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Nurses' Spiritual Care Practices: Assessment, Type, Frequency, and Correlates

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in conjunction with the
Faculty of Graduate Studies

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by
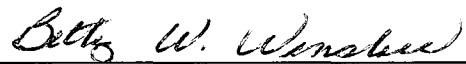
Iris Mamier

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the requirements for the degree of
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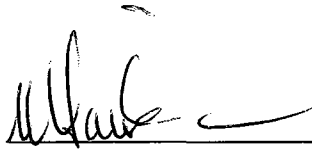
Each person whose signature appears below certifies that this dissertation in his/her opinion is adequate, in scope and quality, as a dissertation for the degree Doctor of Philosophy.

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DEDICATION

I would like to dedicate this dissertation to my husband Günter Mamier and my son Lucas Mamier. A commitment such as pursuing one's PhD truly is a family endeavor and not possible without the continued support and encouragement of one's inner circle of loved ones. Günter's support in all my professional aspirations was truly amazing and without his self-sacrificial love this would have never happened. It has been a rewarding experience to grow and develop together since our high school days.
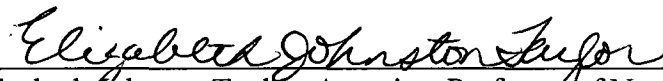
My son Lucas has been the ultimate gift in the middle of my PhD program, and he has taught me what matters most in life. I have been amazed how much a four-year old can support his mother and be brave in that final phase of bringing closure to this project. I hope that seeing his Mommy learn and study long into adult life encourages him to become a life-long learner himself and to live his life wisely and responsibly.

ACKNOWLEDGEMENTS

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ABBREVIATIONS

a	Cronbach's alpha
ANOVA	Analysis of variance
AS	Associate Degree
APN	Advanced Practice Nursing
ATLA	American Theological Library Association's index to journals
ß	Beta
BS	Bachelor of Science Degree
BS	Bachelor of Science in Nursing Degree
BMC	Behavioral Medical Center
CAM	Complementary Alternative Medicine
CEU	Continuing Education Unit
CH	Children's Hospital
CINAHL	Cumulative Index to Nursing and Allied Health Literature
CVI	Content Validity Index
DBT	Dialectical Behavioral Therapy
df	Degrees of freedom
DNR	Do not resuscitate
DV	Dependent variable
DSE	Daily Spiritual Experience Scale
DUREL	Duke University Religion Index
EBSCO	database of Ebsco industries providing full-text articles
EC	East Campus (community hospital)

ED	Emergency Department
EFA	Exploratory Factor Analysis
EM	Expectation Maximization method
ER	Emergency Room
F	*F*-value in Multiple Regression Analysis
FA	Factor Analysis
GSS	General Social Survey
HRSA	Health Resources and Services Administration
HNA	Hospice Nursing Association
ICN	International Council of Nurses
IR	Intrinsic Religiosity (subscale of the DUREL)
IV	Independent Variable
JCAHO	Joint Commission on Accreditation of Healthcare Organizations
KMO	Kaiser-Meyer-Olkin Measure of Sampling Adequacy
LDS	The Church of Jesus Christ of Latter-day Saints
M	Mean
MC	Medical Center
MD	Medical Doctor
MS	Master of Science Degree
N	Number of Subjects
NICU	Neonatal Intensive Care Unit
NORA	Non-Organized Religious Activity (Subscale of the DUREL)
NSCPS	Nurses' Spiritual Care Perspective Scale

NSCQ	Nursing Spiritual Care Questionnaire
ONS	Oncology Nursing Society
ORA	Organized Religious Activity (subscale of the DUREL)
QoL	Quality of Life
p	Probability Value
PhD	Doctor of Philosophy
r	Correlation Coefficient
R^2	Coefficient of Determination (percentage of variance explained)
RN	Registered Nurse
RWBS	Religious Wellbeing Subscale
SCP	Spiritual Care Practice Questionnaire
SD	Standard Deviation
SDA	Seventh-day Adventist Church
SIBS	Spiritual Involvement and Beliefs Scale
SPS	Spiritual Perspective Scale
SPSS	Statistical Package for the Social Sciences (version 17)
SRPB	Spirituality, Religiousness, Personal Beliefs Scale
SSCRS	Spirituality and Spiritual Care Rating Scale
SWBS	Spiritual Wellbeing Scale
t	Test Statistic
U.S.	United States
VAT	Vascular Access Team
X	Mean

ABSTRACT OF THE DISSERTATION

Nurses' Spiritual Care Practices:
Assessment, Type, Frequency, and Correlates

by

Iris Mamier

Doctor of Philosophy, Graduate Program in Nursing
Loma Linda University, September 2009
Dr. Betty W. Winslow, Chairperson

This descriptive, correlational study described the type, frequency, and correlates of

nurses' spiritual care practices (quantitative) and their experiences with the sacred at

work (qualitative). A convenience sample of 554 (24%) of the Registered Nurses

employed at a western United States faith-based tertiary care health system participated

in this online survey. Nurses' spiritual care practices were assessed using the 17-item

Nurses' Spiritual Care Practice Questionnaire (NSCQ). Factorial validity and reliability

of the pilot NSCQ were established. Spiritual care practices most frequently endorsed

were assessing patients' spiritual beliefs pertaining to health and listening to patients'

stories of illness and their spiritual concerns. Over 90% of the nurses reported remaining

with a patient after completing a task to show caring. Although nurses' mean spiritual

care practice scores were relatively low, item endorsement showed variability. Bivariate

analyses revealed associations between nurses' spirituality, religiousness, and work

environment and the dependent variable, nurses' spiritual care practices. Working day

shift, past education in spiritual care, and nurses' comfort level with spiritual care also

were significant. No demographic variables were significant. Predictors in the final

multivariate model (in order of strength) were nurses' perception that spiritual issues at

the work place came up frequently, nurses being more spiritual, nurses not working in pediatric care, and nurses having received education about spiritual care in the past. The qualitative analysis revealed that nurses' experiences with the sacred at work reflected mostly positive engaging experiences supporting their personal spirituality and their desire to continue to engage with spiritual situations. Where there was a misfit between nurses' and patients' spiritual orientation, some nurses disengaged from the presenting spiritual concerns. This study is most informative about spiritual care practices of nurses who integrate their spirituality with traditional religiousness. Findings show differences in frequency of spiritual care provided across various areas of nursing, and they raise questions about whether the NSCQ adequately captures spiritual care practices in pediatric settings.

CHAPTER ONE

Introduction to the Study

The Research Problem

Publications of spirituality in nursing have rapidly increased in numbers over the

past two decades. This proliferation reflects a larger societal trend: "Never in recent

memory has spirituality seemed to be so much on people's mind," Gallup and Jones

(2000, p. 14) assert in their book, *The Next American Spirituality*. This trend is also

reflected in health care. The spirituality-health link in research has seemingly triggered

vigorous discussions within the different health disciplines, such as medicine (e.g.,

Berlinger, 2004; Koenig, 2008; Levin, 2001; McCullough, 1997; Sulmasy, 2002),

psychotherapy and counseling (e.g., Sperry, 2001; Sperry & Shafranske, 2005),

psychology (e.g., Hill et al., 2000; Zinnbauer et al., 1999), social work (e.g., Chamiec-

Case, 2006; Hodge, 2003), sociology (Grant, 2004; Grant, O'Neil, & Stephens, 2003;

2004); theology (Gilliat-Ray, 2003; Swinton, 2006), and nursing (e.g., Cusveller, 1998;

Martsolf & Mickley, 1998; Mayer, 1992; McSherry & Draper, 1998; Pesut & Sawatzky

2006; Reed, 1992; Ross, 1994b; 1995; Taylor, 2002; 2007; Taylor & Mamier, 2005;

Speck, 2005; Wright, 2005). In fact, as Swinton and McSherry (2006) in a special

editorial by the *Journal of Clinical Nursing* assert:

> ...of all the caring professions, nursing is probably the most advanced and
> forward thinking within this area of care. Nursing academics, educators,
> researchers, and of course most importantly practitioners, have offered new, rich
> and challenging insights and clarifications in relation to this vital and sometimes
> contentious area of research and practice. (p. 801)

Beyond engaging and sometimes harsh discussions within the disciplines (e.g.,

Bash, 2004; Berlinger, 2004; Gilliath-Ray, 2003; Paley, 2007; Pesut, 2006; 2008b; Pesut

& Sawatzky, 2006, Pesut & Thorne, 2007; Ross, 2006; Stifoss-Hanssen, 1999; Swinton, 2006; Swinton & Narayanasamy, 2002), spirituality also has caught the attention of policy makers both internationally (e.g., Codes of Ethics, International Council of Nurses [ICN], 2006) and a nationally (e.g., by The Joint Commission on Accreditation of Healthcare Organizations [JCAHO], 2004). JCAHO has formulated quite specific expectations regarding spiritual assessment (La Pierre, 2003). At a minimum, they require healthcare professionals to determine the patient's denomination, beliefs, and important spiritual practices and how these might affect the courses of health and illness. As Swinton and McSherry (2006) point out, the legislative side of such governing bodies quickly is moving towards an understanding that meeting patients' spiritual and religious needs in fact represents professional integrity. Conversely, not meeting patients' spiritual needs may be interpreted as a breach of patients' human rights (Article 9, Human Rights Act, 1998 as cited in Swinton & McSherry, 2006).

Not quite as clear is the practical side of this issue: What are policy makers and governing bodies prepared to do to ensure working conditions for nurses that allow for a more individualized care accounting for patients' higher order needs (Maslow, 1943) such as their spiritual needs? Although priorities in nursing practice reflect personal and professional precedence, they also reflect choices that are being made within a health care system and its organizational context. To date, very few studies have considered this larger context in which spiritual care in nursing does or does not take place (Swinton & McSherry, 2006). Although many studies have reported on nurses' opinions, perceptions, and attitudes (but not their specific behaviors), few studies have tried to capture in a quantitative way how much spiritual care is part of nurses' daily practice. At present,

there is not much data documenting what nurses do with the spiritual dimension of care in their practices.

Of the studies that have tried to describe actual practice, few have looked at factors that are associated with providing spiritual care. The few studies that have systematically explored correlates for nurses' spiritual care practice usually have centered on either nurse specific variables or on context variables (e.g., hospital size). There is a need for more precise understanding about frequencies of nurse-provided spiritual care across nursing subspecialties in acute care and for a better understanding about what nurse specific as well as organizational factors are associated with providing or not providing spiritual care. Specifically, the role of nurses' spirituality and religiousness in relation to providing spiritual care needs to be explored in more detail, drawing on multi-item, well established, spirituality and religiousness measures.

Purpose and Aims of the Study

The purpose of this study is to evaluate nurses' spiritual care practices in a faith-based tertiary care setting. Three specific aims of the study are:

1. To describe the type and frequency of nurses' spiritual care practices in a faith-based tertiary care setting.

2. To examine the potential effects of nurses' bio-demographic characteristics and their spirituality and religious orientation on their spiritual care practices.

3. To examine the potential effects of organizational variables of a faith-based acute care setting (e.g., type of hospital, type of unit, workload, and nurse-patient ratio) on nurses' spiritual care practices.

Significance of the Study

Significance for Nursing

To date, many of the publications about spirituality in nursing stem from nurse academicians and educators. The present research provides insight into clinician perspectives. Study results inform what kind of practices registered nurses may prioritize and what kind of practices they least endorse. Although nurse academicians have tended to emphasize the spiritual dimension decontextualized from religion, the question arose: What role does nurses' spirituality and in some cases nurses' religiousness have in regard to spiritual care practices? Are they associated, and if so, in what ways?

Significance for Theory

The study uses a new research instrument that measures practice instead of nurses' attitudes or perceptions. Measuring practice is much more difficult, and historically there have not been very many instruments that could assess practice. The NSCQ is theoretically based, and each item has been tested for content validity (Taylor, 2008). Thus, the study actually allows for comparisons of nurses' practices across environments and informs factors associated with higher or lower spiritual care practice. Hence, study findings about nurses' spiritual care practices also contribute to a better theoretical understanding of nurses' spiritual care within an organizational environment.

Significance for Health Policy

A better understanding about factors associated with nurses' spiritual care practices may be helpful to health governing bodies if they are serious about wanting to facilitate these practices. Particularly, the role of environmental/organizational factors has

to be better understood. This study highlights the potential effect that education about spiritual care may have on a nurse's practice.

Philosophical and Historical Perspectives on Spirituality

Swinton (2006) establishes that spirituality in nursing is an emerging field of inquiry; however, in his critical appraisal of the existing literature, he points out that the discipline is lacking a rigorous internal critique and that many problematic questions are either not being raised or not seriously being addressed. Although nursing has made a strong and persistent case for the inclusion of spirituality in holistic nursing care, the literature is far from being clear what the implications of this emphasis might be. Nursing as a profession has a longstanding history with spirituality, specifically with models of spirituality grounded in formal religion (Narayanasamy, 1999, Barnum, 2003). The nursing profession's conversion to the scientific paradigm after the 1950s helped the profession establish itself in academia, but this implied a paradigm shift where spirituality was relegated to the back seat as Barnum (2003) formulated it so aptly. Instead of caring for body-mind-spirit, nurses cared now for bio-psycho-social beings. This change also implied a shift from the spiritual to the psychosocial. Recently though, under the umbrella term of holism, there is a renewed interest in spirituality.

This renewed interest in a spirituality-in-nursing is much more generic in nature than what was previously rooted in formal religion (Barnum, 2003; Lane, 1987; Pesut, 2008a; Swinton, 2006). Although it is emphasized that spirituality-in-nursing is different from religion-in-nursing, there is little clarity about what exactly spirituality-in-nursing is apart from religion, and it has not been well argued on what grounds the nursing profession should abandon the related construct of religion (Cusveller, 1995; Swinton,

2006). As a consequence, definitions of spirituality and spiritual care oscillate somewhere along the two poles of an imaginary continuum between what used to be called "good psychosocial care" and the religious care of old. This dichotomy has raised questions about the emperor's new clothes (Bash, 2004; McSherry, Cash, & Ross, 2005) where the difference between the previous construct psychosocial care and the new en vogue construct, spiritual care, is virtually impossible to clarify. Thus, regardless of countless conceptual papers (Burkhardt, 1989; Chiu, Emblen, Van Hofwegen, Sawatzky, & Meyerhoff, 2004; Coyle, 2002; Dyson, Cobb, & Forman, 1997, Emblen, 1992, Emblen & Peverall, 2002; Fawcett & Nobel, 2004; Goddard, 1995; Golberg 1998; Greasley, Chiu, & Gartland, 2001; Henery, 2003; Kendrick, Robinson, & Kendrick, 2000; Lane, 1987; Ledger, 2005; Mansen, 1993; Mayer, 1992; McBrien, 2006; McEwen, 2005; McLaren 2004; McSherry, Cash, & Ross, 2004; Newlin, Knafl, & Melkus, 2002; Nolan & Crawford, 1997; Oldnall, 1995; Ormsby & Harrington, 2003; Pesut & Sawatzky, 2006; Rassool, 2000; Sawatzky & Pesut, 2005; Sheldon, 2000; Smucker, 1996; Tanyi, 2002; White, 2000; Wright, 2002), it remains a messy business to clarify the meaning of the concepts "spirituality" and the related concept "spiritual care" in an authoritative way. The pragmatic way out has been to choose a definition one likes and to develop one's own operational definition and instrument; however, this lack of clear definition has resulted in a-theoretically developed instruments that have been poorly validated (e.g., Vance, 2001), and very little comparison is possible across studies because each researcher operationalizes his/her own definition.

To resolve some of those persisting conceptual misunderstandings, Pesut (2008a) conducted a philosophical analysis of the spiritual in the nursing literature. She found that

there are basically three main traditions in nursing from which spiritual care has been conceptualized: from a (a) theistic perspective, (b) monistic perspective, and (c) humanistic perspective. As Pesut (2008a) illustrates, each of the three traditions represents a distinct worldview. That is why humanism cannot simply be seen as the lowest common denominator upon which a one-size fits all spiritual care approach is crafted. By contrast, the solution that can be deduced from her work points towards differentiation. She developed a typology that suggests nurses need to understand there are fundamentally different worldviews that inform an individual's spiritual outlook. Pesut's dissertation (2005) and her recent articles (Pesut, 2008a; Pesut & Johnson, 2008; Pesut & Thorne, 2007) illustrate those differences and call for a reflective practice that is aware of the distinctness of each. Contrary to the scientific paradigm that would reduce spirituality to an endless study of different diets and religious rituals important to a long list of religious traditions, this approach cuts through to fundamental differences that have direct implications for the way spiritual care must appropriately be tailored to the needs of an individual.

As Swinton (2006) notes, the separation of spirituality and religion is a "key issue" and a "central debate" in the nursing theoretical literature. The driving force behind this "separationist" position is the assumption that all people by virtue of being human are spiritual even if they are not religious. Although some (e.g., Paley, 2007) have challenged the position of a universal spiritual dimension that would require the nurse to be aware of the spiritual needs of both religious as well as non-religious patients, others have advocated nurses' awareness in regard to patients who are not religious (e.g., Noto,

2006). Overall, there is still very little clarity as to how nurses should approach the spiritual and religious or how the two should be separated appropriately.

These issues have not only challenged scholars in the nursing profession, but there have been attempts to define and clarify these same concepts in neighboring disciplines. For example, scholars from the psychology of religion have addressed the tension between the two constructs. Zinnbauer et al. (1997) conducted a study to measure how individuals define their own religiousness and spirituality. Among other questions, they asked a religiously diverse sample of 346 participants how they believed the two concepts spirituality and religiousness related to each other. Participants were offered five distinctive descriptions from which to choose. The first choice was "spirituality is the broader concept than religiousness and includes religiousness." This choice was selected by 36.8% of their study participants. This high agreement is not surprising because it is a popular model in contemporary society and very much in line with postmodern spirituality and the perspectives of many nursing scholars (e.g., Emblen, 1992; Lane, 1987; McSherry, 2006; Narayanasamy, 1999; Reed, 1992). It is also the model that can be found in Koenig, McCullough, and Larson's *Handbook of Religion & Health* (2001).

The second item or model was "religiousness is the broader concept than spirituality and includes spirituality." The second model was supported by 10.2% of the participants. This model is also supported by Zinnbauer and Pargament (2005) in the *Handbook of the Psychology of Religion and Spirituality* and reflects the historic understanding of William James where spirituality has not been separated from religiousness (Zinnbauer et. al., 1997). In a more practical way, today's elderly are likely

to relate to spirituality in terms of religion, something which nurses who are caring for the elderly should be aware of.

The third model recognizes "religiousness and spirituality are different and do not overlap." Here Zinnbauer et al. (1997) found that 6.7% saw spirituality and religiousness as unrelated concepts. Members of the group that self identify as "spiritual but not religious" probably would support this view. This group tends to define their spirituality outside the tenets of traditional religion.

The fourth model states, "religiousness and spirituality are the same concept and overlap completely." Only 2.6% of the sample thought that both concepts are identical. Some respected contemporary scholars would still see it this way. Fuller (2001), for example, notes,

> The confusion stems from the fact that the words "spiritual" and "religious" are really synonyms. Both connote belief in a Higher Power of some kind. Both also imply a desire to connect, or enter into a more intense relationship, with this Higher Power. And, finally, both connote interest in rituals, practices, and daily moral behaviors that foster such a connection or relationship. (p. 5)

The fifth and final choice was "religiousness and spirituality overlap but they are not the same concept." This last model where both concepts are distinct but shared some common ground is the model that was supported by most participants, 41.7%. Support for this view is found in the writings of Stifoss-Hanssen (1999) who adds that the core of spirituality is the existential while agreeing with Pargament (1997) that the core of the concept of religiousness is the sacred.

In these five models, it is clear that only one conceptualizes spirituality totally apart from religion. All other models establish some relationship between spirituality and religiousness. Zinnbauer et al. (1997) furthermore asked their participants how they

would self identify in relation to the two concepts spirituality and religiousness. The majority of the participants (74%) saw themselves as spiritual and religious. This percentage is contrasted with 4% who saw themselves as religious but not spiritual and 3% who identified as neither religious nor spiritual. Nineteen percent of the participants saw themselves as spiritual but not religious. This finding is supported by Fuller (2001) who says that about one in every five Americans would identify with this category.

In sum, Zinnbauer et al.'s (1997) findings show that 93% identify themselves as spiritual, and 78% identify themselves as religious. Hence, a substantial number of people identify with religion while being spiritual. These individuals are contrasted with the group of individuals who neither identifies with the notion of spiritual or religious. Fuller (2001) says it is safe to assume that these people account for anywhere between 8-15% of the population. He classifies them as "secular humanists," representing a group that for the most part is well educated. The third group, spiritual but not religious, can be described according to Zinnbauer et al.'s (1997) findings as follows:

> less likely to evaluate religiousness positively, less likely to engage in traditional forms of worship such as church attendance and prayer, less likely to engage in group experiences related to spiritual growth, more likely to be agnostic, more likely to hold nontraditional "new age" beliefs, and more likely to have had mystical experiences. (p. 564)

It is noteworthy that these profound differences between spiritual and religious and spiritual and not religious also were supported by recent psychological research. Saucier and Skrzypinska (2006) actually labeled those two groups "subjective spirituality" and "tradition-oriented religiousness" and concluded that the two groups are empirically highly independent with each having distinctly different correlates in the

personality domain. Therefore, individuals may gravitate to different spiritual/religious styles depending on their profile in psychological dispositions.

Overall, the findings in the literature along with empirical support suggest the following conclusions for the discussion of spirituality-in-nursing:

1) Conceptualizing spirituality totally apart from religion does not reflect how the majority of people in the United States see the concepts. The same probably can be said for many other countries where religion plays an important part in people's lives.

2) Nurses need to understand two basic categories of spirituality: religious versus non-religious spirituality. This position is also supported by Swinton (2006).

Theoretical Framework

In a recent publication, Burkhart and Hogan (2008) noted that there is no empirically-derived theoretical framework to guide research in spirituality-in-nursing. Swinton (2001), however, found some theoretical assumptions that seem to be useful to guide an understanding about spiritual care and its legitimacy. Drawing on the cross-cultural perspectives of David Augsberger and Emmanuel Lartey–a perspective that seeks to avoid stereotyping and negative or even racist assumptions–Swinton (2001) introduces the following framework of three propositions about the universal and particular of every human being.

