsko sestro in pacientom, temelji na negovalčevi sposobnosti poslušanja in zmožnosti vzpostavitve pozitivnega odnosa, torej prepoznavanja in negovanja resničnega bistva oskrbovančevega doživljanja. Medicinske sestre se morajo seveda v veliki meri zanašati na svojo sposobnost posvečanja pozornosti, kar velja za vsak odnos med medicinsko sestro in pacientom, saj je ta sposobnost nujno potrebna za natančno ovrednotenje stanja pacienta in za kompetentno in etično pomoč oskrbovancu. Medicinske sestre morajo biti na sposobne izluščiti dragocene informacije podlagi najmanjših indikacij, kar velja tudi pri telesni negi, npr. oskrbi ran, obravnavi bolečine, okužbah sečil ali pljučnici. Duhovna oskrba zato ne pomeni dodatne nege, ne pomeni nečesa dopolnilnega ali dodanega splošni zdravstveni negi, temveč pomeni nego, ki skrbi za pacientovega duha med polno prisotnostjo ob pacientu. Skratka, pomeni prisotnost v početju oziroma »being in doing« (Baldacchino, 2010).

Conflict of interest/Nasprotje interesov

The author confirms that there are no conflict of interest./Avtorica izjavlja, da ni nasprotja interestov.

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Cite as/Citirajte kot:
Haugan, G. (2022). Spiritual and existential care in nursing homes. *Obzornik zdravstvene nege*, 56(4), 0–0. https://doi.org/10.14528/snr.2022.56.4.3196