Every human person is in some aspects:

1. like all other people (the universal human dimension)

2. like some other people (the historical, cultural, social, and political dimensions)

3. like no other people (the intrapersonal dimension)

Swinton translates those three propositions into the realm of spirituality by stating:

1. All human beings have a spiritual dimension.

2. Everyone's spirituality is like some other people's spirituality.

3. Everyone's spirituality is like no other person's spirituality.

The first assumption that spirituality is a universal human experience leads Swinton (2006) to deduce that "we might safely approach everyone whom we encounter with the expectation that the spiritual dimension will be present either implicitly or explicitly" (p. 21). This understanding is foundational for the so called "broader view of spirituality"–the dominant paradigm in the nursing literature–where spirituality is not seen as an explicitly religious concept

> . . .but as a common human experience that forms an integral part of every person's striving to make sense of the world and their life within it. Such understanding incorporates humanistic, existential, and philosophical perspectives as well as religious ones. (Swinton, 2001, p. 23)

Swinton's first assumption seems foundational for any discussion about spirituality-in-nursing. Second, this assumption expands the notion of "spiritual care" potentially to all patients because, regardless of differences in the belief system, there is more shared ground than differences. The last assumption balances this view by reaffirming the uniqueness of everybody's spirituality. Thus, in spite of shared ground, one should never generalize too quickly based on religious labels. A person will, therefore, express his/her spirituality in ways that may be similar to those of certain others yet very different from others, too.

The questions remain: When is spiritual care indicated from a professional nursing perspective? What are defining characteristics of a situation that invites the nurse to pay attention to the spiritual? Drawing on Chick and Meleis' (1986) and Meleis and

Schumacher's (1994) transition theory that had been enhanced by Meleis, Sawyer, Im, Messias, and Schumacher (2000), health transitions may at times trigger distress, even spiritual distress. The nurse is in a unique position to witness this distress, including possible spiritual pain. Ignoring this distress or pain would not be a therapeutic response. Because human suffering invites the nurse to respond on a spiritual level (McLeod, 2003), the nurse will search for ways to ease pain when seeing cues of (spiritual) distress. Wright (2008) points out that the intensity of suffering has a lot to do with the beliefs that patients and families attach to an illness. These beliefs can either enhance or soften the suffering experience. According to Wright (2005), spiritual care would cause a nurse to explore these beliefs or subjective meanings attached to an illness experience, which implies active, non-judgmental listening, reflection, and acknowledging of the experience. Käppeli (2000) brings to the attention of the profession that patients' interpretations of their suffering are often framed by their religiousness. Moreover, as patients draw on their personal religiousness, they may find ways to cope with the effects of their health transition. Therefore, nurses' attention to patients' spiritual distress often includes acknowledging and listening to patients' religious experience, too.

In conclusion, the three propositions that Swinton (2001) suggested are relevant and potentially helpful in understanding the underpinnings of the construct of spiritual care in nursing. Both Swinton's (2001) work and Zinnbauer, et al.'s (1997) conceptual research are foundational to the following construct definitions that will be used for this proposed study.

Definitions of Major Constructs

The following constructs, defined below, are central to this research:

Spiritual Care

Drawing on Swinton's (2001) understanding of spirituality, spiritual care is defined as "identifying and working with that which gives the person their source of meaning, value, and a sense of inner and outward connectedness" (p. 24). Swinton also contends that "spiritual care in its widest sense pertains to strategies designed to endow meaning, value, hope, and purpose to people's lives. Interventions here would include the development of meaningful personal relationships, meditation, enabling access to sources of value and so forth" (p. 38).

Religion

The definition of religion is "an organized system of beliefs, practices, and symbols designed to facilitate closeness to a higher power and includes the understanding of one's relationship and responsibility to a community" (Larson, Swyers, & McCullough, 1997 cited in Koenig, George, Titus, & Meador, 2004, p. 303). In the present study, religion is conceptualized broadly and includes forms of religion that extend beyond organized religion where the individual may not formally belong to a religious community.

Religiousness

This term is defined as adherence to religion as expressed through beliefs and practices. Both, the term "religion" and "religiousness," "refer to the larger social, institutional, and cultural context of spirituality" (Pargament, 2007, p.32).

Spirituality

Spirituality, according to Pargament (1999) has been defined as "a search for the sacred" and "has to do with however people think, feel, act, or interrelate in their efforts

to find, conserve and if necessary, transform the sacred in their lives" (Pargament, 1997, p. 12).

World View (Weltanschauung)

Essentially, a worldview is an orienting system from which one perceives the world (Pargament, 1997). Moreover, Sire (2004) explains the meaning of worldview by giving the following definition:

> "A worldview is a commitment, a fundamental orientation of the heart, that can be expressed as a story or in a set of presuppositions (assumptions which may be true, partially true or entirely false) which we hold (consciously or subconsciously, consistently or inconsistently) about the basic constitution of reality, and that provides the foundation on which we live and move and have our being". (p.17)

Summary and Conceptual Model

Chapter one can be summarized with the following graphic representation of the conceptual model (Figure 1). On the left side, personal, spiritual, and organizational variables are listed. This study explores how these factors may be associated with the frequency of nurses spiritual care practices. The other side of the diagram depicts some of the basic assumptions underlying this research. Although the client is not part of the statistical model that will be tested, the client perspective is displayed on the right side of the diagram: Individuals/clients experiencing a health transition cared for within an acute care environment. They may experience distress as a result of this transition. Distress possibly involves all dimensions of the being, body-mind-spirit. As the health transition leads to distress, the patient sends cues, which may or may not be recognized by the nurse. As Burkhart and Hogan (2008) in their framework for spiritual care point out, these cues are like an invitation to the nurse to respond with spiritual care. At this point the nurse must make a decision to engage or not engage. From a preventive perspective,
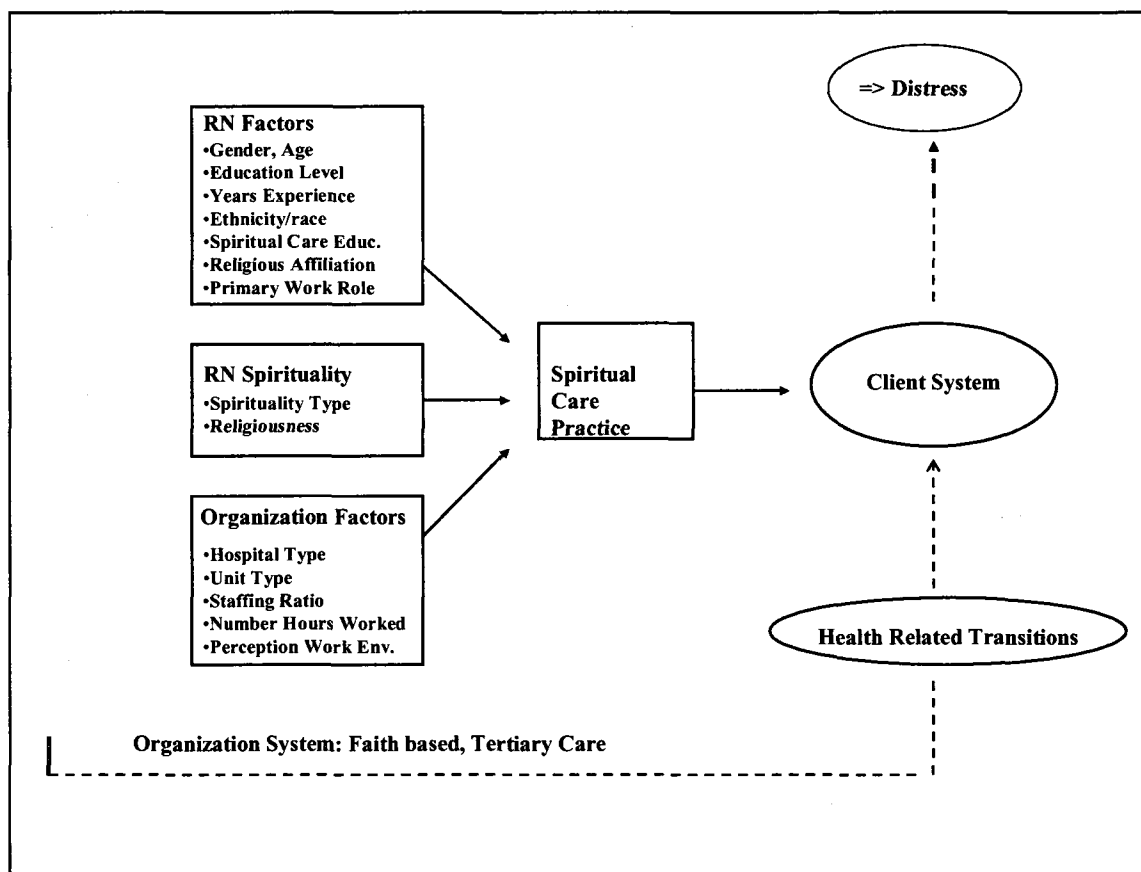
Figure 1. Conceptual model of predictors of nurses' spiritual care practices.

spiritual care may also strengthen patients in such a way that they do not even reach a

point of spiritual distress. Finally, the graphic illustrates that spiritual care takes place in

an organizational context to which both the nurse and the client respond. This model

assumes that beyond personal factors of the nurse the organization also provides a

context that is either conducive or hindering to the outcome variable frequency of nurse

provided spiritual care.

CHAPTER TWO

Review of Literature

Introduction to the Literature Review

In this chapter, the relevant research literature on spiritual care from a nurse's perspective will be reviewed to both identify what is known about spiritual care and the gaps in the existing body of knowledge. A systematic literature search of the *PubMed* supported *Medical Subject Headings* database was conducted using the following search strategy: First, enter the key word "spirituality." Second, enter the key word "spiritual therapies" and third, combine this with the key word "nursing." This search yielded a total of 500 abstracts that were reviewed to retrieve all research articles relevant to the topic. Beyond that, other search engines and databases, such as CINAHL, EBSCO, Google Scholar, and the ATLA Religion Database, were used at different points in the research project. Finally, reference lists from relevant articles were used to find other important research reports.

To be more precise, the literature searches were on articles in which nurses' perspectives on spiritual care had been explored. From the final set of articles, the following thematic structure emerged: research articles that had (a) described nurses' perceptions, attitudes, and beliefs regarding spirituality, spiritual needs and spiritual care; (b) identified predictors for nurses' attitudes towards spiritual care; (c) explored nurses' spiritual care practices; and (d) compared nurses' spiritual care giving, both across settings or across disciplines. Consequently, the following literature report is divided into four sections, each of which concludes with a summary and makes suggestions for future research. The four sections are followed by a final summary.

Section One: Nurses' Perceptions, Attitudes, and Beliefs regarding Spirituality, Spiritual Needs and Spiritual Care

In the early 1990s, a number of studies were published in which nurses' perspectives of spirituality, spiritual needs, and spiritual care were explored. Questions regarding nurses' definitions and understanding of these concepts were evaluated with qualitative methodologies, and the concepts were often discussed in an interrelated way. Subsequent studies were more structured with quantitative questions about what nurses held true in regard to spirituality and spiritual care. Thus, some of the first instruments were developed to measure nurses' attitudes and beliefs regarding spirituality in nursing and spiritual care, respectively.

Taylor, Highfield, and Amenta (1994) and Taylor, Amenta, and Highfield (1995) explored the perspectives of 181 cancer nurses on spiritual care in the US. They drew on a stratified, random sample of 700 members of the Oncology Nursing Society. The study was a mixed method design using descriptive and multivariate analyses as well as content analysis of a few essay questions (Taylor et al., 1994). Although nurses identified spiritual care as an important element of nursing, they were only moderately committed to and had a moderate level of confidence about their spiritual care practice (Taylor et al., 1994). Nurses' perceptions about spiritual care centered on promoting well-being, respecting and supporting patients' beliefs, providing emotional care in suffering, promoting peace/meaning/hope, sharing self through presence, facilitating relationships and religious needs. A few respondents were unable to define spiritual care, whereas most saw it as serving the purpose of growth, coping, well-being, and relationships. Spiritual care activities most frequently described were verbal interactions, active listening, and encouraging patients. Even with a "biased sample" (Taylor et al., 1994, p.

485) that tended to be highly interested in spiritual care--Caucasian, Christian, female, and working with adult oncology patients--definitions showed a broad range of understandings rather than a uniform perception of the concept. Clearly, these differences match the conceptual ambiguity that can be found in the scholarly nursing literature.

Out of the sample of 181 oncology nurses, 168 gave observable cues that would alert them to patients' spiritual needs (Taylor et al., 1995). Content analysis revealed that death and fear issues prompted more than half of the respondents to think in terms of spiritual needs, whereas almost 40% of the nurses listed patients' direct request to talk about spiritual or religious matters with either the nurse or the chaplain as a trigger for spiritual care. Nurses referred to overt signs of religiousness, as well as hidden cues, such as withdrawal and sleeplessness, and identified critical times in the cancer illness trajectory that would make patients prone to experiencing spiritual needs.

Taylor et al. (1994) also discovered a positive correlation between nurses' self-reported spirituality and religiosity and their attitude toward spiritual care. Furthermore, attitudes and beliefs about patients' spirituality and the kind of interventions used by the nurse differed in relation to the variables of religious service attendance, ethnicity, and education (Taylor et al., 1994). Thus, the study revealed some interesting cultural differences between the Caucasian majority and the minority group of Asian or Latino nurses in regards to what is appropriate spiritual care. The latter believed more strongly than the Caucasian and also the African-American minority group that nurses should initiate a discussion of spiritual issues and that nurses should freely share personal beliefs in this context.

The Taylor et al. (1994) study sheds light on a number of variables related to either attitude toward spiritual care or with actual spiritual care practices: First, they suggest that nurses' spirituality and religiousness play an important role in whether or how nurses pick up on underlying spiritual issues at the bedside. Rather than relying on a one-question self-report measure, however, future research would be more informative if spirituality were measured according to actual spiritual and religious behaviors and if the constructs were assessed with a variety of measures. This approach would also minimize the probability that answers are highly influenced by supposed cultural expectations in a society that values religion. Second, the study findings suggested that educational and cultural differences may influence the way nurses view spiritual care. Although this finding intuitively makes sense, comparisons across different groups are not without statistical challenge unless there are sufficiently large numbers in the groups that are being compared. Therefore, if another study allows for such comparison, it would certainly be interesting to see if similar results are found. Third, Taylor et al. (1994) used some interesting measures such as "comfort level when giving spiritual care," which have also been used in other studies. For example, Lundmark's (2006a) study showed that this particular measure proved to be statistically relevant as both an influencing factor of attitude toward spiritual care and as an indicator of spiritual care (see next section).

Taylor et al.'s (1994) measure of nurses' attitudes towards spiritual care and some of their conclusions do, however, raise questions. For example, three of the items in the Oncology Nurse Spiritual Care Perspective Scale may be problematic for some respondents. These items are "A person must believe in a higher being/power to be spiritually healthy," "Atheists and agnostics are spiritually healthy," and "I believe as a

nurse that I should freely share my spiritual beliefs with patients." The first two statements are written in such a way that there is little room for a balanced answer from a nurse with an explicit theistic worldview. Such a worldview often assumes that wholeness includes a vertical transcendent (relating to God) as well as a horizontal dimension (relationship to other human beings). Thus, the question may pose a dilemma for some nurses if they answer the question according to their understanding of wholeness and spirituality. In such a case, the wording of the question and the response options make it appear that if a patient does not accept the transcendent dimension, they are spiritually unhealthy. Subsequently, agreement with the statement is interpreted as having a negative attitude toward these patients; in their discussion, the authors suggested that nurses who saw these patients as spiritually unhealthy would not be able to "…appreciate the spiritual well-being of a patient who believes differently" (p. 486).

Of concern also is the third question above: "I believe as a nurse that I should freely share my spiritual beliefs with patients." The authors showed that the correlation between nurses' frequency of religious service attendance and nurses' belief that they should freely share their spiritual beliefs suggested "… the very religious nurse may be inappropriately eager to proselytize" (p. 486). Here again, this interpretation of the relationship may not accurately reflect the meaning of the nurses' response. In fact, when reviewing the qualitative findings, this interpretation was not supported. The authors do note, in their conclusion, that these concerns they raised may be exaggerated.

This study, nevertheless, does trigger a very interesting future research question: Given that a considerable number of nurses in the United States self identify as both spiritual and religious, how do such nurses engage in spiritual care when caring for

patients with a different worldview? In sum, Taylor et al.'s (1994, 1995) studies reveal important factors influencing spiritual care. The fact that these studies resulted from a national sample representing nurses from several regions and multiple sites of the country adds credibility to studies' findings. Taylor et al.'s (1994, 1995) studies can be considered solid and foundational work upon which future research can be built.

Harrington (1995) conducted interviews with 10 hospice and 10 acute care Australian nurses regarding their understanding of spiritual care. Her sample included equal numbers of nurses who identified with a religious community of faith as well as nurses who did not. Nurses were asked four open-ended questions about their understanding of spirituality, how they would give spiritual care to a client, if they deemed asking permission to give spiritual care as important, and if they felt adequately prepared to assess a patient's spiritual needs and offer spiritual care. Nurses' responses differed a great deal, ranging from seeing spirituality as abstract, nebulous, non-concrete and very difficult to define and implement to having very clear ideas about what it is and seeing it as an integral part of nursing and an important part of care. Harrington (1995) noted that hospice nurses were more convinced than acute care nurses of the importance of spirituality and reported hospice nursing to be conducive to spiritual care. Nurses tended to perceive their formal educational preparation for spiritual care as inadequate; particularly hospice nurses who had made efforts to fill this gap by reading and attending continuing education.

Harrington (1995) concluded her qualitative analysis by suggesting a model of spiritual care. A precursor for spiritual care delivered to clients and their relatives is the ability of the nurse to establish rapport and build a trusting relationship. Second, spiritual

care is primarily understood by nurses as the ability to listen to and explore spiritual

issues, to express tender loving care, and to pray with a patient. Third, central to the

process of spiritual care are nurses' own beliefs, traits, values, life, and nursing

experiences. Fourth, Harrington concluded that two factors, "practice setting" and

"educational preparation," influenced the nurse most in the kind and quality of spiritual

care offered. Fifth, nurses do not address patients' spirituality for fear of being unable to

handle the situation or because they do not want to be perceived as intrusive when

addressing a private issue such as spirituality. They also have been socialized to not see

spirituality as part of their scope of practice, relegating this responsibility to the clergy.

They may fail to address it for lack of personal spiritual awareness and feeling threatened

by these issues. These emerging barriers should be tested further through quantitative

studies of nurses' perceptions.

Although Harrington (1995) cited from her original interviews to support her

findings related to each of the four questions, she did not give insight into how the

qualitative analysis of her data was conducted, what the 29 emerging themes were, and

how she arrived at the model. Nevertheless, in light of what has been published, the

model appears valid and establishes relationships that may likely be confirmed through

further theory testing.

Harrington (1995) drew a number of comparisons between her two groups of

nurses showing differences between nurses depending on their work environment, that is,

hospice versus acute care. Clearly, it makes sense that hospice nursing, generally

following a palliative paradigm, allows more space for patients' spiritual concerns than

does an acute care model. It is not clear; however, on what basis Harrington can establish

these differences in a qualitative study. Therefore, larger quantitative studies across work settings are needed to confirm that there are differences between work settings in regard to nurses' spiritual care priorities.

Since Harrington (1995) conducted her qualitative study, spirituality has received increasing attention in undergraduate as well as continuing education curricula in nursing. It would be interesting to see the effects of education on spiritual care practices particularly because Lundmark's (2006a) recent study established that those who considered education in spiritual care as important were more at ease in providing such care than those who did not see it as important. Furthermore, Harrington's (1995) study drew attention to the work environment in which nurses practice. To date, very little research has been done examining the effect of environmental factors on nurses' spiritual care. Research is needed to show how environmental factors compare with factors within the nurse when it comes to actual spiritual care practice.

Narayanasamy and Owens (2001) asked 115 nurses for critical incidents prompting them to initiate spiritual care. Their analysis comprised nurses' responses in the following four categories: (a) patients' religious background or (b) a shared religious background; (c) patient conversation loaded with spiritual religious content, which can be interpreted as a patient-initiated form of spiritual care; or (d) severity of patient diagnosis, which can be seen as nurse-initiated. Based on these categories, Narayanasamy and Owens (2001) raise the concern that their nurse sample tended to interpret spirituality too much in terms of religion and may thereby overlook spiritual needs in the absence of overtly religious cues.

Kuuppelomäki (2001) conducted a large survey in 32 large, middle sized, and small health centers across Finland to explore nurses' readiness and willingness to provide spiritual support to terminally ill and dying patients. A structured questionnaire was used for the purpose of this study, consisting of mostly multiple choice questions that were subject to statistical analysis and 12 open-ended questions that were analyzed through content analysis. The nurse sample comprised a total of 328 nurses and reflecting a high response rate of 72%. The majority of the sample was married, female nurses over the age of 36 who self identified as Evangelical Lutheran Christians and who frequently worked with terminally ill patients.

Kuuppelomäki (2001) found her sample to be divided almost equally in their perception of two issues: whether terminally ill patients expressed their spiritual needs often or rarely and whether they felt prepared through knowledge and skills to provide spiritual care. Kuuppelomäki (2001) also found that nurses differed in attitude towards providing spiritual care. Two-thirds of the nurses showed a willingness to discuss spiritual issues with their patients, and one-third were reluctant. Because her research did not explore factors associated with attitudes towards spiritual care, Kuuppelomäki recommended that this area be studied in future research.

Strang, Strang, and Ternestedt (2002) conducted a study on nurses' perceptions of the meaning of spiritual needs and explored whom nurses perceived as needing spiritual support. Their sample of 141 nurses represented different areas and subspecialties of nursing (e.g., neurology, neurosurgery, oncology, psychiatry, nursing home, and palliative care) from two Swedish cities. Under "nurses," the research team included

registered nurses (about 50% of the participants) as well as nursing auxiliaries (about 40%), and managerial staff (about 10%).

Out of 141 participants, 102 responded to the open-ended question. Participants identified the following groups of clients as potentially in need of spiritual or existential support: severely ill or dying persons and ill immigrants who actively practiced a religion. More generally, this Swedish sample recognized that patients who held strong religious beliefs and practiced religious rituals might welcome such care.

Strang et al. (2002) categorized the definitions given by their participants into three main categories derived from the researchers' theoretical understanding of an existentialist approach to holistic care in a secular society: religious issues, general spirituality, and existential issues with the subcategories of freedom, meaning(lessness), existential isolation, and death. Respondents' definitions reflected a broad spectrum of perceptions, although Strang et al. (2002) noted that their participants experienced some difficulty in theoretically defining the phenomenon and in distinguishing between spiritual and psychosocial care. About half of them interpreted "spiritual needs" in relation to religious issues. The other half conceptualized "spiritual needs" totally apart from religious issues in terms of general spirituality or existential issues. Two researchers sorting data achieved an initial inter-rater reliability of 72%. Hence, 28% of the items could be placed in several categories, and the research team had to find consensus on where to place them depending on the context of the descriptions.

Strang et al. (2002) found different patterns of conceptualizations of spiritual needs–those within a religious and those outside of a religious framework. Hence, the nurses' background may influence their perceptions of spiritual needs. It is also possible

that their interpretation may reflect the secular nature of Swedish society. Future research should explore nurses' differences or patterns of spiritual care practices in relation to their background variables. Operationalizing all three aspects of care found in this research the religious–the existential, and the general spirituality–may represent three common approaches to spiritual care used by different nurses.

Strang et al. (2002) also asked their participants to rate how much they agreed with six statements about holistic care and spiritual needs on a 7-point Likert-type scale ranging from "very much indeed" to "not at all." The scale did not allow for a neutral option such as "I don't know." Because holistic care is generally expected to encompass the spiritual dimension, the statements in the Strang et al. (2002) scale might be interpreted as being informative about the respondents' attitudes towards spiritual care (Lundmark, 2006a).

Strang et al. (2002) also found strong agreement with the notion of holistic care to be important in nursing (98%); however, only half of the participants were equally convinced that holistic care existed on their unit. Three-quarters of the respondents believed that holistic care included spirituality, and one-fourth were not convinced. Eighty-seven percent of the participants strongly agreed with a mandate that staff should pay attention to spiritual needs; however, less than half of them would see this happening on their unit. Last, there was strong support for the importance of education in spirituality (60%), and limited support of it in a third of the respondents.

Overall, the respondents in this study tending to score moderate to high in personal spirituality saw spirituality and spiritual care as important aspects of patient care; however, there were differences in perceptions of what this care entails. Although

Strang et al. (2002) did not quantify holistic/spiritual care practice, it is interesting to see the discrepancy in what nurses believe ought to happen and their perception of what is actually happening on their units. Future research should explore in more detail the reality in nurses' daily practice and factors contributing to higher or lower levels of spiritual care practice.

Grant (2004) conducted a comprehensive quantitative survey on 334 nurses in a large tertiary care health system in the southwestern United States. Among other questions, he presented nurses working across the spectrum of a tertiary care facility with a complex list of possible cues and asked them to indicate which of the cues prompted them to initiate a spiritual intervention. In Grant's study, reasons for initiating spiritual care were patients' explicit request (98%), when a patient is about to die (96%), grieving (93%) or crying (86%), or has received bad news (93%). Although more subtle cues, such as "is angry at staff" (30%), "struggles to sleep" (35%), or "complains more than usual" (26%), prompted some nurses to probe for spiritual concerns, the majority of nurses would not consider spiritual care in these situations. It is also noteworthy that nurses deemed it appropriate to offer spiritual care to a patient whom they perceive to be close to God and to be praying often (81%), whereas only 32% of the nurses would consider offering spiritual care to someone who was not a member of a church.

Overall, Grant's (2004) study results complement and support what other researchers found in qualitative studies: nurses appear to be most inclined to detect and act on spiritual patient cues in the context of dying and crisis and when they care for an obviously religious patient.

In a recent study, Boero et al. (2005) tested a WHO quality of life tool with regard to spirituality on 116 health care workers, 90% categorized as nurses and 10% as physicians. These professionals worked on three rehabilitation units of two faith-based hospitals in Northern Italy and on average scored above the mid-point of the scale (indicating a good quality of life with respect to their spirituality). Higher scores on the Spirituality/Religiousness/Personal Beliefs (SRPB) scale represented a higher quality of life (QOL). Scores were attained by those health care workers who classified their own health status as good, who considered themselves as religious or very religious, and those who scored high in personal beliefs. Conversely, poorer QOL was reported in all aspects investigated by those who reported fewer spiritual, religious or personal beliefs. Participants who considered themselves as religious had higher scores in strength and inner peace, and those to whom personal beliefs were important showed higher scores in wholeness and hope. Additionally, the research team (Boero et al., 2005) asked healthcare workers if they believed it was important that someone attended to the spiritual dimension of suffering people and if they believed as staff they should attend to spiritual care. Virtually all respondents (97%) confirmed the need for spiritual care for suffering people, and 89% specifically affirmed the usefulness of health workers attending to the spiritual dimension of ill people. Although the formulation of these questions is less than ideal, it was interesting to find this additional dimension in an instrument validation study.

Although the tool is well developed and well tested, a limitation of this study is the fact that the sample population is not purely nursing. A look at some of the demographic information on educational background raises questions about inclusion

criteria for the category "nurse" in the context of this study. Therefore, the label "health workers" as used by the research team is more accurate. Nevertheless, Boero et al.'s (2005) findings add to the discussion of spirituality in healthcare by highlighting variables that may be positively correlated with healthcare providers' spiritual care practice. Furthermore, they are adding a European/Italian perspective that has not been previously published in international nursing journals.

Summary and Discussion of the Findings across Studies

Nurses' perceptions of spirituality, spiritual needs, and spiritual care in relation to their patient. Nurses' definitions of spirituality, spiritual needs, and spiritual care differ across individuals, settings, western countries, and cultures. Nevertheless, there are reoccurring themes in studies that have explored nurses' perceptions of the concepts. To a large degree, those views match what has been suggested in the theoretical nursing literature: Nurses see spiritual care as part of whole person care in health care (Lundmark, 2006a; Strang et al., 2002; Taylor et al., 1994), as supporting a patient in his or her cultural religious beliefs and practices (Taylor et al., 1994; Narayanasamy & Owens, 2001; Kuuppelomäki, 2001), and as alleviating patients' suffering that occurs in relation to the illness experience through emotional care and promoting transcendent qualities such as hope, peace, and meaning (Taylor et al., 1994). Nurses recognize the value of their own presence in relation to spiritual care and highlight silent presence, touch, as well as verbal interactions and empathetic listening as ways of being present (Narayanasamy & Owens, 2001, Taylor et al., 1994). Nurses also believe that spirituality and spiritual care are about facilitating patients' relationships both in terms of the transcendent as well as the horizontal dimension of interhuman relationships (Taylor et

al., 1994). Nurses understand that spirituality may be connected with religion for some patients and totally disconnected from organized religion for others, and they emphasize their role as supporting both groups (Narayanasami & Owens, 2001; Taylor et al., 1994). Similarly, there are nurses who comfortably pick up the religious part of spirituality in their spiritual care, and those who tend to be uncomfortable or helpless with religious aspects.

Overall, existing studies suggest that nurses acknowledge the importance for nurses' spiritual care in certain situations and express a general willingness to provide such care. However, there appears to be a gap between this attitude and nurses' perception of what is happening in actual practice (Kuuppelomäki, 2001; Strang et al., 2002).

Nurses' perceptions of their own spirituality. Several studies report nurse samples that self identify as moderately to highly spiritual (Taylor, Highfield, & Armenta, 1999; Tuck, Pullen, & Wallace, 2001; Stranahan, 2001, Vance, 2001). Some nurses see themselves as "spiritual but not religious" (Grant 2004); however, in several studies the majority of nurses self identified with some religious tradition (Kuuppelomäki, 2001; Taylor et al., 1994). These factors may explain in part the positive attitude toward spirituality in the nurses surveyed. It must be acknowledged, however, that considerable differences exist in how nurses' spirituality has been explored across studies. For example, Strang et al. (2002) simply made some general remarks about religion in Sweden but did not describe their sample in terms of religiousness and spirituality. Similarly, Narayanasamy and Owens (2001) did not describe their nurse sample in terms of spirituality. Kuuppelomäki (2001) simply described her sample in terms of affiliation

with the Evangelical Lutheran Church of Finland as Christian. Taylor et al. (1994) asked how much nurses perceived themselves as spiritual or religious in addition to inquiring about the tradition of faith with which nurses identified. Moreover, they inquired about nurses' habits in attending worship services. Lundmark (2006a) asked if nurses believed in God and in afterlife and also extended the question to private religious practices other than worship service attendance.

Across studies, a number of useful measures to assess nurses' spirituality have been suggested. The measures varied across studies and differed in the religious cultural climates of the countries in which the studies were conducted. Therefore, it is difficult to draw inferences from the existing information about nurses' spirituality and religiousness. Because some of the research results suggest that nurses' personal spirituality may be related to spiritual care practices, future studies should assess this information carefully with a number of measures.

Factors leading nurses to respond or not respond with spiritual care. Two comprehensive qualitative studies analyzed a number of direct and subtle observations of nurses leading them to offer spiritual care when perceiving a patient in spiritual distress or as a religious person: Taylor et al.'s (1995) findings about triggers for spiritual care in U.S. oncology nurses match what Narayanasamy and Owens (2001) found in the United Kingdom. Similarly, the Swedish study by Strang et al. (2002) with a diverse nurse sample identified severely ill and dying patients as being in need of spiritual or existential support. Swedish nurses also mentioned immigrants who practiced their religion as a group of potential recipients of spiritual care; however, these studies only allow, to a limited degree, for inferences regarding patient cues that prompted nurses' responses.

Grant's (2004) study takes a different slant and a quantitative approach to the question, asking U.S. nurses to rate a given set of situations that lead them to respond with a spiritual intervention; overt requests of the patient or signs of crisis or dying were what triggered most spiritual care. Thus, Grant's (2004) findings supported Taylor et al.'s (1995) and others' findings about overt patient requests, death and fear issues as dominating concerns leading nurses to offer spiritual care. In addition, according to Grant (2004), nurses frequently pick up on religious cues they observed in a patient, whereas more general and subtle cues were acknowledged by a smaller number of nurses. Grant's research (2004) can be seen as confirming the concerns raised by Narayanasamy and Owens (2001) and noted in a nursing dissertation on the meaning of spirituality for terminally ill individuals with no religious affiliation (Noto, 2006) that nurses may overlook spiritual concerns in the absence of religious cues. Rather than overlooking, this apparent hesitancy to address spirituality in the absence of obvious religious cues can also be interpreted as a sign that nurses do not engage in spiritual care when they are not sure that patients desire such care (Harrington, 1995). Thus, it appears that when in doubt, the majority of nurses will not initiate a spiritual conversation whereas a minority will explore this approach if it seems helpful to the patient in a given situation. Additionally, it is noteworthy that Kuuppelomäki (2001) found a striking difference in the way that her Finnish nurse sample perceived terminally ill patients' spiritual needs. Although a little more than half of the respondents perceived that terminally ill patients expressed their spiritual needs often, a little less than half believed the same group of patients expressed these needs quite rarely. This finding raises concern about how often cues may not be recognized.

In conclusion, although nurses in research studies across the Western hemisphere demonstrate familiarity with cues that signal patients' spiritual needs, it is not known how this familiarity translates into actual spiritual care practice as far as frequency and types of spiritual practices are concerned. The fact that a fourth to a half of nurses may either not notice spiritual cues in a crisis situation (e.g., when dying) or may not respond raises questions about the practical relevance of spirituality in everyday hospital situations as well as in existential situations. Although it is possible that nurses underestimate the contribution they make to patients' spiritual well-being, future research ought to explore what nurses usually do in regard to spiritual care and what factors influence their practice. From existing studies, we cannot deduce that religious nurses provide spiritual care and less religious nurses do not. Therefore, a more differentiated approach is warranted to assess the spiritual/religious background of nurses to identify patterns and explore relationships with other variables.

Section Two: Predictors of Spiritual Care Attitudes

A number of studies exploring nurses' perspectives in regard to spirituality have also attempted to describe nurses' attitudes to spiritual care. Because nurses who are providing spiritual care usually also have a positive attitude towards spiritual care, the latter has not only become a popular measure in this type of research but also a proxy for actually providing spiritual care. Researchers have taken this a step further in asking: What are the predictors for attitude towards spiritual care?

Musgrave and McFarlane (2004a; 2004b) studied predictors for oncology nurses' attitudes towards spiritual care. In particular, they examined the role of nurses' spiritual well-being, nurses' religiosity (intrinsic versus extrinsic), and religious orientation

(secular, traditional, religious) in relation to nurses' attitude towards spiritual care. Their sample consisted of 155 oncology nurses who were members of the Israeli Oncology Nursing society. Ninety-six percent of them were Jewish, 58% classified themselves as secular, 21% as traditional, and 21% as religious (Musgrave & McFarlane, 2004a). The first part of the study used a descriptive design. Based on findings in the literature, they developed a theoretical model that was systematically tested by means of regression and path analysis.

Musgrave and McFarlane's analyses (2004a; 2004b) support the findings in the literature that nurses' spiritual well-being is a good predictor for attitude towards spiritual care both directly as well as indirectly and mediated through the variables of intrinsic and extrinsic religiosity. In fact, intrinsic and extrinsic religiosity accounted for the greatest contribution of indirect effects on attitude toward spiritual care. Extrinsic religiosity and education, however, also had a direct effect on attitude towards spiritual care, supporting the provision of education for nurses about spiritual care. It is noteworthy that the hypothesized indirect influence of the variables of age, ethnicity, and education on nurses' attitudes towards spiritual care was not supported.

Although the path analysis gives some clear ideas about predictors of nurses' attitude towards spiritual care, it is beyond the scope of this study to determine what this means for the actual likelihood of nurses with a positive attitude towards spiritual care to provide spiritual care. As intriguing and clear as their statistical model appears on its face, it must be noted that the results of the study are not easy to interpret. For example, the effect of extrinsic religiosity on nurses' attitude toward spiritual care has not been fully explicated in their report (Musgrave & McFarlane, 2004a). Part of the problem may

be that there is a considerable amount of overlap between related variables. Musgrave and McFarlane's (2003) goal was to explore whether findings from non-oncology nurses could be confirmed in an Israeli oncology nurse sample. With an almost entirely Jewish sample, however, the generalizability of these findings to other specialties, religions, and geographic areas is questionable, and as Musgrave and McFarlane (2004a) suggest, similar studies in different populations are desirable. Also, the literature points to the fact that a positive attitude toward spiritual care does not necessarily imply actual spiritual care practice as the researchers acknowledged in their recommendations. Therefore, more research is needed to determine whether these predictors and nurses' positive attitude towards spiritual care may actually be predictive of higher frequencies in attending to patients' spiritual needs.

Musgrave and McFarlane (2004b) also completed a descriptive, comparative analysis in the same sample of 148 Jewish oncology nurses with respect to their spirituality and religiosity. Spirituality was measured in terms of spiritual well-being and attitude toward spiritual care. Religiosity was differentiated as religious, traditional and secular, and as either intrinsic or extrinsic. Musgrave and McFarlane (2004b) found significant differences between religious, traditional, and secular nurses. Not surprising, the more religious nurses scored higher in intrinsic religiosity, spiritual well-being, and religious well-being. Secular nurses had the lowest spiritual well-being scores. There were no significant differences, however, between these levels of religiosity and nurses' existential well-being, which measures psychological well-being, or nurses' attitudes toward spiritual care. Musgrave and McFarlaine (2004b) reported that secular and traditional nurses had a more positive attitude towards spiritual care (although not

statistically significant) than did the religious nurses (who may feel that the realm of the spiritual should be reserved to teachers of the Jewish Law).

In conclusion, Musgrave and McFarlane (2004a; b) showed that religious, traditional, and secular Jewish oncology nurses differed significantly in relation to their spiritual and religious well-being and intrinsic/extrinsic religiosity. Furthermore, their study suggests that nurses' attitudes toward spiritual care are directly influenced by three factors: nurses' spiritual well-being, extrinsic spirituality, and education. It remains unknown, however, how all of these factors influence nurses' actual spiritual care practice.

Taylor et al. (1994) found a positive correlation between nurses' self-reported spirituality and religiosity and their attitude toward spiritual care in that nurses with higher spirituality/religiosity scores had a more positive attitude towards spiritual care. They also found that the variables of religious service attendance, ethnicity, and education correlated with type of interventions used by the nurse and with the nurses' attitudes and beliefs about patients' spirituality (Taylor et al., 1994). These study findings point to possible differences in attitude and approach to spiritual care depending on nurses' cultural/ethnic background. It would be interesting to know whether such differences in attitude and beliefs can be measured with other established tools and whether they actually correlate with differences in practices in a study that has a large enough sample size to allow for such comparisons.

Strang et al. (2002), who had asked 141 registered nurses, nursing auxiliaries, and nurse managerial staff of six different subspecialties of nursing in two geographical areas of Sweden about their perceptions of holistic care and spirituality, found an

overwhelmingly positive attitude towards holistic care. A fourth of the nurses, however, were not sure holistic care included the spiritual dimension, and only about half thought this type of care existed on their unit. Similarly, they described a discrepancy between 87% who affirmed clearly that staff ought to consider patients' spiritual needs and 42% who felt this actually happened on their unit. Lundmark (2006a), commenting on Strang et al.'s (2002) study results, noted that their findings match what he had found in a third geographic area of Sweden exploring oncology nurses' attitudes toward spiritual care and believed that the findings could be seen as representative for Swedish nurses' attitudes toward spirituality and holistic care.

Strang et al. (2002) also explored differences in opinion on attitudes towards holistic care by age, unit type, and type of occupation. No significant relationships were found between attitudes to holistic care and unit type/subspecialty of nursing, nor were there any age-related differences in perception of holistic care. They did, however, report, that registered nurses were particularly willing to address spirituality with patients.

In sum, Strang et al.'s (2002) study findings represent a very heterogeneous group of nurses in several aspects: area of subspecialty and level of education plus function. It remains unclear whether the subgroups were too small to yield any statistically significant relationships (in other words, a Type II error). Therefore, future research ought to explore differences in relation to background variables of the nurse or the environment. In fact, a next step might be to differentiate the large heterogeneous group of nurses to understand better what different sub-groups of nurses have to offer in the realm of spiritual care. Also, future research building on larger sample sizes needs to either confirm Strang et al.'s (2002) findings in different geographical areas or establish

there is indeed a relationship between area of subspecialty and nurses' attitudes in a different population. This finding clearly points towards a need for larger quantitative studies that shed light on factors associated with attitude to spiritual care.

Last, the study points to a phenomenon that had already been described in earlier research by Piles (1990), which is also cited by Strang et al. (2002): there appears to be a discrepancy between nurses' positive attitudes towards spiritual care and the actual occurrence of spiritual care in nurses' bedside practices. Clearly, Strang et al.'s (2002) study can be criticized for using a very heterogeneous sample with only 50% of the nurses working as registered nurses at the bedside. It is unclear whether measures of registered nurses' perception of frequency of implemented holistic care would have been higher than what Strang et al. (2002) reported if they had surveyed registered nurses working at the bedside only.

A follow-up survey of attitudes toward spiritual care among Swedish oncology nursing staff was done by Lundmark (2006a), confirming several of Strang et al.'s (2002) findings about Swedish nurses' generally positive attitudes toward spirituality and holistic care. His sample was more homogenous and also quite a bit smaller, consisting of 68 Swedish oncology nurses on four wards of a university facility. Lundmark (2006) took the study a step further in systematically testing influencing factors of spiritual care and indicators of attitude toward spiritual care. The three factors influencing the highest number of indicators of spiritual care were non-organized religiousness, faith in God, and sentiments of being at ease when giving spiritual care. Lundmark's (2006a) results suggest that nursing staff who believed in God and in an after life and who spent time

with activities like prayer, meditation, or reading the Bible tended to be more prone to giving spiritual care than those who did not.

Lundmark (2006a) compared registered nurses with nursing auxiliaries and found that nurses' professional education made a statistically significant difference in regard to self-reported frequency of spiritual care giving. Six out of 10 RNs versus 3 out of 10 nursing auxiliaries considered themselves giving spiritual care. These results are not very surprising given the differences in mode of education and scope of practice (Ross, 2006). Yet, it is interesting that those differences persisted, despite the two groups not differing significantly in background variables such as belief in God or non-organized religiousness.

Another finding of the Lundmark (2006a) study was that non-organized religiousness operationalized as private religious practice (time spent with activities like praying, meditation, or reading the Bible) was more positively correlated to any of the indicators measuring attitudes toward spiritual care than was organized religiosity. The researcher interpreted this finding with reference to the dominant Swedish culture's divide between believing and belonging. In other words, in a culture where the vast majority of people do not attend religious services on a regular basis, this study showed the importance of assessing personal religious practices of the health practitioner to capture their religiosity.

A more nuanced representation of spirituality and religiosity may also be advised for research on nurses in the United States in light of the changes in perception and habits in regard to spirituality and traditional religion (see Fuller, 2001; Roof, 1994; Wuthnow, 1998). It may be important to understand the role of personal spiritual practice in a

culture where spirituality may or may not be lived within a religious and organizational context to understand which form of religiousness may be correlated with attitudes towards spiritual care and actual spiritual practice. Differentiating between "organized" and "private" religiousness in a future study may allow for greater understanding of the facilitating and hindering factors in spiritual care giving.

Most at ease in giving spiritual care were nurses who affirmed that staff ought to be concerned with patients' spiritual needs, who believed that education in spiritual care was important, who self-reported to provide spiritual care sometimes too often, and who were confident about their ability to provide this type of care. Lundmark (2006a) measured a nurse's attitude towards spiritual care with eight questions that he referred to as indicators for attitudes towards spiritual care. These indicators were positively influenced by three factors, namely faith in God, belief in life after death, and organized or non-organized religiousness. A positive attitude toward spiritual care in turn seemed to be correlated with a higher degree of spiritual care practice.

In conclusion, although the identified relationships between variables in Lundmark's (2006a) study represented a very limited sample size, the findings are still in line with the results of a larger Swedish study (Strang et al., 2002) and are, therefore, not isolated. Lundmark has successfully contextualized his findings and revealed a facet of religiousness that the nursing literature has not paid much attention to thus far when perceiving religiousness as a more dichotomous variable rather than understanding its qualitative differences.

Summary and Discussion of the Findings across Studies

The previously reviewed studies show that nurses' spiritual and religious orientation influences their attitude toward spiritual care. At this juncture, however, there is no clear picture how these variables are related. Whereas Musgrave and McFarlane (2004b) reported that secular and traditional Jewish oncology nurses (i.e., less religious nurses) scored higher in attitude toward spiritual care than did religious Jewish nurses, Taylor et al. (1995) found that U.S. oncology nurses' self-reported spirituality and religiosity correlated positively with their attitude toward spiritual care. Interestingly, both studies have been conducted with oncology nurses, thus, raising the question about how nurses' spirituality, religious orientation, and spiritual well-being might influence nurses' attitude towards spiritual care in other subspecialties of nursing. In Lundmark's (2006a) study, both religiousness and non-organized religiousness contributed to a positive attitude towards spiritual care, which in turn was correlated with higher levels of practice of spiritual care. Strang et al.'s (2002) findings about a discrepancy between positive attitude and the actual practice of holistic/spiritual care may require cautious interpretation of Musgrave and McFarlane's (and similarly designed studies) that rely on "attitude towards spiritual care" as outcome measures. It remains to be demonstrated that a positive attitude also means more frequent practice.

Section III: Nurses' Spiritual Care Practices

Introduction

The existing research literature on nurses' spiritual care practices from the perspective of nurses comes primarily from the United States and Europe. Hence, the discussion at this point is mostly shaped by research perspectives about nurses'

perceptions of spirituality and spiritual care in secular countries like the United Kingdom and Scandinavia and is compared with U.S. American perspectives. Unquestionably, there are signs of an emerging global interest in the concept as reflected by studies of Australian (Harrington, 1995), Israeli (Musgrave & McFarlane, 2004a; 2004b) and, recently, Chinese (Chung, Wong, & Chan, 2007) nurses. The bulk of research still comes from the United Kingdom and the United States (see also McSherry, 2006).

The context for discussions of spiritual care appears somewhat different in the United States than in Europe or Australia. Despite secularization, the United States is still one of the most religious nations in the world (Fuller, 2001). More than 90% of Americans believe in some kind of Higher Power and report praying to God on a fairly regular basis (Roof, 1994). Sixty-two percent of Americans belong to some kind of church or religious institution, whereas less than 40% are not affiliated with organized religion (Fuller, 2001). As Fuller (2001) points out, many of the "unchurched" would still self-identify as strongly religious or spiritual on a personal level. Hence, any research on spirituality and spiritual care in the United States takes place in a cultural context where religion is prevalent, be it "organized" or "personal." Although many of the European nurses do not actively practice any religion despite nominal church membership (e.g., McSherry, 2006), substantial numbers of U.S. nurses would self identify as quite spiritual and religious (Tuck, Pullen, & Lynn, 1997; Tuck, Pullen, & Wallace, 2001; Tuck, Wallace, & Pullen, 2001; Taylor et al., 1994, 1995) and in their spiritual or religious habits and behaviors, nurses tend to reflect the larger societal trends (Gallup & Jones, 2000; Koenig, Bearon, Hover, & Travis, 1991; Zinnbauer et al., 1997). These reported differences in the spiritual cultural climate of the United States and the more secular

countries of Europe have implications for how nurses approach spirituality and spiritual care on the different continents. The following literature review highlights relevant studies of nurses' spiritual care practices from the nurses' perspectives in Europe before turning to studies from the United States, which set the stage for the cultural context of the proposed study.

European Research on Nurses' Spiritual Care and Perception of Spirituality

Ross (1994a) conducted a postal survey with 1170 Scottish nurses caring for the elderly. She attained a response rate of 67.8% and was able to use a total of 685 questionnaires for her analysis. Participating nurses defined patients' spiritual needs in terms of need for meaning, purpose, and fulfillment; giving and receiving love and forgiveness; hope and creativity; belief and faith; and peace and comfort. Relatively few nurses (38 out of 685) were unable to identify spiritual needs. Seventy percent of the nurses believed that spiritual needs were mainly communicated through non-verbal cues, and 77% had identified spiritual needs in the past. The formulation of the research question, however, did not allow for any inferences as to how often nurses saw themselves confronted with spiritual needs of patients and their families and how often they found themselves responding to those needs.

In response to observing spiritual needs, nurses suggested the following spiritual care interventions (Ross, 1994): respecting/meeting spiritual needs (6.8%); facilitating religious rituals (6.7%); listening and talking (6.5%); being with or caring, supporting, empathizing (18.8%); promoting a sense of well-being (9%), and referring to others (51.6%). Although few expressed difficulties in defining or giving spiritual care, about half of the participants were willing to get more intimately involved in spiritual care by

describing ways of caring in response to those needs. These interventions, however, appear not to differ much from what could also be labeled "psychosocial care." Furthermore, it is striking that more than half of the participants responded to perceived spiritual needs of patients by referring the patient to someone else. Nevertheless, over 90% of the nurses perceived themselves at least to some extent responsible for patients' spiritual needs. Almost 30% saw themselves as very effective in their responses, and over half perceived themselves as more effective than ineffective. Given that the majority would refer to someone else when confronted with spiritual needs, Ross (1994a) concluded that nurses appear to do better in the assessment of spiritual needs and evaluation of spiritual care than in getting personally involved in this type of care.

Ross (1994a) found four factors that were significantly associated with nurses' identification of spiritual needs: (1) grade, that is, bedside nurse versus charge nurse, (2) religious affiliation, (3) type of ward, and (4) geographical area. Hence, the following groups were more likely to identify spiritual needs than their counterparts: charge nurses (regardless of age and experience) versus regular staff nurses and nurses who identified with a religious tradition of faith versus those claiming none. Ross also noted differences between nurses working in a variety of environments versus those working in one type of environment only and between nurses working in different institutions and geographical areas. This difference raises the question of whether these same factors might be related to nurses' actual practice of spiritual care.

Ross (1994a) also explored what factors appear to be influencing nurses' spiritual care through twelve qualitative interviews with nurses. Her analysis led to a model that outlined four main influential factors: the nurse (personal spiritual awareness, past

personal experience of growth under impression of life crises, willingness to give of

himself/herself at a deep personal level, particularly sensitive/perceptive people), patient

(condition of the client), environment (physical, staff, shifts), and other professionals

(availability, skills, communication). This model seems coherent but requires testing in

future research.

In sum, Ross' (1994) research showed variation in spiritual care practices. Some

nurses limited spiritual care to general behaviors that might touch the spiritual dimension,

whereas others demonstrated comfort in interacting with the patient's spiritual/existential

quests for meaning in the face of loss and suffering. Likewise, the degree of personal

involvement and nearness of the nurse varied across caregivers and situations. Overall,

Ross found that nurses who were personally invested in providing spiritual care and who

were able to outline a broad range of spiritual responses to patients' spiritual needs were

likely to show more of the following characteristics: they had higher amounts of spiritual

awareness in their own lives, they had experienced personal crisis and grown under these

experiences, they were willing to invest themselves at a deep and personal level, and they

were particularly sensitive/perceptive people. By contrast, nurses who were less invested

in spiritual care giving showed these characteristics to a much lesser degree. Ross

(1994a) concluded that personal characteristics of the nurse may be more influential than

environmental and other factors. Future researchers should explore how these factors

interact in determining nurses' actual spiritual care practice.

McSherry (cited in McSherry, 2006) reported on a large descriptive study where

he surveyed a total of 1029 British nurses in a large National Health Service Trust; 559

questionnaires were returned by nurses yielding a response rate of 55.3%. McSherry

(2006) included "nurses of all grades" (p. 189) and distinguished between 72% "qualified" and 28%"unqualified" nurses; however, he does not give further explanation regarding the educational difference between both groups of nurses. Three-quarters of the qualified and one-eighth of the unqualified noted that they were identifying patients' spiritual needs. Nurses also reported that patients' would alert them about their spiritual needs, and most of the nurses reported giving spiritual care. Over fifty percent had not been prepared for this role through their nursing curricula. The majority of nurses preferred a team approach with shared responsibility for spiritual care. The generalizability of these findings is limited because the findings represent a mixed group. It seems therefore reasonable to follow Ross' (2006) recommendation to limit the sample to registered nurses (RNs) in future studies instead of mixing the perceptions of two groups of health care professionals with different educational backgrounds and job descriptions.

To assess nurses' spiritual care practices, McSherry, Draper, and Kendrick (2002) and McSherry (2006) developed *The Spirituality and Spiritual Care Rating Scale* (SSCRS). The scale operationalized spiritual care interventions as arranging for clergy; having the chaplain visit; showing kindness, concern, and cheerfulness; spending time with patients, giving support and reassurance; listening and allowing patients time to discuss beliefs, fears and troubles; respecting dignity and privacy. The final 17-item scale (six items were dropped) had an alpha coefficient 0.77. Although three-quarters of the sample identified with a formal religion, less than 30% were practicing their religion (McSherry, 2006). McSherry reported that nurses' religious beliefs and practices did not appear to significantly influence the provision of spiritual care.

Interestingly, McSherry's (2006) instrument operationalized spiritual care in such a way that there were no overtly religious intervention options (i.e., prayer) in his tool. Thus, McSherry's finding of no relationship may have resulted from the way spiritual care was operationalized. If spiritual care is operationalized as acts of listening and human caring, there is not necessarily a significant difference between secular and religious nurses. Nurses' underlying motivation may differ (i.e., Humanist versus Christian), but they may display the same behaviors. However, if a tool includes religious or for that matter even New Age interventions, then nurses who do not identify with the underlying worldview of a practice will not practice such interventions. Hence, such a tool is more likely to discriminate between different groups.

Narayanasamy and Owens (2001) investigated 115 nurses across different hospitals and health care settings in the United Kingdom regarding their responses to perceived spiritual needs of patients. After studying the descriptions of incidents where nurses had given spiritual care, the following four general approaches to spiritual care were characterized:

1. Personal approach: As the nurse builds a trusting relationship, gives time and attention to individual patients with spiritual non-religious needs, the nurse becomes personally involved and uses a counseling approach. Spiritual care in this context means providing a safe place for patients who want to express feelings, thoughts, and questions that center around meaning and purpose in life. Narayansamy and Owens (2001) stress that this is the ideal model for spiritual care.

2. Procedural approach: If the nurse understands from the patient or the family that they actively practice their religion, chaplain and religious services are offered to meet their needs. Narayansamy and Owens (2001) describe this approach as directed through routine procedures with the nurse remaining rather impersonal and uninvolved. Furthermore, they raise the concern that nurses adhering to this approach might not recognize or respond to spiritual distress in a patient without religious cues.

3. Cultural approach: Nurses following this approach are particularly attentive to the religious cultural needs of minorities when hospitalized or dying. Nurses go out of their way to become informed as to what is important to these patients to accommodate for their needs as far as diet, space, and rituals are concerned. This approach is described as holistic practice.

4. Evangelical approach: Nurses sharing a similar religious background with a patient respond to the patient's spiritual distress by drawing on that mutual heritage of faith. Narayansamy and Owens (2001) portray this approach in a negative light and are concerned about nurses' imposing personal values on vulnerable individuals.

Narayansamy and Owens stressed that almost all nurses experienced positive effects as a result of providing spiritual care. In nurses' accounts, positive outcomes were noted in both patients and their families; however, facing limitations in time and resources to respond to identified spiritual needs in ways seen as appropriate also challenged nurses.

Although the identified four patterns of nurses' spiritual caregiving are an interesting research finding from a descriptive point of view, there are concerns about

Narayanasamy and Owens' (2001) conclusions. First, they assume that nurses' descriptions fit neatly within their four categories, not allowing for mixed types or ambivalent cases. Because the proposed categories are not mutually exclusive, questions about the rigor of the qualitative method used emerge. Were both researchers categorizing all the incident reports independently from each other? If so, how was consensus on categories achieved, and what were the checks, if any, for reducing subjective bias? Second, from the way Narayanasamy and Owens (2001) describe the categories, there appears to be bias against two of the suggested categories. This potential bias is evidenced by the way labels of the two categories are named. Such labeling raises questions regarding implicit, non-transparent criteria for evaluating the critical incidents. On what basis do the researchers then draw the conclusion that the personal and cultural approaches are the only ones deserving future development? Usually this type of value-laden conclusion is not derived from qualitative data. One would assume that the fittingness of spiritual care practices would be evaluated by care recipients provided the study is appropriately designed.

Third, ethical concerns could be raised in several of the referenced examples, yet Narayanasamy and Owens (2001) only refer to ethical concerns in their fourth category. Selecting and highlighting a negative case to portray a category is not likely to be representative of the data. One would expect that the researchers would not choose from the fringes but would find the most poignant examples to illustrate each type of the described categories in the clearest possible way. Here, again, is an example of what appears to be a biased view and a biased methodological approach to what constitutes appropriate spiritual care practices.

Last, the authors' conclusion that nurses' spiritual care was delivered in an unsystematic way and seemingly arbitrary is surprising and appears unsupported based on the research findings presented above. With 88% of the nurses giving a detailed report of something they experienced and did, as well as a specific description of a spiritual or religious clinical situation, it is unclear why the authors state "that there is confusion over the notion of spirituality and roles related to spiritual care" (p. 454). Clearly, the qualitative analysis of the incident reports was possible and was based on specific cues described by the nurses leading the researchers to interpret the data and to identify and describe patterns. It would have been more helpful had Narayanasamy and Owens (2001) explicated their assumptions and prior views about spiritual care before conducting the study. As it appears from their conclusions, a large portion of the described incidents did not meet their expectations. Although the purpose of the study was to describe nurses' understanding of spiritual needs and to typify nurses' involvement in spiritual dimensions of care, it appears after reviewing this study, and based on the issues pointed out in this critique, that the researchers also intended to evaluate the appropriateness of the care. If evaluation was indeed the aims of the study, it would have been more appropriate for the researchers to state their criteria of appropriateness and revise the purpose statement to encompass their additional goal.

Narayansamy et al. (2004) conducted a similar study – descriptions of critical incidents – with a convenience sample of 52 nurses who worked with elderly patients. They confirmed much of the findings of the previous study (Narayanasamy & Owens, 2001) with the same cues that led nurses to initiate spiritual care and the same outcomes, that is, positive effects on patients and their families as well as on the spiritual caregiving

nurse. Elderly patients' spiritual needs were conceptualized by these nurses around the terms need for respect for religious beliefs and practices; need for absolution or forgiveness; need for connectedness and harmonious relationships; need for comfort and reassurance; need for healing, meaning, and purpose (Narayanasamy et al., 2004). The authors identified two main categories that summarized the interventions suggested to meet elderly patients' spiritual needs: one, respect for patients' spiritual needs, including respect for patients' privacy and dignity, and, two, helping strategies that included helping patients to complete unfinished business, listening to their concerns, comforting, and giving reassurance. As in the previous article, the researchers continued to be concerned about two issues: one, a conceptualization of spiritual care that is not clearly delineated from religious care and, two, the role of nurses' personal (Christian) beliefs affecting their spiritual care practices. For these researchers, then, a generic approach to "spiritual care" is preferred. If an inductive approach is taken seriously, nursing academics need to be open to learn what bedside nurses tell them.

Kuuppelomäki (2001), in a study of 328 Finnish nurses in 32 health centers across Finland, found that nurses were split nearly equally when it came to providing spiritual care: 48% reported providing spiritual support to dying patients often, whereas 52% rarely provided spiritual support. Most nurses saw themselves providing spiritual care by facilitating patients' participation in spiritual events on the ward or in the Holy Communion (Kuuppelomäki, 2001). Such activities allowed the nurse to be helpful from a neutral position where his or her own spiritual convictions remained unidentified and where the nurse did not have to personally engage in practices with the patient. More than half of the respondents (56%), however, reported having discussions with patients about

the meaning of life very or quite often, yet less than 30% reported having discussions about God or life after death with the patient very or quite often. Most nurses preferred to refer to the chaplain rather than discussing religious issues.

Practices that Finnish nurses engaged in "rarely" or "not at all" were reading the Bible, praying with patients, singing spiritual hymns with the patient, or taking spiritual literature to the patient. In light of the fairly homogeneous religious population of Finland, where 90% of the patients and 90% of the nurses self identify with the same Christian religion, the Evangelical Lutheran Church of Finland, this is an interesting finding. By comparison, in the United States where patients and nurses belong to hundreds of different religious groups, Grant (2004) found prayer to rank fourth after holding a patient's hand, listening, and laughter as spiritual interventions. In fact, 71% of the nurses had practiced or else suggested prayer in the past. Tuck, Wallace, and Pullen (2001) in a national sample of parish nurses reported that prayer was consistently the primary intervention made by this group of nurses. These findings may point towards differences between nurses practicing in different cultures.

Kuuppelomäki (2001) also searched for factors associated with the provision of spiritual support. She compared the mean of the summed variable that measured spiritual support of terminally ill patients for nurses working in small, medium, and large health centers. Factors associated with higher scores of nurses' spiritual support in Kuuppelomäki's study were frequency of taking part in training seminars about care of terminally ill patients, whether the nurse had read literature on death and caring for terminally ill patients in the past year, or whether nurses regarded religious values as important. She found that nurses working in large health centers scored significantly

higher in their mean score of spiritual support than did nurses working at small and medium-sized health centers. Such findings were explained by large health centers' development efforts to raise the standard of care so that nurses in those centers were more likely to have attended training on care of terminally ill patients or to have read literature on death and dying than nurses at the smaller sites.

In sum, Kuuppelomäki's (2001) study shows that organizational factors such as health centers' catchments and efforts to develop a strong profile in terminal care as well as educational efforts to provide further training for nurses showed a significant positive relationship with nurses' spiritual care mean scores. Factors not associated with the provision of spiritual support were the demographic variables of age and work experience.

Kuuppelomäki (2001) also asked nurses an open-ended question about problems they experienced in providing spiritual care. Content analysis of 219 references given by 185 nurses revealed that most of the problems (75%) nurses perceived had to do with the nurses themselves, 19% were patient related, and 6% had to do with difficulties in contacting the chaplain. Among the problems related to nurses themselves, doubt about nurses' skills and competencies ranked highest. Nurses also commented on finding it difficult to identify patients' spiritual needs, all of which highlight the need for additional education for nurses. The main resource problem was shortage of time. Lack of religious convictions were cited as was strong diverging religious convictions. The three nurses' beliefs that were the greatest barriers to spiritual support were that spirituality was not part of nursing, that religion was a taboo subject or private matter, and that for spiritual support to be effective, the patient needed to take the initiative. Among the problems

related to patients, the inability of patients to express spiritual needs ranked highest, followed by difficulties related to diverging convictions between various parties involved. In conclusion, Kuuppelomäki (2001) stated that the overall spiritual care delivered by Finnish nurses was quite modest. Future research should explore actual frequencies of practices with standardized instruments that allow for comparative studies. Furthermore, future research should expand on the predictors found in the qualitative analysis and test if they are statistically relevant in another sample.

Carroll (2001), exploring nurses' perceptions of the nature of spirituality and spiritual care, conducted semi-structured interviews with 15 hospice nurses in the U.K. and analyzed the data following a heuristic phenomenological approach. Based on her interviews, she described spiritual care as a holistic integrated practice that sought to recognize and assess spiritual needs, demonstrate empathy, and develop a trusting relationship. Spiritual care from a hospice nurse perspective was interdisciplinary in nature with consultation with other professionals, such as physicians and chaplains. Furthermore, spiritual care was about recognizing when to let the patient be, referring to certain loneliness in dying that cannot be bridged. Last, spiritual care was about fostering the search for meaning. Overall, the study described qualities that may be helpful to define the concept for hospice nursing.

Summary of the European Studies

The studies from Europe have first of all sought to reveal nurses' understanding of spirituality and spiritual care. This phenomenon has been commonly studied through qualitative (Carroll, 2001; Narayanasami & Owens, 2001; Narayanasami et al., 2004) and mixed methodologies (Ross, 1994a). Three of the reviewed studies also used quantitative

methodology with large sample sizes (N=685, N=559, N=328). These studies have laid some groundwork for theory and instrument development upon which further research can and should build.

The studies with adequate sample sizes have included nurses who either worked with elderly (Ross, 1994a) or terminally ill patients (Kuuppelomäki, 2001); a context in which death is imminent and therefore the notion of spiritual care may not be challenged. McSherry's (2006) sample, however, was acute care and more heterogeneous. His study included nurses of different subspecialties of a large hospital. He also included nurses who appeared to have no formal training in nursing ("unqualified nurses"); however, his analysis did not differentiate between level of education or specific workplace. Narayansamy and Owens (2001) included a diverse sample of nurses with regard to work environment, yet they did not differentiate by work environments, either. This seems to point towards a need for future research in acute care rather than at the end of life and across the spectrum of nursing specialties. Ideally, future research will include the perspectives of many nurses even within the same organizational context to explore whether there are differences in nurses' spiritual care behavior in relation to work environment/specialty of nursing. This conclusion is also supported by McSherry (2006).

There seem to be three main interpretations of nurses' spiritual care roles that dominate the European perspective: one, nurses saw themselves in a triage position assessing spiritual needs and making sure that spiritual needs were met. These nurses were aware of the importance of spiritual needs being met; however, many believed that they did not have the tools to personally respond to those needs and responded by making referrals to appropriate others. Two, patients' spirituality was seen as a cultural

characteristic of the patient. Assuming that the patient was aware of his or her cultural needs, the nurse was willing to support rituals or special wishes. In this case, the nurse remained in the personally neutral position of a facilitator of patients' spirituality. There were concerns, however, in the research literature that nurses may overlook cues for spiritual needs if the patient is not religious or not aware of or unable to verbalize such needs, or if those needs are communicated in a masked way. The third interpretation of the role was one that responded to the suffering and spiritual distress through ways of doing and ways of being that expressed compassion, kindness, openness to listen following the caring paradigm which historically characterizes the nursing profession.

For some nurses, it was mainly about these qualities of being with the patient, whereas others were comfortable engaging with the patient in his or her spiritual practices such as prayer, affirming faith, or reading scripture. Such religious practices, however, were not reported as common practices in Europe (Kuuppelomäki, 2001). Some critical reflection about a religious interpretation of spiritual care surfaced also in some research reports (Narayanasami & Owens, 2001). Kuuppelomäki's (2001) remark that praying with patients is not part of the dominant Finnish culture raises the awareness that future research will have to take cultural considerations into account when evaluating nurses' spiritual care practices. To date, the European research is ambivalent regarding the role of nurses when dealing with the religious aspect of spiritual care beyond the perspective of religion as a cultural patient characteristic. Ambivalence also characterizes what is reported on nurses' personal spiritual orientation in relation to spiritual care practices. Future research will have to explore this area further.

U.S. Research on Nurses' Spiritual Care and Perception of Spirituality

A national study on cancer nurses' perceptions of spiritual care by Taylor et al. (1994) was presented in detail in the first section. Out of their 181 nurses, 85% provided a definition of spiritual care. Qualitative analysis of the sample's perceptions about spiritual care revealed the following themes: promoting well-being, respecting and supporting patients' beliefs, providing emotional care in suffering, promoting peace/meaning/hope, sharing self through presence, facilitating relationships, and religious needs. Most respondents had some subjective understanding of the concept, whereas a few were unable to define it. Participants noted that spiritual care served the purpose of growth, coping, well-being, and facilitating relationships. Many participants defined spiritual care by identifying typical interventions. Most frequently they described verbal interactions with the patient, active listening, and encouraging patients but also making a referral and facilitating religious practices such as prayer. A recurrent theme was nurses' conviction that spiritual support meant supporting patients' beliefs regardless of whether or not they were religious (Taylor et al., 1994).

Scott, Grzybowski and Webb (1994) explored perceptions and practices of registered nurses in regard to chaplains' services and spiritual needs of hospitalized patients by means of a self-administered questionnaire in a large metropolitan, non-faith-based hospital. In addition to asking their sample of 280 nurses representing about 41% of the total RN workforce about their awareness and perception of pastoral services of that hospital, they explored nurses' ways of assessing and responding to patients' spiritual needs. Furthermore, they collected data on participants' demographics, educational background, employment status as well as personal religious beliefs and

practices. Last, they investigated the interface between nursing and pastoral care by asking about reasons for consulting pastoral care services and inquiring about the perceived efficacy of this service in meeting patients' spiritual needs. Because nurses surround the patient 24 hours a day, they are likely to be in a triage position when noticing patients' spiritual distress. Hence, nurses' cooperation with chaplains' services can be seen as an important indicator of nurses' sensitivity for spiritual issues in whole patient care.

In this study, almost three-fourths of the nurses had consulted with pastoral care at least once (Scott et al., 1994). It is unknown how the remaining 25% percent of the nurses, who had never collaborated with pastoral care, would deal with patients' spiritual needs. Furthermore, the research report does not reveal what portion of the nurses referred patients on a regular basis. Reasons for involving pastoral services included seeking pastoral support for patients and their families in times of death and emergency or when religious rites were requested. Another typical situation was in the case of patients who were fearful or anxious.

Although the study was conducted in a secular workplace, the vast majority of nurses (87%) identified with one of the Christian faiths, and 50% attended religious services at least 2-3 times per month (Scott et al., 1994). Most surveyed nurses expressed the belief that it is important for the nursing process to include attention to patients' beliefs and values (86%) and to assess patients' spiritual needs (87%). Further analysis revealed that those who believed in the importance of patients' spirituality assessed spiritual needs on admission 4.7 times more often than those who did not believe in the importance of spirituality. Those who believed spiritual assessment was important were

more likely to develop a care plan that included the spiritual dimension for their assigned patients (Scott et al., 1994).

The research team found discrepancies between perception and actual behavior, however; for example, there was a discrepancy between nurses' perceptions of situations in which they saw chaplains' support as useful and their actual practice of consulting pastoral care. Likewise, whereas nearly all nurses agreed with the practice of spiritual assessment at the time of admission, only half of them would consider patients' spiritual needs on the actual care plan. In sum, Scott et al.'s (1994) research shows that nurses' expressed attitudes do not necessarily drive behavior. This discrepancy challenges the assumption that a positive attitude is an appropriate proxy for actual spiritual care giving, which raises an important question: "What are the characteristics of nurses who make a positive statement about the importance of spiritual care and who are at the same time committed to the actual practice of it?" It will be necessary to probe all the measures that have been predictive of actual practice of spiritual care in this and other studies and to differentiate nurses more than has been done through superficial religious measures such as religious affiliation and attendance at church services. Furthermore, the question arises whether nurses may set different kinds of priorities in a non-secular environment.

Kristeller, Zumbrun, and Schilling (1999) surveyed 267 oncology nurses in Indiana regarding their practice in addressing spiritual distress/emotional distress. Almost half of them (47.5%) saw themselves responsible for addressing patients' spiritual distress. Furthermore, three-fourths of the oncology nurses rated their effect on patients' spiritual distress between "some" to "a lot." Nurses who reported addressing patients'

spiritual distress also reported significantly higher levels of perceived positive effects of their spiritual care than nurses who tended not to address patients' spiritual distress.

Oncology nurses rated several interventions that they would choose when seeing a patient in spiritual distress (Kristeller et al., 1999). Thirty-nine percent of nurses noted that they would discuss the issue in detail with their patients followed by 37% who would make a referral to a chaplain. Twenty-seven percent would inform the patient about local resources, and 11% would suggest the patient seek help. Only a few nurses would typically not address spiritual/existential distress (9%) or would respond by offering an educational brochure to the patient (7%). Over 90% of the nurses asserted that ideally there should be a chaplain available to address these issues. Almost two-thirds reported consultation with a chaplain on a regular basis in an inpatient setting where chaplains were easily accessible.

Nurses were also asked to rank order 18 psychosocial interventions across three different vignettes (Kristeller et al., 1999). The vignettes included one in which the patient had a good prognosis, a second in which the patient had a moderately good prognosis, and a third in which a patient had a poor prognosis. Facing competing demands and a limited time of just ten minutes to talk with the patient, few of the nurses opted to place "addressing spiritual/emotional distress" among the top three issues. Interestingly, spirituality did not receive a higher ranking on nurses' "to do" list when the vignette reflected a poor prognosis.

Although the vignettes were hypothetical cases, they show how oncology nurses prioritize under experimental conditions. The findings illustrate a disconnection between seeing oneself largely responsible for addressing patients' spiritual distress and a

moderate to low priority given to spiritual distress. Kristeller et al.'s (1999) assessments (e.g., how nurses are likely to prioritize given limited time resources) were, however, very creative.

The spiritual interventions for spiritual distress in this study do not allow for much differentiation; however, they highlight possible responses of the nurse. These interventions were to ignore the client's spiritual distress, to refer the client to chaplains or other resources, or, third, to listen and talk with the patient about spiritual concerns. These interventions reflect a progression of spiritual awareness and willingness to listen to spiritual concerns. The numbers found in this study regarding willingness to offer spiritual support and cooperation with chaplains are very similar to what Scott et al. (1994) found. The study makes a contribution in illustrating the gap between nurses' conviction of their own central role in addressing spiritual distress and the relatively low priority assigned to spiritual care in the hypothetical clinical situations. Although the researchers did not provide much detail regarding spiritual care interventions, Kristeller et al. (1999) did identify a predictor, "perceived impact when providing spiritual care," upon which future research can build.

Sellers and Haag (1998) conducted a study to explore what interventions are implemented by registered nurses to enhance patients' spirituality. Their study targeted nurses they believed to be most prone to implement spiritual care: oncology, hospice, and parish nurses. Seven hundred and fifty questionnaires were mailed to nurses in three Midwestern states. The nearly 30% response rate constituted a sample of 224 nurses; 208 were usable.

The vast majority of nurses were women and Caucasian. The mean age was 49 years, ranging from 28-73 years, and years of nursing experience ranged between 1-52 years with a mean of 23 years. The majority of respondents were practicing parish nurses (58%), 12% worked in oncology, and 15% in hospice nursing. The remaining participants worked as educators, nurse practitioners, or in a variety of community-based health care settings.

One hundred and seventy-nine respondents identified a total of 95 interventions that were sorted and clustered by the research team (Sellers & Haag, 1998). Approximately14% of the respondents did not identify any intervention. The number one intervention identified was referral to a minister, chaplain, or spiritual advisor followed by prayer in all its different forms. The next group of most frequently mentioned interventions centered on communication, such as active listening, therapeutic communication that validates clients' feelings and thoughts, and conveying an accepting, non-judgmental attitude. The following interventions were instilling hope, spiritual assessment including clarification of spiritual values, touch, and presence. Last, referral to other community resources was the tenth most frequent intervention listed.

Participants were asked to rank order the interventions previously outlined in order of the frequency that they were implemented in their own practice: active listening ranked highest followed by spiritual history. Various forms of therapeutic communication and use of self and prayer followed. Respondents named a variety of other religious interventions that they would practice, which the research team recognized as being potentially reflective of the over-representation of parish nurses in the sample.

Sellers and Haag's (1998) exploration of nurses' perception of spiritual care highlighted that nurses are aware of several methods that can be used to address patients' spiritual needs. This research points towards a typology of nursing spiritual care interventions that could be used as a basis for future quantitative research. The attempt to quantify practice through rank ordering of individual practices, however, did not yield conclusive results. For one, those frequencies are averages of a diverse group of oncology, hospice, parish nurses. This raises the question: To which group of nurses are those frequencies generalizable? Is it not more likely that they differ in their preferences for spiritual care interventions?

Tuck, Pullen, and Lynn (1997) conducted a study of 50 mental health nurses' descriptions of incidents to each of the following categories: (1) an ideal spiritual care situation, (2) a general spiritual care situation as it might typically happen in a specific population, and (3) an actual spiritual care intervention that had been provided within the last two weeks. Qualitative analysis revealed the following categories of spiritual care interventions: (a) nurses being with patients, (b) nurses doing for patients, (c) nurses encouraging patients to look inward, (d) nurses encouraging patients to look for outward resources. All but seven participants would describe an ideal situation, and all but two would describe a general situation. An actual spiritual care situation that happened within the previous two weeks, however, was only described by 31 participants. Nurses' reflections of an ideal situation were largely about the "being aspect" of spiritual care, whereas the general situation was described in terms of facilitating patients' spirituality through "doing for" or "looking outward." The actual situation centered on being and doing for, with limited looking inside or outside.

In sum, the findings suggest that mental health nurses are potentially able to recognize spiritual needs, yet they may not readily intervene through spiritual care. This lack of intervention is illustrated by the finding of well described ideal situations, whereas only a little more than half of the participants gave specific descriptions of recently provided spiritual care. This finding raises questions about why mental health nurses exhibiting a high level of spirituality would report comparatively few cases of actual spiritual interventions. This finding also illustrates that nurses' perspectives about the value and legitimacy of spiritual care do not necessarily imply that they are invested in providing such care. Tuck et al. (1997) has interpreted these results as displaying nurses' level of discomfort, need for additional education, need for self awareness or lack of recognition on the part of the nurse of the broader dimensions of spirituality beyond religion, and nurses' awareness about separation between church and state in the public sector. It must be acknowledged that future research exploring this area in greater detail will have to answer whether these are indeed the factors that impede nurses' spiritual care practice.

Tuck, Wallace, and Pullen (2001) conducted a study in which they examined parish nurses' spirituality in relation to their spiritual care interventions in the context of their ministry for different Protestant and Catholic faith communities. Out of 305 mailed surveys, 137 were returned for a response rate of 45%. After dropping incomplete surveys, the research team was able to perform correlational analyses based on 119 participants. As in the previously described study, they also explored parish nurses' descriptions about an ideal, a typical, and a specific spiritual care intervention performed in the last two weeks.

Parish nurses reported very high mean scores in spirituality as measured by Reed's (1987) Spiritual Perspectives Scale (mean 5.65, range: 2.9-6.0, *SD*: 0.43) and Paloutzian and Ellison's (1982) Spiritual Well-being Scale (mean: 108.58, range: 64-120, *SD*: 11.96). Not surprising, the researchers (Tuck, Wallace, & Pullen, 2001) found significant correlations between the SPS and the SWBS in particular between the SPS and the Religious Well-being subscale (RWB). When asked about their most frequent nurse activities, providing spiritual care ranked fourth after screening, educating, and visiting, thus showing that providing spiritual care is seen as an important part of parish nurses' job descriptions. When describing an ideal, typical, and the most recent spiritual intervention, giving prayer was consistently reported as the number one intervention. Across the three categories of ideal, typical, and recent intervention, the research team created four large categories of spiritual interventions: religious (e.g., praying, offering spiritual service), interactional (e.g., being with, caring, instilling hope), relational (e.g., listening, encouraging, talking) and professional (e.g., assessing, referring, teaching). Clearly, religious activities were well embedded in parish nurses' professional self understanding, which highlights that the environment/context in which spiritual care is delivered may influence the type of spiritual care interventions delivered.

Vance (2001) conducted a descriptive correlational study featuring a stratified random sample of 173 nurses (response rate 40.7%) providing direct acute patient care in the areas of critical care, medical and surgical care, women's health and behavioral health nursing in a community teaching hospital of a large midwestern city. Her sample was predominately White (94%), Christian (88%), and female (90%). Three quarters of the participants had graduated from non-religiously affiliated schools of nursing and worked

either in critical care or medical-surgical nursing. About half of them held a baccalaureate or higher degree, and the majority of participants were in their thirties and forties (70%).

Vance (2001) surveyed nurses' attitudes and beliefs towards spirituality in relation to their spiritual care practice and explored barriers to spiritual care giving. To measure nurses' self-reported spirituality, Vance used two standardized instruments: the Spiritual Well-Being Scale (SWBS) (Paloutzian & Ellison, 1982) and the Spiritual Involvement and Beliefs Scale (SIBS) developed by Hatch, Burg, Naberhaus, and Hellmich (1998). To explore nurses' spiritual care practices and the barriers they encounter, Vance developed the Spiritual Care Practice Questionnaire (SCP) and correlated the instruments with each other to establish their validity and internal consistency.

Nurses' spirituality was measured by scores on the SWBS (possible range = 20-120 with a normative mean of 70) and the SIBS (possible range = 24-130; with a normative mean of 77). Nurses' mean scores were 101.7 on the SWBS and 97.1 on the SIBS; however, the standard deviations were not reported (Vance, 2001). Hence, their scores were clearly above the normative means, respectively – on average nurses classified themselves as quite spiritual. Vance (2001) also found a significant positive relationship between nurses' spirituality and nurses' delivery of spiritual care. Nurses' spiritual care practices scores showed that only 34.6% (*n*=60) of the nurses provided spiritual care at what had been established an ideal level, in other words, somewhere in between occasionally and often.

Vance's part II of the SCP Questionnaire explored nurses' perceived barriers to spiritual care that she had compiled from the literature and to which participants

expressed agreement/disagreement. Nurses determined that insufficient time (82.9%) was the strongest barrier to their involvement in spiritual assessment and intervention. Insufficient education was ranked second with 65% believing that they had not received adequate education to meet patients' spiritual needs. Third was the belief that spiritual matters are too private to discuss in the context of patient care. An important finding of Vance's (2001) study was a negative correlation between nurses' spiritual care practice (assessment and intervention) and perceived barriers. Hence, nurses who had a higher spiritual care practice score perceived fewer barriers to providing spiritual care.

Vance (2001) did not find any significant interaction between level of education and frequency of spiritual care. Neither was there an interaction between frequency of spiritual care practice and years of experience or training in a religiously or non-religiously affiliated school of nursing. She, however, found a significant correlation between areas of specialty; that is, nurses who worked in women's health scored significantly lower in spiritual care practice than did nurses of other nursing specialties such as critical care, medical/surgical, and mental health nursing. This finding suggests that clinical specialty is a potential correlate of spiritual care delivery.

In sum, Vance's (2001) research shows a gap between assessing spiritual needs and the actual delivery of spiritual care interventions. An important contribution of this study is that Vance actually quantified the proportion of nurses making spiritual care a priority in their practice and the positive relationship between spirituality and the delivery of spiritual care. In spite of relatively high scores in personal spirituality across the sample, spiritual care delivery does not seem a priority for most acute care nurses.

Surprisingly, Vance's (2001) research report does not expand on the kind of spiritual care practices her instrument assessed but sums all spiritual care delivered with a summary score that is then compared across participants. This approach emphasizes the overall delivery of spiritual care but leaves the reviewer wondering about the details, for example which practices were used the most or least. Vance (2001) discussed her findings in light of conditions in the contemporary hospital system; however, future studies should explore intrapersonal versus organizational barriers or facilitators of spiritual care practice. Barriers are potentially obscured by personal perception because, as reported in Vance's study, nurses who had occasionally-to-frequently provided spiritual care did not perceive barriers in the same way as those who refrained from providing such care. Future research might explore differences between nurses who provide spiritual care on a regular basis and those who do not.

Last, Vance's (2001) study makes a contribution by studying acute care nurses (rather than oncology, hospice, or palliative care nurses) in their specialized work environments. Her finding of a significant difference in regard to one clinical specialty encourages future research along the same lines with larger samples. Additionally, other factors such as nurse ethnicity should be explored as to whether or not they affect practices of nurses' spiritual care.

Stranahan (2001) explored nurse practitioners' self-reported spiritual care practices in Indiana using a modified version of Taylor et al.'s (1994) Nurses' Spiritual Care Perspective Scale (NSCPS) Part 1&2 and Reed's (1987) Spiritual Perspective Scale (SPS). Her sample of 102 nurse practitioners was on average 50 years of age and had

worked almost eight years as nurse specialists. Her female respondents (95%) self identified as highly spiritual (74%) and fifty-nine percent as very religious (59%).

The majority of the nurse practitioners provided spiritual care rarely or never (57%), and about the same number of participants stated their educational preparation for this role had been inadequate or somewhat inadequate. About a third of the respondents stated they were uncomfortable providing spiritual care. By contrast, about one fifth of the nurse practitioners saw themselves providing spiritual care on a daily basis, and 24% felt well prepared. More specifically, respondents rated their frequency of engaging in twelve spiritual care practices on a 5-point Likert-type scale. The most frequent spiritual intervention respondents cited was praying privately for a patient. Second ranked referral to clergy or religious leader, and third was to facilitate religious rituals of patients. By contrast, rarely would respondents mention spiritual needs in the medical progress notes, read spiritual/religious writings to the patient, or offer to pray with a patient. Stranahan (2001), therefore, concluded a preference for less direct, less personally involved spiritual interventions in nurse practitioners confirming what Taylor et al. (1994) had found in oncology nurses. Furthermore, the study confirms an aforementioned discrepancy in nurses' positive attitude towards spirituality while practicing spiritual care rarely.

Stranahan (2001) also found the greater the degree of spirituality in the nurses, the more frequently nurse practitioners provided spiritual care. SPS scores were significantly correlated with self-identifying as "very religious" (although not with self-identifying as "very spiritual"), with 9 out of 12 spiritual care practices and 8 out of 13 items on attitude about spiritual care. More specifically, this result means that the higher participants' perception of personal spirituality measured by the SPS, the more likely they were to see

spiritual care as a significant part of advanced nursing practice, that a person must believe in a higher power to be spiritually healthy, and that relationships with others are important to patients' spiritual health. Higher SPS scores were correlated to all practices except referral to chaplain, facilitating religious rituals, and mentioning spiritual needs in documentation. As noted above, documenting patients' spiritual needs was rarely considered by the nurse practitioners; however, the referrals and facilitating patients' rituals were practices nurse practitioners identified with frequently regardless of their spiritual/religious orientation. Clearly, there are options for nurses to attend to patients' spiritual needs even if they themselves are not spiritual in their orientation.

Stranahan (2001) acknowledges two shortcomings of the study: there are no measures to establish the validity and reliability of the data after her modification of the original instruments, and the researcher's definition for spirituality and religiousness that formed the basis for evaluating the analysis had not been shared with the participants. Thus, respondents would self-identify according to their own understanding of the concepts, which may differ from the researcher's understanding. A third criticism is that, in the conclusions, Stranahan (2001) suggested the need to address the problem of covariation of conceptual definitions in future research. She sees covariation as a problem because she fears that professional nursing may mistakenly address religious needs and engage in religious care instead of addressing spiritual needs and delivering spiritual care. Therefore, she suggested distinctions be made between the two concepts and emphasis be placed on the universal dimensions of spirituality. This position is not promising, however, because it seems impossible to achieve consensus on these definitions. In fact, there may be two basically different ways to conceive of spirituality and religion, and

patients and nurses are likely to agree with one or the other. This is the integrated view where spirituality and religion overlap to a varying degree and where one's spirituality is informed by one's religious convictions. Alternatively, people do not see religion as a relevant concept for their lives; however, they stress they see themselves as spiritual to varying degrees. Future research could yield relevant findings if differences in spiritual care practices were explored in relation to an integrated vs. "spiritual but not religious" view of spirituality.

Grant (2004) and Grant, O'Neil, and Stephens (2003, 2004) explored nurses' shared views of spiritual care from a sociological and organizational perspective rather than as a phenomenon of the individual nurse. They suggested that nurses who function as spiritual caregivers in the workplace essentially assume the role of a "clergy surrogate in a secular setting" (Grant et al., 2003, p. 485). This idea supports not only the reality of spirituality in a secular environment but can also be seen as neosecularization – a form of relocation of religious authority (Grant et al., 2003). By contrast, classical secularization theory cannot account for such a phenomenon because it assumes the progressive decline in religious authority in society and its organizations (Grant et al., 2003).

Grant (2004) asked 597 nurses in a large tertiary care acute medical center in the southwestern United States about the spiritual interventions they had ever provided. He aimed to provide descriptive data of nurses in regards to perceived efficacy of spirituality and the types of circumstances that would typically prompt them to offer spiritual care. Two hundred and ninety-nine nurses responded to his comprehensive research tool of 270 closed-ended questions. There was almost unanimous support among the nurses for the belief that spirituality could produce positive outcomes. Grant offered nurses a list of 24

spiritual therapies covering the whole spectrum of spiritual care practices described in the nursing literature and asked them if they had ever used them. The three practices that were used most by nurses were holding a patient's hand (92%), listening (92%), and laughter (84%). All of these could also be interpreted as good caring practices or psychosocial skills within the context of nursing. Furthermore, the wording of the questions did not allow for drawing any inferences regarding the frequency of use of practices by the nurses.

An interesting finding in Grant's secular research setting was that over two thirds of the nurses (71%) had at least once used prayer as a spiritual intervention. Prayer was most likely categorized as a religious, not value or worldview neutral practice. As such, prayer requires a certain underlying belief system or philosophy for one to be comfortable practicing it. It is unclear, however, whether prayer was practiced by the nurse in private or together with the patient. Moreover, it remains open whether this practice was patient or nurse-initiated.

The relatively common use of prayer can also be interpreted in light of Zinnbauer et al.'s (1997) research findings about religious/spiritual self classification of a worldview diverse group of Americans (N=346). With 74% of the sample self identifying as spiritual and religious, it may be that prayer is a spiritual/religious practice that was frequently asked for by patients who had to cope with illness and challenging health transitions.

Practices that had been used less were those in a New Age tradition such as repatterning (2%), chanting (4%), and energy work (9%) (Grant, 2004). By contrast, nearly half of the nurses (43%) had at least once engaged in the "therapeutic touch practice." The latter is also derived from the New Age paradigm, and therefore, not

worldview neutral. The high percentage of nurses using therapeutic touch may reflect the organizational culture of a secular university hospital "that has taken several significant steps to incorporate spirituality into its corporate culture" (Grant et al., 2004, p. 270). Nearly 41% of the nurses in this setting saw themselves as "spiritual *but not* religious." By contrast, in the Tuck et al. (2001), study nearly all nurses claimed a religious affiliation. Zinnbauer et al. (1997) found in his diverse sample of Americans that only 19% self identified as spiritual *but not* religious. Because the number of spiritual *but not* religious nurses matches almost the number of spiritual *and* religious nurses in Grant et al.'s (2004) study, the findings in regard to therapeutic touch may be interpreted as preference on the part of some nurses for these types of spiritual care practices. Future research should, therefore, explore if there are measurable differences in preferences for spiritual care interventions between nurses who self identify as "spiritual *and* religious" and those who self identify as "spiritual *but not* religious." In practice, nurses will want to be sensitive to the fact that the spiritual care practices they offer ought to match patients' spiritual orientation.

It must be noted, however, that in this study, the wording of questions related to spiritual care interventions does not allow inferences about the frequency of use of spiritual care at the bedside and the frequency with which nurses might not address spirituality. Grant et al. (2003, 2004) are adding to the discussion of spiritual care in nursing by demonstrating that personal piety and spirituality as well as organizational culture affect spiritual care practice in an organization. Rather than comparing practices at different sites, they explore differences within one organization and factors that might contribute to such differences (Grant et al., 2004). Although the authors of this study

interpret nurses' spiritual care as a sign of neo-secularization within a secular tertiary care setting, the findings do raise the question about how factors of personal spirituality and organizational culture may come together in a faith based tertiary care environment.

Cavendish et al. (2004) conducted a study following a mixed method design exploring U.S. nurses' spiritual perspectives and practices and educational needs through surveying a random national sample of 545 Sigma Theta Tau International Nursing Honor Society members. For this purpose, they triangulated three sources of data: nurses' demographic information, nurses' scores on Reed's Spiritual Perspective Scale (SPS), and qualitative analysis of nurse respondents' replies to the question: "Do you have any views about the importance or meaning of spirituality in your life that have not been addressed by the previous questions?" As a theoretical framework, the study outlines elements of Parse's theorizing on nursing; however, the linkages between those assumptions and their connection to the study variables of demographics, Spiritual Perspectives (the ten items are not listed), and the open-ended question (upon which a nurse can write anything that comes to mind) remain unclear.

The qualitative analysis of nurses' perceptions of spirituality revealed the following six categories: strength, guidance, connectedness, belief system, promoting health, and supporting practice. One of the central findings of this study is a correlation between the demographic variable "religious affiliation" and nurses' Spiritual Perspective Scores. Both male and female nurses with a religious affiliation had higher SPS scores than nurses without any religious affiliation (Cavendish et al., 2004). Furthermore, married nurses scored higher on the SPS than did unmarried nurses or those who lived with a partner. Last, agnostic nurses scored significantly lower in spirituality than any

other group under investigation. This result may not so much support Reed's assumption that "spirituality permeates one's life" (p. 208) as the nine researchers suggest (Cavendish et al., 2004), but it demonstrates how difficult it is to conceptually disentangle spirituality from religion. It is interesting to note that spirituality and religion tend to be highly correlated when measures of both are taken. Hence, findings like this point to overlapping concepts, so that nurses who score high in spirituality are most likely to be religious, too. The research team goes a step further when concluding that nurses who have a spiritual base are more likely to draw on this spiritual base in nursing practice. Strictly speaking, the research team introduces here an interesting new hypothesis. (Cavendish et al. (2004) yet can not show evidence that this is the case.) Future research must verify whether it is the religious nurses who score high in spirituality and how nurses' spiritual disposition plays out in actual attention to spiritual matters in nursing practice.

Belcher and Griffiths (2005) followed a descriptive qualitative design to explore the spiritual care perspectives and practices of hospice nurses. They obtained a national sample of 880 addresses of members of the Hospice and Palliative Nurses Association to which they sent a survey that contained 15 open-ended and demographic questions. A total of 204 returned questionnaires, resulting in a response rate of 23%. Respondents were predominately Caucasian, female, and on average 50 years old (Belcher & Griffiths, 2005). Study participants represented a broad range of professional and life experiences; for example, age ranged between 29-70 years, and the nurses completed their education between the 1950s to the present decade. The research team used the content analysis

method (Miles & Huberman, 1994) to reduce, code, and extract data. They also noted frequencies of contents mentioned and drew inferences from these.

With regard to the expression of spirituality in their personal life, nearly all participants described themselves as spiritual. In over two thirds of the respondents, this spiritual orientation found a religious expression on a personal level through activities such as daily prayer, Bible study and meditation, and an active role in church services and worship. Others mentioned nature, music, and art as the means to express their individual spirituality. Nevertheless, over 50% of the participants clearly described their spirituality in terms of a vital relationship to a "Higher Power." For many respondents, their personal expression of spirituality matched who they were and how they related in the work field. Professional expressions of spirituality centered on displaying a caring and positive attitude towards patients, families, and co-workers. On a practical level, this was communicated verbally and non-verbally through empathic listening, encouragement, and comfort as well as through prayer with a person or silent prayer for others.

A few respondents, however, were reluctant to initiate spiritual conversations, noting that they would keep their personal spirituality strictly apart from their professional life. Other expressions of spiritual caring were described in terms of humor, art, storytelling, and therapeutic/healing touch. Overall, the respondents reported little conflict between the realm of their personal spirituality and their professional life. In fact, participants indicated comfort with their role as spiritual caregivers in the hospice work setting; however, some indicated that this had not been the case until they started working in this area of nursing. When asked about their learning experiences about spiritual needs,

respondents referred to patients, families, and peers as agents through whom they gained deeper insight into the subject matter. Thus, the hospice workplace as well as personal life and spiritual experiences appeared to enhance hospice nurses' understanding about spiritual needs.

In an attempt to become more competent as spiritual caregivers, some engaged in self-directed journal reading or participated in special continuing education programs or seminars. In addition to autodidactic learning, the overall satisfaction with formal instruction during one's basic nursing education was low. Only one-fourth were satisfied with the level of preparation received from their nursing program. Interestingly, these respondents tended to have graduated from religiously affiliated nursing programs. In spite of their positive ratings of their nursing programs' instruction about spirituality, they also acknowledged the latter would not match their present more advanced needs as practitioners in a hospice environment.

The majority of respondents had completed a spiritual assessment at admission; however, modes of doing the assessment varied widely. Some asked the patients directly about their self perceived spiritual needs, some used formal assessment tools, and others relied on their own interview skills. Beyond that, nurses also observed religious practices and symbols patients exhibited. The main reason for not following through with a spiritual assessment was patients' or families' reluctance for this area to be addressed. Only few respondents cited their own discomfort and helplessness. Typical situations in which respondents felt uncomfortable in their interaction with patients were patient or family attempting to convert them, patient requesting prayer particularly with the expectation for healing, situations where nurses' own religious or professional beliefs or

even psychosocial skills were challenged (e.g., patient's belief in a punitive God, issues of suicide, or euthanasia). Some nurses found it challenging to care spiritually for someone with no religious preference or for an agnostic/atheist patient.

Overall, Belcher and Griffiths' (2005) study yields some interesting results in regard to hospice nurses' attitudes towards spirituality and spiritual care. The researchers support a previous finding that nurses working in this setting described a heightened awareness of personal spirituality and appreciated the integration of the spiritual dimension in the context of end-of-life care. As in other studies, expressions of spiritual care varied. Two factors, however, were foundational for nurses to feel at ease about this type of care: One was personal spirituality, and the second was a knowledge base upon which they could draw to provide spiritual support. Most respondents did not believe that their basic nursing education had prepared them for their role as spiritual care providers and outlined extended learning needs in regard to spiritual care in hospice.

Belcher and Griffiths (2005) drew a number of their conclusions based on the frequency of topics mentioned; however, their survey consisted of open-ended qualitative questions only. The fact that something was mentioned by a respondent may highlight the importance of that issue, but it does not imply the topic is not an issue when it is not. Hence, generalizations from frequencies must be cautioned, even more so in light of the large number of non-respondents (77%).

Another difficulty is to compare Belcher and Griffiths (2005) qualitative study with other studies that have been conducted in the field of hospice nursing. It seems that Belcher and Griffiths' (2005) results are from nurses who are spiritually oriented in their private lives and practicing spiritual care in their professional lives as hospice caregivers.

By contrast, Taylor et al. (1999), who surveyed hospice nurses a couple of years earlier and compared them to oncology nurses, concluded that both hospice and oncology nurses delivered spiritual care infrequently.

It remains unclear whether the differences in evaluating frequency and comfort level of hospice nurses' spiritual caregiving is due to a more pessimistic evaluation of frequency of nurses' spiritual care practice than Belcher and Griffiths' (2005) study or whether it reflects the fact that no true comparison is possible between the qualitative and the quantitative study. This study does suggest that nurses are providing spiritual care in the hospice setting; however the amount is still unknown. As with the other studies reviewed, one might reasonably wonder just how much spiritual care practice is occurring in hospice and in other areas of nursing.

Summary of U.S. Research on Nurses' Spiritual Care and Perception of Spirituality

A number of the U.S. studies have also been conducted in the area of oncology, hospice, or end-of-life care (Taylor et al., 1994; Kristeller et al., 1999; Belcher & Griffiths, 2005) where few would argue the relevance of the concept of spirituality. In addition, studies have explored the field of parish nursing in relation to nurses' spiritual care practices (Tuck et al., 2001; Sellers & Haag, 1998). Although a number of those studies used qualitative methodologies that do not allow for exact comparisons in frequencies of spiritual care practices, it appears that hospice and parish nurses are more inclined and comfortable with integrating spirituality into their care practices (Belcher & Griffiths, 2005; Sellers & Haag, 1998; Taylor et al. 1995; Tuck et al., 2001) than nurses working in other fields of nursing. This includes the understanding that nurses may feel

more supported in their role as spiritual caregivers in some work environments than in others.

Research on nurses' spiritual care practices seems to have moved beyond the usual settings (oncology, hospice and end-of-life) towards acute care situations (Scott et al., 1994; Grant, 2004; Vance, 2001). A number of studies have simply lumped all acute care nurses together in one category (Cavendish et al., 2004; Scott et al., 1994; Grant, 2004), whereas one study differentiated acute care nurses according to their work environment and found a significant difference between one set of nurses compared to another (Vance, 2001). Future research should build on this and have large enough sample sizes so that medical surgical nursing, critical care, behavioral health, pediatric nursing, and women's health can be compared in regard to nurses' preferences for spiritual care practices within the context of the same organization.

A few other studies have been conducted in specialized areas such as mental health (Tuck et al., 1997) and advanced clinical practice (Stranahan, 2001). Here, as in other areas of nursing, however, there is a consistent gap between the value that nurses attach to spiritual well being and the relatively modest attention that this dimension receives "in real life" (Kristeller et al., 1999; Scott et al., 1994; Stranahan, 2001; Vance, 2001). Past studies were more concerned about nurses' perceptions and attitudes, and some studies have avoided the issue by asking nurses if they had ever engaged in certain practices (Grant, 2004). Future research should target the issue of frequencies more systematically. Furthermore, this research ought to take into account what kind of predictors and barriers have been found in numerous studies and also test those

systematically. Clearly, nurses' spiritual religious backgrounds play a role (Stranahan, 2001; Vance, 2001) and deserve more detailed attention.

A common critique in these studies has been that the samples of nurses have been too homogenous: typically, White, female, and Protestant. If future research could take place in an area of the country where the nursing workforce is ethnically more diverse, this setting would allow for the exploration of the unique contributions that different ethnicities make in regard to spiritual care.

Conclusions

Qualitative studies have explored nurses' perspectives and understanding of the concepts of spirituality, spiritual care, and spiritual needs. These studies have demonstrated how broad the spectrum of understandings is and how unlikely it is that there will be consensus on any one of these concepts across cultures. The main tension remains around the religious aspect of spiritual care and how this aspect can and ought to be included or not included. This tension raises questions regarding nurses' religious backgrounds or the absence of it and how this also affects spiritual care. Some have argued that nurses' positive spiritual/religious orientation predicts actual spiritual care practice (Ross, 1994; Vance, 2001). This was supported by what Stranahan (2001) found in U.S. nurse practitioners; however, McSherry (2006) reported that nurses' religious beliefs and practices did not appear to significantly influence the provision of spiritual care. As this aspect came up in several studies from both Europe and the United States with inconclusive findings, it is recommended that researchers further explore the role that nurses' spiritual and religious beliefs play and how these might affect their spiritual care practice.

In addition, several quantitative studies have been conducted in the United States and in Europe yielding other important variables that seem to be related to nurses engaging in spiritual care. These variables should be included in other studies; possibly even in another cultural climate to see whether they are stable and yield the same statistical relationships. What has been explored least at this point are organizational factors affecting nurses' spiritual care practice. Clearly, whether and how a nurse responds to the mandate to attend to patients' spiritual needs has been interpreted more individually than collectively. An analysis of barriers to spiritual care across studies, however, is pointing to their being factors in the environment that seriously impede spiritual and holistic care. Furthermore, recent studies in the United States (Grant, 2004; Grant, O'Neil, & Stephens, 2003; 2004) suggest that organizations may take measures to create a climate that encourages nurses to be more aware of patients' spiritual needs. A research model that could analyze simultaneously nurse specific as well as organizational factors could yield some new perspectives.

Section IV: Comparisons of Nurses' Spiritual Care: Across Settings and Disciplines

As documented in the previous sections, most research on nurses' perceptions and practices has been completed on one specialty group of nurses (i.e., oncology nurses, nurse practitioners) or has not differentiated nurses by work environments for the analysis (Tuck et al., 2001; Strang et al., 2002; Narayanasami & Owens, 2001; Grant, 2004). Thus, there is very little research where differentiation by area of practice has been reported or where the same measures in more than one specialty cohort have been applied.

When it comes to comparisons across health care professions, that is comparing nurses' perceptions, attitudes, and behaviors in response to patients' spiritual needs with those of other health care professionals, there are only a limited number of studies to review. The following section gives an overview of studies that have compared nurses of one area of specialty with another as well as nurses with other health care providers.

Comparisons between Nurses across Settings

Taylor, Highfield, and Amenta (1999) conducted a cross-sectional, descriptive comparative study between their 181 oncology nurses and 683 hospice nurses, all of whom were members of national professional organizations (ONS or HNA). They found differences between the two groups in that hospice nurses who tended to be older and less educated but were more experienced in nursing, more spiritual, and reported to engage in spiritual care more frequently than the more ethnically diverse and more religious oncology nurses. Drawing on work with the same tool critiqued in the previous section, Taylor and colleagues (1999) concluded that hospice nurses had more positive and appropriate attitudes and beliefs regarding spiritual care giving than oncology nurses. Furthermore, hospice nurses self-reported greater ability and a greater comfort level with spiritual caregiving than the oncology nurses' group. Self-reported spirituality and comfort with spiritual caregiving were highly correlated with perceived ability. The study also revealed that certain background variables were influential in explaining these differences. Hospice nurses perceived their training in spiritual caregiving as more adequate and felt more supported by their employers in regard to spiritual caregiving.

Taylor et al.'s (1999) study highlighted at least two aspects that seem to be relevant for future research. One, there appear to be differences in regard to spiritual care

behavior between subgroups of nurses. Carrying Taylor et al.'s (1999) idea further, there is a need for larger comparative studies that compare nurses' spiritual care practices across work environments. Such studies would allow testing a range of possible predictors of spiritual care practice that have been identified in specialized settings. Second, there are important organizational variables that may influence the frequency of nurses' spiritual care practice. Future research should be designed in such a way that it will be possible to understand the role of nurses' own spirituality versus organizational factors that predict actual engagement in spiritual care.

Tuck et al. (2001) compared 132 mental health nurses working at different public mental health facilities with 95 parish nurses residing in the southeastern United States. Both cohorts showed high levels of spirituality measured by the Spiritual Perspective Scale, and nearly all (99%) claimed a religious affiliation. Race, gender, and group membership were the best predictors of variance in Spiritual Perspective Scale scores. They asked their respondents what kind of spiritual interventions they would do (a) in an ideal situation, (b) in general and (c) what they had done in the last two weeks. Listening and praying were indicated by both groups of nurses in all three situations; however, praying was the primary intervention used by parish nurses across situations. Offering self or being present or available was also seen as an ideal way to give spiritual care by both groups. Whereas mental health nurses favored referring, touching was rated high as a spiritual intervention for parish nurses. Across all three situations, the number of spiritual interventions mentioned was twice as high in parish nurses as in mental health nurses. When asked about providing interventions in the last two weeks, 16% of the mental health nurses and 17% of the parish nurses had not made any spiritual

intervention. The numbers may well be higher as Tuck et al. (2001) do not comment on the number of participants who simply left blanks across the situations.

Two findings seem particularly noteworthy in this comparison study (Tuck et al., 2001). First, when it comes to the spiritual/religious profile of mental health and parish nurses, the two groups are more alike than different in the measures used in this study. This could be pointing towards a bigger difference in the environment in which they practice nursing. Whereas parish nurses see patients who are most likely parishioners, they may well be able to integrate who they are spiritually with the kind of (spiritual) care they give. Mental health nursing is a very different context. As Sperry and Shafranske (2005) point out, psychological approaches have traditionally emphasized body, mind, emotions, and behavior leaving out the spiritual dimension, the soul of the human being. In light of an alienation between mental health professions and religion for most of the 20th century (Sperry & Shafranske, 2005), mental health professionals have tended to either ignore or pathologize the spiritual and religious dimension (Anderson, 2003). Therefore, mental health nurses may be more likely to bracket their personal spirituality, relegating it to the private realm and be less likely to address spirituality in a professional patient encounter. Parish nurses and mental health nurses may constitute opposite extremes on a continuum of nurse spiritual care behavior. Second, Tuck et al. (2001) found a decline in numbers of interventions when comparing hypothetical situations to lived experience. This decline is apparent in both groups of nurses across the three situations (58/39/31 and 117/119/59) with the numbers of interventions being twice as high in parish nurses as in mental health nurses. Future research will, therefore, have to

explore the interplay between environmental and intrapersonal facilitators and barriers to nurses' spiritual care practice.

In sum, this research shows there may be considerable differences in how and to what degree nurses approach spiritual care in different health care settings. Tuck et al.'s (2001) study adds some interesting comparison aspects on which future research could expand. Furthermore, the study shows a discrepancy between nurses' ability to describe ideal practice in regards to spirituality and nurses' actual spiritual care practice. In light of scoring comparatively high on the Spiritual Perspective Scale, this raises questions about the function of nurses' spirituality in relation to providing spiritual care and the role of the work environment in being conducive to this practice. Future research should explore this interplay of factors in more detail.

Comparison between Healthcare Providers across Disciplines

Three studies from the 1990s are relevant for this review as they show a comparison of nurses with another health care provider's perspective. Additionally, two of those studies assess the clients' perspectives.

Koenig, Bearon, Hover, and Travis (1991) explored the religious perspectives of doctors and nurses and compared them to the perspectives of patients and families. Their study built on an existing research finding that healthcare professionals such as psychologists or psychiatrists have tended to be considerably less appreciative and practicing of any religion than the general population. The investigators held that if religious beliefs and attitudes between healthcare professionals and patients diverge too sharply, there may be a lack of understanding and support from health care providers in

regard to patient and family spirituality even though this support is what individuals and families draw upon most in times of crisis.

Koenig et al. (1991) surveyed a group of 130 physicians, 38 nurses, 77 inpatients, and 60 inpatient family members at a large tertiary care medical center in the southeast of the United States. The sample consisted of 90 nurses, 38 of whom responded, yielding a response rate of 42%. There were no follow-up measures of non-respondents. Respondents were predominantly middle-aged females working as head nurses and assistant head nurses on medical and surgical wards. Of 1075 physicians, a random sample of 200 was mailed the survey. One hundred and thirty of them, representing 12% of all physicians of this institution, returned the questionnaire. Most of respondents were middle aged males. Among 413 hospitalized patients on a certain day, 199 in-patients met eligibility criteria, 38% of which completed and submitted the questionnaires. Non-respondent patients either refused to complete the questionnaire or had other reasons for not participating. Overall, they tended to be more severely physically or mentally ill. Thirty percent of the responding patients required some degree of help by staff or family. The research team was also able to recruit a total of 60 fathers, mothers, sons, daughters, husbands or wives, brothers or sisters as well as grandparents of in-patients who were waiting in the waiting area of the hospital (Koenig et al., 1991).

Although belief in a higher power was high in all groups, Koenig et al. (1991) found considerable differences between groups. Church attendance at least weekly was highest in patients (62%) and families (59%), whereas only 35% of the physicians and many fewer of the psychiatrists and neurologists attended at least weekly. Fifty-one percent of the nurses attended church at least weekly, which differs little from the

percentages for the patient and family groups. Church membership tended to be primarily Protestant in patients and families (85.8% and 98.7%, respectively) with fewer than 2% Catholic and no Jewish affiliation. Patients and families identified to a large degree with conservative Protestant denominations (43% of patients and 49% of family groups); however, physicians were either liberal Protestant, Catholic, Jewish, or not religious. In the nursing profession, church membership was mostly Protestant (79%), and 21% identified as Roman Catholic. There were no individuals self identifying as Jewish, agnostic, atheist or not religious in the patient, family, and nurse groups, whereas 9.8% of the physicians were Jewish, and 8.9% of them self identified as non-religious. Finally, religious coping measured by a visual analogue scale (scores between 1-100) was seen as the most important factor enabling an individual to cope by 44% of the patients, 56% of the families, but only by 26% of the nurses and 9% of the physicians.

Koenig et al. (1991) reported that 14% of the nurse respondents had made no referral to the chaplains' department in the previous six months, whereas roughly 40% of the nurses had made 1-10 referrals, and 46.5% (versus 5.3% of the physicians) had made more than 10 referrals in that time period. By contrast, 49% of the physicians had made no referral to the chaplain's department in the previous six months. Those who had made a referral claimed a religious affiliation and tended to be family physicians, surgeons, or attending physicians rather than residents, fellows, or interns. Jewish physicians were more inclined to make referrals than non-Jewish physicians.

In sum, the study findings demonstrate a contrast between the spiritual profile of physicians and patients/families (Koenig et al., 1991). They concluded from the religiously liberal orientation of physicians, there is a potential lack of appreciation for

religion. They suspect that this view may lead physicians to underestimate the importance of spirituality in patients and families coping with health challenges as evidenced by a lack of referrals initiated by physicians. Thus, Koenig et al. (1991) interpreted a lack of patient referrals to chaplains as a lack of recognition for patients' spiritual needs by health care providers. This notion can be particularly serious when physicians, such as psychiatrists and neurologists, who scored lowest among physicians in personal religiosity, have a gate-keeper function in allowing patients to access spiritual resources. By contrast, the nurse cohort that tended to have a more similar spiritual profile to patients and families scored relatively high (86%) in involving pastoral and chaplains' services, which could be interpreted in this study as demonstrating a greater awareness of patients' spiritual needs. It is noted that sampling bias limits the generalizability of these findings. Nevertheless, the results of this study support the interpretation that health care professionals who are sensitive to the spiritual dimension in their own lives may be more prone to seeing patients' and families' spiritual needs.

It is acknowledged that Koenig et al.'s study, published in 1991, may not completely reflect the current practices of patients, families, nurses, or physicians. The chasm between the spiritual profile of patients and their families and of health care providers can have augmented or decreased during the past 15 years. Future research should take a closer look at nurses' spirituality in relation to their attention to patients' spiritual care needs, preferably beyond the variable of referral to chaplains. It may be that nurses were more prone to refer patients than physicians because nurses tend to witness the spiritual pain of patients and their families much closer than other health care

professionals and therefore search for ways to be supportive of patients' and family needs regardless of their own spiritual orientation.

In another study, Emblen and Halstead (1993) conducted early qualitative research in which they interviewed three groups: 12 nurses, 19 surgical patients, and seven chaplains. Their purpose was to explore perceptions of the meaning of spiritual needs and related interventions within each group and across the three groups. The nurses and patients were from the same surgical unit, and the chaplains worked either at a non-religiously affiliated or at a religiously affiliated hospital. The number of interviewees in each category depended on the point of data saturation reached. All but two patients and all members of the two professional groups identified with some kind of Judeo-Christian tradition. During the interviews, Emblen and Halstead (1993) noted considerable differences in comfort level when talking about spirituality. Female patients tended to be more at ease and more vocal about their ideas than male patients.

In the first step of the analysis, one of the researchers identified six emerging themes in which patients' and caregivers' descriptions were categorized. Then the second researcher used those six categories for subsequent coding and confirmed their scope as sufficient and useful: religious, values, relationships, transcendence, communication, and affective feeling. Some differences were found among the groups. For example, Chaplains did not mention any items from the affective feeling category, and nurses were the only ones to differentiate between "good" and "bad" religion in the sense of functional or dysfunctional for patient coping.

On the intervention side, Emblen and Halstead (1993) found that there was a fit between patients' understanding of the meaning of spiritual care and that of nurses and

chaplains. All three groups agreed on the following five interventions listed in order of preference: (1) listen and talk, (2) offer prayer, (3) read scripture, (4) be present, and (5) refer to chaplain. This list represents a broad variety of ways in which health care professionals could respond to patients' spiritual needs. Activities (2) and (3) are grounded in religion, but activities (1), (4) and (5) can be seen as more generic spiritual interventions. The sequence of the proposed interventions suggests that in the cultural context of the United States, both generic spiritual care and religious care may be acceptable to nurses, chaplains, and patients.

Furthermore, Emblen and Halstead (1993) compared each nurse and chaplain respondents' discussion of patients' spiritual needs with the interventions the same individual suggested. Overall, the researchers found congruity and noted a pattern: Respondents who recognized the religious aspects of spiritual care tended to identify religious interventions. By contrast, those whose descriptions of spiritual needs were more relational in nature identified more relational interventions. These findings raise important questions about nurses' spiritual care practices when there is a fit between their own understanding of spirituality versus when there is not. In other words, more research is needed to explore the relationship between nurses' own spiritual perspectives and experiences and nurses' perceptions of patients' spiritual needs and subsequent spiritual interventions chosen to meet those needs. In light of the professional mandate that spiritual care should promote an environment in which patients' values, customs, and beliefs are respected (American Nurses' Association Code of Ethics, 2001), it is a relevant question to be pursued through future research in how much different spiritual/religious backgrounds of nurses empower them to provide this type of care.

Although the Emblen and Halstead (1993) study is also 15 years old, there have not been many studies that have done a simultaneous analysis of the perspectives of two professional groups with corresponding patients' perspectives. Their study represents a valid acute care perspective from a single site, but the study has not been repeated at other sites. As in other studies done in the United States, the sample represented predominantly a Judeo-Christian worldview, and within this view there was both heterogeneity and homogeneity of ideas and perceptions. The researchers' optimistic conclusion to declare those six categories as applicable for all spiritual nursing assessments may be premature given the under-representation of minority groups such as Moslems, Hindus, Buddhists, and other faith traditions as well as those who do not identify with any particular religion or with spirituality in general in all three of the sub-samples. Still, Emblen and Halstead's (1993) finding that there was a similar general understanding between health care providers' and health care recipients' view of spiritual needs and interventions is encouraging.

Kristeller et al.'s (1999) study of oncology nurses' attitudes and spiritual care practices also explored oncologists' perspectives. The research team compared perspectives of oncology nurses (N =267; 59% of all oncology nurses affiliated with their professional organization in the State of Indiana) and oncologists (N = 94; 47% of the oncologists in the State of Indiana).

The basic question addressed by this survey was about practitioners' perceptions of who is responsible in their settings for addressing spirituality/emotional distress. Both professionals saw themselves primarily responsible in their setting: 37.5% of the oncologists regardless of work environment (private practice or hospital) and 47.5% of

the oncology nurses. Nurses who worked in private practice tended to see themselves more responsible than nurses working in a hospital environment. Both professionals perceived chaplains as primarily responsible (both approximately 37%). Very few nurses, however, thought that this was a primary responsibility of the oncologist (4.2%), and only 12.5% of the oncologists believed that spiritual/existential distress is a nurse's responsibility. Furthermore, both professional groups agreed that under ideal circumstances, it should be the chaplain who addressed this issue; only 66.7% of the MDs and 59.6% of the RNs reported having access to chaplain's services. If available, 64.2% of the RNs but only 40.3% of the MDs would regularly consult with a chaplain. For nurses, but not so much for physicians, availability was strongly related to likelihood of conferring.

In the next part of the study, 18 relevant psychosocial interventions were ranked, one of which was addressing spiritual/existential distress in three hypothetical clinical cases: one case with a very good, one with a fair, and one with a poor prognosis. Few oncology nurses as well as oncologists would rank addressing spiritual distress among the top 3 issues. This fact did not change much even in the case of poor prognosis. In fact, nurses ranked addressing spiritual distress even lower than did oncologists. Those oncologists who gave a higher priority ranking to spiritual distress tended to be younger and also likely to address issues like anxiety, depression, and family distress. For the oncology nurses, no such relationships could be identified.

Both professional groups showed similar patterns of intervening in regard to spiritual distress: (a) discuss issue in depth with patient, (b) make a formal referral, and (c) inform patient of local resources. In light of the relatively few professionals who

actually ranked spiritual concerns as a priority, Kristeller et al. (1999) concluded that spiritual concerns are likely to be not addressed at all, and even if they are, they are most likely not discussed in depth.

Last, this research explored oncology health care providers' perceived effects when addressing spiritual distress. Surprisingly, both professional groups rated their influence comparatively high: 64% of oncologists and 76% of oncology nurses believed that it was between "some" to "a lot." Physicians and nurses who addressed spiritual distress themselves reported significantly higher perceived levels of effect than did those who did not. For nurses, their perceived effect was even predictive for ranking addressing patients' spiritual concerns among the top three concerns in the hypothetical cases.

This study shows how unlikely it is in light of competing demands, that health care providers such as nurses and physicians address spirituality even if the situation warrants it. More research is needed about factors that are predictive for actually doing it.

There are two other studies in the late 1990s that compared different spiritual care perspectives. Both studies were conducted in the hospice setting, and both studies compared nurses', social workers' and chaplains' involvement in spiritual care.

Reese and Brown (1997) conducted a chart review of the most recent visits of nurses, social workers, and clergy at 37 home hospice patients representing 105 home visits. They drew on a theoretical framework that established a relationship between the following five variables: denial, death anxiety, hospice values, social support, and spirituality. To operationalize these variables, Reese and Brown (1997) used several established scales (e.g., Spiritual Perspective Scale, Denial Scale, Death Anxiety Questionnaire) that had been used in previous studies. The researchers used individual

items from each scale as themes for the chart analysis. All but two themes were identified by the researchers in health care providers' chart entries. Reese and Brown (1997) presented the ten most frequently discussed themes including the professions that used each theme. Then they rank ordered the themes (or variables) by their frequency of discussion and the professions most frequently discussing them. The most frequently discussed variable was spirituality, and, not surprisingly, it was mostly addressed by clergy. The second most frequently discussed variable was death anxiety, most frequently addressed by social workers. The third and fourth ranked variables were hospice values and denial, mostly addressed by nurses. The least frequently addressed variable was social support, addressed by social workers.

It appears from the Reese and Brown (1997) chart analysis that both social work and nursing addressed spirituality infrequently, with social work scoring slightly higher than nursing in addressing spiritual themes. It must be mentioned, however, that this significant difference was found with a significance level of .1 which was chosen due to the small sample size. Furthermore, both nursing and social work only addressed one out of four spirituality topics. Clearly, both professional types tended to leave the spiritual dimension to the part-time professional spiritual care giver (chaplain). Nevertheless, Reese and Brown (1997) argued that their chart analysis showed that on every home visit, at least one spiritual or psychosocial issue was addressed, and in more than 91% of the cases, more than one issue was addressed. According to Reese and Brown (1997) this supported a prevalent holistic orientation in hospice even if the issues were addressed in varying degrees by different professionals. The authors acknowledge limitations of this study, among others the fact that it had been conducted at one site. Two of the three

professions (namely social work and chaplaincy) were represented through one individual. This information makes it hard to generalize from these findings to all hospice nurses and to nurses in general.

A different approach was taken by Babler (1997) who used an adapted version of the "Spiritual Care in Hospice Survey" to assess the level of spiritual care provided by hospice professionals and to determine whether there were significant differences in the level of spiritual care provided by nurses, social workers, and chaplains. Babler mailed his survey to a stratified random sample of 20% of the members of the Council of Hospice Professionals of the National Hospice Organization and obtained a return of 71%. He recruited 196 participants, 188 registered nurses, 58 social workers, and 50 chaplains. Comparing the three groups with one-way analysis of variance, Babler found significant differences between the three groups: Hospice social workers scored lowest and minimally in providing spiritual care, chaplains who have specific training for this role scored highest, and nurses scored in the middle about half as much as chaplains. In conclusion, Babler is concerned that the level of spiritual care provided by hospice social workers and some nurses may not be sufficient to meet the actual needs of hospice recipients.

Summary and Discussion of the Findings across Studies

There are two larger quantitative studies, Taylor et al. (1999) with $N = 864$ and Tuck et al. (2001) with $N = 234$, each comparing two different groups of nurses by using the same methodological approach. Both studies found significant differences in the frequencies of nurses' spiritual care practices. Interestingly, in one study, the spiritual profile of the two groups of nurses was the same, whereas in the other study, the spiritual

profile between the two groups differed. This suggests that the spiritual profile of the nurse may contribute to differences in the frequency of addressing spiritual needs. Future research will have to explore the effect of nurses' spiritual and religious background on nurses' spiritual care practice. A variety of measures has been used to assess nurses' spiritual and religious profile and ought to be tested simultaneously in a comprehensive future study.

Another difference between the two groups of nurses in both studies was the environment in which they practiced: One group experienced their work environment as encouraging them to provide spiritual care (hospice nurses in Taylor et al., 1999, and parish nurses in Tuck et al., 2001), whereas the other group felt less so (oncology nurses in Taylor et al., 1999, and mental health nurses in Tuck et al., 2001). Future research ought to explore in more detail the role of the environment in encouraging or discouraging nurses from providing spiritual care.

Overall, there is a lack of research where comparisons of nurses' spiritual care behavior across specialties are analyzed. Moreover, studies tend to be single site studies, all of which use different designs and their own questions and instruments. Future research ought to use the same methodology, drawing on well developed, reliable instruments (as far as they are available) while assessing nurses' practices across sites.

In contrast to many studies in nursing, Koenig et al. (1999) established "referral to chaplain" as an indicator for awareness of spiritual needs in patients and their families. They linked this with the spiritual profile of health care providers and deduced that greater similarity in spiritual profile with the patient may imply greater awareness as evidenced by higher numbers of referrals by nurses. Although Emblen and Halstead's

(1993) qualitative study supports a similarity in views on the meaning of spiritual needs as perceived by patients, nurses, and clergy, Koenig et al.'s hypothesis ought to be tested through further research that compares spiritual care practices with the different spiritual profiles of nurses.

Two studies in hospice have been conducted from a clergy (Babler, 1997) and social work perspective (Reese & Brown, 1997). Taylor et al. (1999), in a large national sample of hospice nurses, found higher levels of spiritual caregiving in this group of nurses whereas Reese and Brown (1997), in their very limited single site chart study, found nurses less involved in addressing spiritual issues than the two other professions. It appeared as if nurses engaged more in psychosocial matters than did the social workers. Babler (1997), however, found nurses scoring half as much in spiritual involvement than professional spiritual caregivers (chaplains) and significantly more than social workers. It remains difficult to describe a comprehensive picture with every researcher using his or her own methodological approach and instruments. Overall, findings in hospice nursing are non-conclusive and do not allow for generalization to nurses' spiritual care practice in acute care settings. Simply put, there is a pressing need for larger comparative studies across nursing specialties in acute care with well-established and reliable instruments.

Summary of Chapter Two

Overview of the State of the Art on Nurses' Spiritual Care

Most nurses have some subjective understanding of spirituality and spiritual care, and in several qualitative studies they described diverse ways of caring for the patient's spirit. Only a minority perceived spirituality as something nebulous or esoteric (Emblen & Halstead, 1993; Harrington, 1995; Narayanasamy & Owens, 2001; Strang et al., 2002;

Taylor et al., 1994; Tuck et al., 2001). Most nurses, regardless of practice environment, agreed with the notion that holistic care includes the spiritual dimension (Lundmark, 2006a; Strang et al., 2002) and perceived themselves as having some responsibility for meeting patients' spiritual needs (Boero et al., 2005; Kristeller et al., 1999; Strang et al., 2002). Some nurses' spiritual care included religious elements, whereas other nurses did not when they described their understanding of spiritual care (Grant, 2004; Kuuppelomäki, 2001; Strang et al., 2002; Tuck et al., 2001).

Overall, there is a broad spectrum of information on nurses' attitudes toward spiritual care and beliefs about practices. What is lacking, however, is commensurability of measures of nurses' spirituality/religiosity, their attitude towards spiritual care, and their spiritual care practices. Future research is needed using similar measures so that comparisons can be made across settings, groups, and cultures. For such comparisons, studies with larger samples sizes are also needed. At present, it is difficult to describe a coherent picture and generalize from the various findings due to the diversity in single site studies (e.g., oncology or hospice settings only), research designs, and instruments. Moreover, several of the studies have used mixed samples of nurses with and without formal education in nursing (Boero et al., 2005; Lundmark, 2006a; Strang et al., 2002) or nurses working in different subspecialties (Grant, 2004; Harrington, 1995; Strang et al., 2002). Larger studies with the same measures should allow for a more differentiated perspective.

In a number of studies, spirituality and spiritual care had not been defined before participants completed their surveys because the researchers did not want to bias participants with their own definition. The results, however, were interpreted with the

researchers' understanding of what constituted appropriate spiritual care (Narayanasami & Owens, 2001; Taylor et al., 1994). This revealed issues that need further exploration; for example, the difference between patient initiated and nurse initiated spiritual care, the role of nurses' spirituality and religiousness in regard to spiritual care, nurses' comfort level and perceived ability to give spiritual care to someone from a different religion or worldview all need additional study.

Nurses often referenced the context of terminal illness and dying as an area where spiritual support is needed (Grant, 2004; Narayanasamy & Owens, 2001; Strang et al., 2002; Taylor et al., 1994). Consequently, many researchers recruited nurses from gerontological nursing (McSherry, 1997; Ross, 1994), hospice nursing (Babler, 1997; Belcher & Griffiths, 2005; Carroll, 2001; Harrington, 1995; Reese & Brown, 1997; Taylor et al., 1999), oncology nursing (Kuuppelomäki, 2001; Lundmark, 2006a; Musgrave & McFarlane, 2004a; 2004b; Strang et al., 2002; Taylor et al., 1994; Taylor et al., 1995, Taylor et al., 1999) and parish nursing (Tuck, Wallace, & Pullen, 2001; Van Dover & Pfeiffer, 2006). Fewer studies have been conducted in specialty areas like mental health nursing (Tuck, Pullen, & Lynn, 1997; Tuck, Pullen, & Wallace, 2001).

Even less is known about nurses' attention to patients' spiritual needs in ordinary, everyday situations, such as preparing for surgery. With nursing scholars' emphasis on a holistic understanding of what it means to be human, spirituality is generally described as a universal human dimension applying to all human beings regardless of their religious or non-religious orientation. One would expect that nurses attend to patients' spiritual concerns across caregiving environments, not limiting caring for patients' and families' spiritual needs only to terminal care. Grant's (2004) qualitative approach of giving nurses

possible situations and asking them to respond to how much each of the situations would prompt a spiritual intervention may be more informative in future research. Nevertheless, the studies of Kristeller et al. (1999), Taylor et al.(1994), and Tuck, Pullen, and Wallace (2001) caution against the assumption that nurses' positive attitudes towards spiritual matters can be taken as a proxy for actual spiritual caregiving. Very few studies have looked at the actual frequency of engaging in spiritual care as described by bedside nurses across medical specialties.

A number of studies have sought to identify predictors for either attitude towards spiritual care or for the actual delivery of spiritual care. Most of these studies have either explored demographic factors of the nurse or factors related to nurses' spirituality/religiosity. Moreover, some studies have explored organizational factors to predict the likelihood of nurses engaging in spiritual care. Organizational factors have been explored particularly in relation to barriers. Less is known about organizational factors that might facilitate nurses' spiritual caregiving.

Specific Findings in Relation to Nurse Demographic Variables

Among nurse demographic factors, the following have been considered in the studies reviewed herein: (a) gender, (b) ethnicity, (c) age, (d) educational level or (e) educational preparation for providing spiritual care, (f) years of experience as a registered nurse, (g) primary role of the nurse, and (h) work setting or type of ward. The following presents the findings pertaining to each of the demographic variables across studies.

Gender

As a predominantly female profession, most nursing studies reflect this gender imbalance and are skewed in favor of the female gender. A 2004 national survey of registered nurses in the United States found a slight increase in male nurses compared to the year 2000. These male registered nurses still represented only 5.8% of the total national workforce (HRSA, 2006). Nevertheless, Tuck, Wallace and Pullen (2001) in their comparison study between mental health and parish nurses found that female nurses scored significantly higher in spirituality than did their male colleagues. Also, Emblen and Halstead (1993) noted a gender difference when interviewing patients: female patients reported more comfortably about their spirituality than did male patients. It appears likely that gender may influence spiritual perspectives and spirituality scores thus influencing choices regarding spiritual caregiving. Though future studies on nurses' perspectives are not likely to produce higher numbers of male participants, it seems still valid to explore how gender influences spiritual care practices of nurses when the sample is large enough to allow for such comparisons.

Ethnicity

In the study by Tuck, Pullen, and Wallace (2001), the research team also found that African American nurses scored slightly higher in spirituality than their Caucasian colleagues. Although these differences were not statistically significant in the bivariate analyses, Tuck et al. (2001) believe they might be if the sample of African American nurses could be enlarged in future studies. Although Musgrave and McFarlane (2004a) could not verify their hypothesized indirect effect of ethnicity on attitudes towards spiritual care, Taylor et al. (1994) found that Asian or Latino nurses held more positive

attitudes toward spiritual care than did other ethnic groups (Taylor et al., 1994). Based on

these findings, further exploration of ethnic differences in spiritual care practices is

warranted. More ethnically diverse nurse samples would be desirable for future research

since most of the existing studies have been conducted with largely Caucasian nurse

samples (i.e., Belcher & Griffiths, 2005; Scott et al., 1994; Taylor et al., 1994; Taylor et

al., 1995; Taylor et al., 1999; Tuck, Pullen, & Lynn, 1997; Tuck, Pullen, & Wallace.,

2001; Vance, 2001).

Age

Age has been found to have a significant effect on several outcome variables.

Tuck et al. (2001) found that spiritual perspective scores were significantly higher in

nurses above the age of forty than in nurses below this age, whereas Musgrave and

McFarlane's (2004) study did not show an age effect on the outcome variable attitude

towards spiritual care mediated through intrinsic/extrinsic religiosity and spiritual well-

being. Taylor et al.'s (1999) comparison study between oncology and hospice nurses

found a small significant correlation between age and frequency of spiritual care and

perceived ability and comfort in providing spiritual care based on a large sample of 711

nurses. No statistically significant correlation was found between age and spiritual care

perspectives. Furthermore, age was not significant as a predictor for attitude towards

holistic care in Strang et al.'s (2002) study. Interestingly, Ross (1994a) found the

hierarchical position of the nurse to be significantly associated with identifying patients'

spiritual needs but stated that this effect could not be explained by age or experience.

Kuuppelomäki (2001) found age to be a non-significant predictor of providing spiritual

care in her Finnish nurse sample. In conclusion, findings in relation to age are not

consistent, thus, requiring further study.

Educational Level

Musgrave and McFarlane's (2004a) path model showed a significant direct

relationship between education and attitudes towards spiritual care. Similarly, Taylor et

al. (1999), in a regression model, noted a small positive effect of education on nurses'

spiritual attitudes and beliefs. Taylor et al. (1999) also found that hospice nurses who

were less highly educated than oncology nurses displayed more positive and more

appropriate attitudes and beliefs regarding spiritual caregiving and reported more

frequently to engage in most spiritual care practices than did oncology nurses.

Furthermore, Taylor et al. (1994) noted a difference in attitudes towards spiritual care

between diploma prepared versus AS, BS, or Master's prepared cancer nurses. Similarly,

findings from a Swedish study, comparing registered nurses with nurse auxiliaries in self-

reported frequency of providing spiritual care, demonstrated a statistically significant

difference between the two groups. Nurses reported more spiritual care than the non-

registered nurse auxiliaries (Lundmark, 2006a). These same subjects did not differ

significantly in their spiritual background, prompting at least one scholar to speculate that

the higher level of care might be attributed to the higher level of education of nurses

(Ross, 2006) although Lundmark (2006b) argues that it is not entirely clear what accounts

for the difference between the two groups of nurses. Nevertheless, a similar impression

can be obtained from a British study where 71.4% of the qualified registered nurses and

only 12.3% of the unqualified nurses identified patients with spiritual needs (McSherry,

2006).

Vance (2001) explored level of education related to delivery of spiritual care and did not find any statistically significant interaction. She also found that approximately 35% of her nurse sample (eight percent of which held a Master of Science degree) practiced spiritual care somewhere between occasionally and often. When comparing this finding to advanced practitioners in Stranahan's (2001) study, it does not appear that master's level prepared nurses practice spiritual care more often than nurses without an advanced practice degree.

In sum, research thus far has not shown consistency in determining the effect of education on spiritual care giving. Nurse scholars appear to assume that if spiritual care is taught in undergraduate and graduate curricula, nurses will feel more confident about addressing patients' spiritual needs (McSherry, 2006). If this assumption is correct, research should show an effect when a nurse has more education.

Educational Preparation for Providing Spiritual Care

Vance (2001) found that insufficient education constituted the second largest barrier (65% agreement, 35% disagreement) to providing spiritual care after lack of time (83% agreement, 17% disagreement). Stranahan (2001) also found that 57% of her nurse practitioner sample would rarely or never provide spiritual care, and the same number of nurses reported their education had been inadequate or somewhat inadequate to prepare them for this role. In the same study, 45% indicated they perceived their ability to provide spiritual care as weak or limited, and one third felt uncomfortable providing such care. Similar findings are reported by Kuuppelomäki (2001) in a Finnish study. She also observed that larger health centers had provided their nurses with additional training in terminal care. Consequently, the following factors were positively associated with the

provision of spiritual support to terminally ill patients: health center's target population and efforts to develop terminal care, nurses' training in terminal care, and nurses' reading of literature about terminal care. Taylor et al. (1999), comparing hospice with oncology nurses, found that hospice nurses perceived their training in providing spiritual care as more adequate while engaging more frequently in spiritual care than did oncology nurses. In their regression model, Taylor et al. (1999) discovered that nurses' perception of the adequacy of training accounted for a small amount of the total variance, which included frequency of delivering spiritual care and attitude towards and comfort level with spiritual care. These findings suggest that nurses' perceptions of the adequacy of education in relation to spiritual care may be of some predictive value.

Years of Experience as a Registered Nurse

Kuuppelomäki (2001) explored whether years of experience had any significant effect on provision of spiritual care and found it to be non-significant in her sample of Finnish nurses providing spiritual care to terminally ill patients. In the large sample (N = 711) of Taylor et al.'s (1999) comparison study between oncology and hospice nurses, there was a small, significant correlation between years of experience and frequency of spiritual care, perceived ability and comfort in providing spiritual care as well as a strong correlation with age, but there was no statistically significant correlation with spiritual care perspectives. Similarly, Taylor et al. (1995) found a small but significant relationship between number of years in nursing and the spiritual interventions of offering to pray, encouraging prayer, and reading to a patient or bringing reading materials to a patient.

By contrast, Vance (2001) in a study with a much smaller sample ($N = 173$) did not find any significant interaction between frequency of spiritual care practice and years of experience or training. It is possible; however, that the sample size was too small to judge this interaction effect to be statistically significant. Additionally, Ross (1994a) argues on the basis of her qualitative interviews ($N = 12$) that what seems to influence whether a nurse makes herself available to the patient at a deep and personal level depends not so much on the nurse's work experience but on his or her past experiences of life crises and the way these have been processed. If personal growth and maturity comes out of such experiences, nurses are more likely to open themselves to the patients' spiritual concerns. Harrington's qualitative analysis of another 10 interviews with a diverse set of nurses comes to the same conclusion; however, this variable has yet not been tested empirically. In light of Taylor et al.'s (1999) noting that there is still a large percentage of variance in spiritual care giving unaccounted for, it may be worthwhile to explore through future research whether nurses' exposure to life crises shows the predicted effect.

Primary Role of the Nurse

Ross (1994a) found nurses' grade (e.g., bedside nursing versus charge nursing), significantly, positively associated with nurses' identification of spiritual needs. It is unknown; however, whether the ability of charge nurses to identify patients' spiritual needs translates into frequent attention to patients' spiritual needs at the bedside. No other studies have identified this variable as predictor for attitudes towards spiritual care or for frequency of spiritual caregiving.

Work Setting or Type of Ward

Ross (1994a) noted that nurses who reported to work in a variety of environments and in different institutions and geographical areas were more likely to identify patients' spiritual needs than those working in one type of environment or geographical area. She did not interpret this finding, however, and it did not come up in any other research study of this kind. Geographical area, however, seems to pertain to inter-institutional differences that are in this case differences between health boards or health care institutions located in different geographical areas of the country. Such differences had also been encountered by Kuuppelomäki (2001) who found nurses working in large health centers scored significantly higher in spiritual support than did nurses working at small and medium-sized health centers. She also found that nurses working in larger health centers had more frequently attended seminars and read more often privately about caring for terminally ill patients. What both Ross' (1994a) and Kuuppelomäki's (2001) studies are pointing towards is that there may be measures taken by an institution, a department within an organization or certain organizational climates that result in measurable differences in frequency of providing spiritual care.

Grant (2004) also reported efforts of a non faith-based tertiary care medical center in the United States to foster nurses' attention to spiritual matters, highlighting the idea that organizational culture may translate into practice. More basic, Vance (2001) found a significant correlation between areas of specialty and frequency scores of providing spiritual care, suggesting that clinical specialty is a potential correlate of spiritual care delivery. Kristeller et al. (1999) reported that oncology nurses working in private practice

tended to see themselves more responsible to support patients' spiritual needs than nurses working in a hospital environment where chaplains are often more accessible.

Although there are limited research findings on work setting, this variable has not been systematically researched and could be much more differentiated to explore what factors within a health care institution predict frequency of spiritual care giving. Most research to date has looked for predictors within nurses' demographic information or nurses' spirituality/religiosity. More research is needed that carefully examines the workplace as a possible predictor and explores how nurses vary in their spiritual care giving patterns across the different subspecialties.

A number of studies have researched nurses' spirituality and religiosity in relation to nurses' spiritual care attitudes, beliefs and the way they provide spiritual care. Of particular interest is the question whether nurses' spirituality/religiosity predict their practices of providing spiritual care. One of the early studies to point in this direction was Ross (1994a). She found in her British sample that nurses who claimed a religious affiliation were more likely than their non-religious colleagues to identify elderly patients' spiritual needs. Musgrave and McFarlane (2004a) studying Jewish oncology nurses, found there was an indirect effect of intrinsic and extrinsic religiosity on attitudes towards spiritual care mediated through spiritual well-being. Hence, a small but significant amount of variance of attitude to spiritual care was explained by spiritual-wellbeing, extrinsic religiosity, and to a lesser degree by education in spiritual care giving.

Similarly, Vance (2001), measuring spiritual well-being and spiritual beliefs as spirituality measures, found a significant positive relationship between nurses' spirituality

and nurses' delivery of spiritual care. In an Italian study, Boero et al. (2005) established that healthcare providers who considered themselves as religious had higher scores in strength and inner peace, and those to whom personal beliefs were important showed higher scores in wholeness and hope. Lundmark's (2006a) results from Swedish oncology nurses brought religious beliefs and non-organized religious practices to the attention as potential predictors for spiritual caregiving. Lundmark found that nursing staff who believed in God and in an after life and who spent time for themselves with activities like prayer, meditation, or reading the Bible tended to be more prone to giving spiritual care than those who did not. Taylor et al. (1999) who systematically explored various predictors for spiritual care practices found that nurses' spirituality accounted by and large for most of the variance explained. Stranahan (2001) found a significant positive relationship between nurse practitioners' spirituality scores and frequency of their spiritual care practices. The higher their spirituality scores the more frequently would nurse practitioners report engaging in spiritual care.

In sum, a number of studies support the notion that nurses' spirituality and religious orientation are correlated with a more open attitude towards and higher frequency of engaging in spiritual care. By contrast, a large British study with a diverse set of nurses did not identify any interaction effect between nurses' religious beliefs and their provision of spiritual care (McSherry, 2006). This latter finding calls attention to the issue of how constructs are defined, operationalized, and measured in a study. Future research should contextualize findings in light of their definitions and measurements of the constructs.

Some of the findings are still hard to interpret and raise further questions. For example, Musgrave and McFarlane's (2004a) finding about extrinsic spirituality impacting attitudes towards spiritual care directly or the relationship between the two related constructs spirituality and religiousness as in Taylor et al.'s (1999) study that compared oncology and hospice nurses needs further scrutiny. They noticed that oncology nurses reported higher religiousness scores, whereas hospice nurses scored significantly higher in spirituality. Not only did the two groups of nurses differ significantly in their spiritual/religious profile, they also differed significantly in frequency and comfort level in providing spiritual care. Thus, more spiritual hospice nurses reported higher frequencies and comfort levels than more religious oncology nurses. With both spirituality and religiousness being broad constructs, future research will have to try to tease out what it is about each of the constructs that predicts actual spiritual care practice. Existing research points towards spiritual well-being, positive appraisal or perception of spirituality, and spiritual care as being of predictive value. New candidates to be tested are quality of life (Boero et al., 2005), nurses' perceived effects of their spiritual care (Kristeller et al., 1999), nurses' private religious practices (Lundmark, 2006a), and nurses' work environment (Vance 2001).

Looking at spiritual care practices internationally, differences in relation to the religious part of spiritual care have emerged. Kuuppelomäki (2001) reported from a Finnish study that her fairly homogeneous Christian nurses engaged moderately in spiritual care practices and did not commonly pray or engage in other religious activities with their patients. By contrast, prayer is named fairly often as a spiritual care intervention in studies of nurses in the United States (Grant, 2004; Sellers & Haag, 1998;

Tuck, Pullen, & Wallace, 2001) and even more so when the sample includes parish

nurses (Sellers & Haag, 1998; Tuck, Wallace, & Pullen, 2001), thus, highlighting the

importance of work environment as predictor for spiritual caregiving. More frequently,

however, do nurses in the United States seem to pray privately for their patients

(Stranahan, 2001; Taylor et al., 1999) which has not been reported by studies outside the

United States.

In sum, existing findings document the need for future research that explores in

detail the role of nurses' spirituality and religiosity in relation to spiritual caregiving. The

issue of measurement and how the related constructs of spirituality and religiousness are

operationalized will be crucial for future research. Furthermore, future research models

will need to take into consideration the possible influence of environmental factors on

nurses' spiritual care giving.

CHAPTER THREE

Research Methods

Research Questions

The purpose of this study was to evaluate nurses' spiritual care practices in a faith-based tertiary care setting. The three specific study aims were as follows:

1. To describe the type and frequency of nurses' spiritual care practices,

2. To examine the potential effects of nurses' bio-demographic characteristics and their spirituality and religious orientation on their spiritual care practices, and

3. To examine the potential effects of organizational variables (e.g., type of hospital, type of unit, workload, nurse-patient ratio) on nurses' spiritual care practices.

A descriptive, cross-sectional, correlational survey study was designed to answer the following specific research questions:

1. What are the most common spiritual care practices of nurses in a faith-based tertiary care setting, and how frequently are they provided?

2. What is the relationship between nurses' spirituality and religiousness and the frequencies and types of spiritual care practices these RNs provide in a faith-based tertiary care setting?

3. What is the relationship between personal characteristics of the nurse, such as gender, age, and education level, and nurses' spiritual care practices in a faith-based tertiary care setting?

4. What is the relationship between organizational variables of a faith-based tertiary care setting (e.g., type of hospital, type of unit) and nurses' spiritual care practices?

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5. What factors are related to not providing spiritual care in a faith-based tertiary care setting?

6. What type of experiences with the sacred encountered at the workplace have shaped nurses' understanding about the meaning of spirituality in nursing?

Population and Sample

The study targeted licensed registered nurses (RNs) who work at a private, faith-based, tertiary care medical facility. The accessible population included nurses working at such a facility in the southwestern United States. Participants recruited for this research worked across the various units of acute health care and met the following eligibility criteria: (a) worked at one of the four hospitals of this health care system, (b) were state-licensed RNs, (c) stated they had provided direct patient care in the two weeks prior to completing the questionnaire, and (d) worked more than 36 hours during the two weeks prior to completing the questionnaire.

In December 2007, the total nurse (RN) population in this health care system was 2351 (Human Resource Department, email communication, December 06, 2007). Thirteen point one percent of the nurses were males. Male nurses were more than twice as highly represented in this system than they were in a recent national census where they accounted for 5.8% of the total national nursing workforce (HRSA, 2006). Most nurses (78.6%) worked full time versus 11.6% who worked part time. Nine point six percent worked unscheduled.

A little more than half of the nurses of this health care system worked in medical-surgical adult nursing at a tertiary care medical center, whereas less than half worked in

pediatric nursing at the institution's affiliated children's hospital. A minority of nurses worked in rehabilitation or at a behavioral medicine center.

The ethnic profile of the nursing workforce in this medical facility presented in the following way: 46% of the RNs were White. The second largest group was Asians, representing 34% of the nursing workforce. By contrast, Asian nurses constituted 3.1% of the total national RN workforce at the last census (HRSA, 2006). Hispanic nurses, representing 1.7% of the national workforce (HRSA, 2006), constituted 14% of this facility's RNs, a figure that matches the national representation of Hispanics in the population of the United States. Black or African American nurses constituted 5% of the RN workforce of this medical facility. This percentage was just about the same as their representation of 4.2% in the national workforce (HRSA, 2006). Therefore, this study had the potential to yield information on RNs whose ethnicities often are underrepresented in nursing, which has resulted in insufficient information in research reports on their spiritual care practices.

A review of the religious profile of the nurses in this study site largely mirrors the religious profile found in a national sample (Gallup & Jones, 2000). Fifty-five percent of these nurses identified with a Protestant denomination versus 58% in the Gallup and Jones (2000) study. Catholics were represented at roughly 19%, which is slightly less than in a national sample where 25% identified as Catholic (Gallup & Jones, 2000). Other world religions such as Judaism, Islam, Hinduism, Buddhism, or other faith traditions such as Latter-day Saints (LDS) were altogether represented in 20.4% of all nurses of this health care system. By contrast, the national Gallup and Jones (2000) study showed that Islam, Hinduism, and Buddhism each were represented with less than one

percent of the total population. Last, 5.1% of the nurses versus 8% in a national study had

not identified with any formal religion. The sample at this site tended to be representative

of the larger U.S. population (Protestants, Catholics) or the U.S. workforce (Black or

African American nurses); however, there was a higher representation of ethnic and

religious minorities (Asian and Hispanic nurses and nurses affiliating with other world

religions or Latter-day Saints) that tended not to be well represented in the national RN

workforce (HRSA, 2006).

Sample Recruitment

All registered nurses working across four hospitals of adult acute care, children's

hospital, rehabilitation, and the behavioral medicine center of a faith-based tertiary care

medical facility were contacted via email and invited to participate in this study through

an on-line survey. Prior to this contact, the study was brought to the attention of the

facility's registered nurses through announcements in newsletters and through their unit

managers as well as flyers within the work environment. In addition, personal

presentations about the study were given to all nurse managers at their regular meetings.

The majority of nurses were contacted through the organization's email system.

Three weeks after the original invitation, a reminder email was sent to all eligible nurses.

Nurses who were interested in participating found a link to an electronic version of the

questionnaire in their email invitation. A tracking system was in place to make sure that

each nurse took the questionnaire only once. Attending staff meetings of the nurse

managers and educators, the research team first presented the study to the leaders in

hopes of their becoming study advocates on their respective units. During the eight-week

study period, flyers were posted at strategic places on the unit (nurses' break rooms,

nurses' restrooms, and so forth) to alert RNs about the study and to invite them to participate. After the initial email invitation, two more reminder emails were sent to non-respondents. To remind nurses of the online survey and to maximize the return rate, the research team approached nurses across the four hospitals several times with little reminder notes that carried a candy.

Sample Size

Based on the assumption that the health care system's total workforce consisted of approximately 2311 registered nurses, it was determined that a 30% response rate would yield an approximate sample size of 600. At the onset, there was a potential of 17 independent variables in the proposed study that could be eligible for the multiple regression analysis. If 2/3 (11) of these were significantly related to the dependent variable, they would conceivably be eligible for entry into the regression model. Using the rule of thumb for a small effect size (.30), 30 subjects per variable ($N = 330$) would be adequate to detect significance at approximately 80% power (VanVoorhis & Morgan, 2007).

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Ethical Considerations

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Ethical approval was sought from the University's Institutional Review Board. Permission to access the nursing workforce was obtained from nursing administration of the health care system and support was sought from the system's Nursing Research Council. Nurses were contacted and informed about this study via their work email addresses. The email document functioned as a cover letter (see appendix) that described the purpose of the study, eligibility criteria, and the fact that nurses' participation was voluntary. Nurses were invited to participate in the study by accessing an electronic

survey through a link given in the latter part of the e-document. Participants were assured of confidentiality and that their answers would not be traced back to any individual participant. Given the measures used to protect their identity, the personal risk in participating in this study was considered minimal. The burden of participating was limited to a time investment of 10-15 minutes. Participants' deliberate attempts to access and complete the electronic survey were regarded as their informed consent to participate in this study. Throughout the approved period of this research, the researcher was available to answer questions via telephone and email.

At the completion of the survey, the nurses were qualified to enter a drawing for one of 25 $20 gift cards. The winners were given the option to choose a gift card from one of two stores. There were no other direct benefits. Nurses, however, were promised to be sent an executive summary of the research through the health system's research newsletters and through the researcher's presentation during the health system's annual nursing research conference. An indirect benefit was the value to the institution, an institution committed to "whole person care" (including the spiritual) as well as to the larger scientific community in nursing, a discipline also invested in spiritual care. Nurses reported that participating in the study challenged them to rethink personally what it meant for them to provide spiritual care to their patients.

Measures

The following measures were used for the electronic survey: demographic information compiled by this researcher. Beyond describing the diversity of the sample, some demographic variables also were tested for their predictive value. Other independent variables that were tested included conceptualizations of spirituality and

religion according to Zinnbauer et al. (1997), the Duke University Religiosity Index (DUREL) as a measure for religiousness, the Fetzer Institute's Daily Spiritual Experiences (DSE) Scale by Underwood (1999, 2003) as a measure for spirituality, and organizational variables compiled from the literature by this researcher. The dependent outcome variable in this study was frequency of providing spiritual care measured by Taylor's (2008) Nurse Spiritual Care Questionnaire (NSCQ). For a comprehensive list of all measures, please refer to Table 1.

Demographic Independent Variables

Participants were asked to provide socio-demographic information for three reasons:

1. To capture the degree of diversity that was represented in the sample and to determine how representative the sample was of the larger local nursing staff.

2. To explore potential relationships between demographics (age, years of experience as a nurse [RN], gender, ethnicity, highest nursing degree, religious affiliation, primary role as an RN, and formal education in spiritual care during their nursing career) and NSCQ scores.

3. To ensure that participants met the eligibility criteria to participate in this study: Participants were asked if they held an active state RN license and if they had worked at the bedside with patients for at least 36 hours in the two weeks prior to filling in the survey. The question, what prompted them to respond to this research, was asked to determine whether they responded to the initial email invitation or after additional IRB approved measures were taken to encourage non-respondents to participate.

After univariate descriptive analyses, bivariate statistical analyses were conducted between demographics and the outcome variable (NSCQ) to determine whether any of them were associated with the frequency of providing spiritual care. Demographics revealing statistically significant relationships were considered for entry in the multiple regression analysis. For a complete list of demographic variables and the appropriate statistical procedure for the bivariate analyses please refer to Table 2. The significance level of $p = .05$ was set for bivariate and multivariate analyses.

Other Non-Demographic Independent Variables

The Daily Spiritual Experiences Scale (DSE). With its 16 items, the DSE represents day-to-day spiritual experiences of spiritually and religiously diverse people (Underwood, 1999, 2003). The instrument purports to measure the effects of spirituality and religion on the daily lives of ordinary people. Specifically, it is meant to assess perceptions of/interactions with the transcendent (higher power or God) in daily life. Some examples of items are "I feel God's presence," "I find strength in my religion or spirituality," "I experience a connection to all of life," and "I ask for God's help in the midst of daily activities." The DSE has been developed on the basis of both theoretical and empirical work over a number of years and builds on a broad conceptualization of spirituality. As Underwood and Teresi (2002) stress, the DSE is "intended to transcend the boundaries of particular religions" (p. 22). It is assumed that spiritual experience can be related to traditional religion or occur independently. The tool is reported to be sensitive to both the spiritual experience of traditionally religious people as well as to highly individualized forms of spirituality, such as Roof's "highly active seekers" (1994) or the "spiritual but not religious" (Fuller, 2001).

Given the profound differences in spirituality across people, the instrument uses the word *God* to describe the transcendent dimension. Specifically, the instructions state that participants are encouraged to "substitute another idea which calls to mind the divine or holy for you" (Underwood & Teresi, 2002, p. 24) if the individual is not comfortable with the word *God*. This wording decision has been supported by the finding that items with explicit reference to God did not factor separately from items without this reference during exploratory factor analysis (Underwood & Teresi, 2002).

Psychometric analyses were based on data that had been collected at three different sites (Underwood & Teresi, 2002). An initial exploratory factor analysis [EFA] suggested a unidimensional scale. When performing EFA with an oblique rotation, all but two items loaded on the first factor with factor loadings between .69 and .93. Underwood and Teresi (2002) decided against a two-item subscale, thus, retaining a one-factor scale. Unidimensionality also was supported by coefficient alphas of .94 and .95. The completion time of the 16-item version was estimated to be less than 2 minutes (Underwood, 1999, 2003). There is a shorter version of the DSE that has been used by the General Social Survey (GSS) in conjunction with other Fetzer measures; however, Underwood and Teresi (2002) do not recommend the short version for general use because the GSS items were not selected on the basis of extensive testing.

First, reliability for the DSE for this sample was established by determining the mean, standard deviation, range, and Cronbach's α for the total scale. Second, univariate analysis displayed the scale's distribution and measures of central tendency. In the bivariate statistics, Pearson's *r* correlation was used to determine whether there was a

relationship between the DSE total score and the total score for the NSCQ. DSE total

scores were entered into multiple regression analysis.

The Duke Religiosity Index (DUREL). The DUREL was developed by Koenig,

Meador, and Parkerson (1997) and is a five-item scale tapping three core dimensions of

the "religious" construct (Koenig, McCullough, & Larson, 2001): organizational religious

activity (ORA) (frequency of attending religious services), non-organizational religious

activity (NORA) (frequency of praying, meditating, or studying religious text), and

intrinsic religiosity (degree of internalization of one's religious practices and beliefs).

ORA and NORA are 1-item subscales that are scored on a 6-point Likert-type scale

(range 1-6). The last three constitute the subscale intrinsic religiosity [IR] and are scored

on a 5-point Likert-type scale, ranging from 3-15. Resulting aggregate scores for these

may range from a minimum of 5 to a maximum of 27. Responses to the three subscales

may be summed yielding a total score.

The decision to use this instrument was based on the fact that the DUREL

measures religiosity broadly in terms of organized as well as non-organized religious

activities, that it takes into account major motivational convictions, and that it was short

and straightforward (less than one minute to complete). Furthermore, there is solid

psychometric support (see Sherman et al., 2000); for example, it has shown good internal

consistency and moderate to high correlations with other measures of religiosity.

Importantly, its positive relationships with psychosocial instruments are modest, which is

evidence that the instrument measures what it purports to measure. Please refer to Table 1

for more details on the reliability of DUREL scores.

In the analysis, reliability was established for the different dimensions of the instrument and the total score for this sample. Univariate analysis displayed measures of central tendency and dispersion in relation to the three subscales and the total scores. Bivariate analysis using Pearson's *r* (correlation) was conducted to explore the relationship to the outcome variable (NSCQ). Based on the intercorrelations with other continuous variables, the DUREL or the subscales were entered into the multiple regression analysis. For an overview of the statistical procedures in relation to research question 3, please refer to Table 2.

Zinnbauer et al.'s (1997) conceptualizations of spirituality and religion. Zinnbauer et al. (1997) have developed several measures to assess individuals' perceptions of the concepts spirituality and religiousness. Two of their categorical questions were used in this research. The first question allows participants to choose one out of five descriptions as to how they perceive the relationship between spirituality and religiousness. In four out of five options, the concepts are somehow related, whereas the fifth option describes concepts that have no overlapping properties

After collapsing the five categories into two categories, there were two groups remaining: Those who see the concepts in an integrated way and those who see the concepts independent of each other. Bivariate analysis using independent t-tests were used to determine if there was a relationship between the two groups and the dependent variable (NSCQ) (see also Table 2-1).

The second question asked participants to define how they see themselves in relation to the concepts. There were four categories to choose from, and participants were asked to check the one that best described how they saw themselves: spiritual and

religious (S & R), spiritual and not religious (S & nR), neither spiritual nor religious (nS & nR), religious but not spiritual (R & nS). This question differentiates between three major groups: individuals who are religious in the traditional way (S & R, nS & R), people who are non-traditional in their spiritual quest (S & nR), and people who identify as secular (nS & nR), neither spiritual nor religious. Based on Zinnbauer et al.'s (1997) findings, it was possible that the nS & R and the nS & nR group would be underrepresented and was dropped from the analysis. Of particular interest, however, was a comparison between the S & R and the S & nR group in relation to the outcome measure as well as the independent variables, DSE and DUREL. (See Table 1 for the description of each of the variables and their level of measurement). These analyses determined whether it was reasonable to use any of those variables for the multiple or logistic regressions.

Organizational Variables

Organizational variables are structural factors that may influence nurses' professional practices. They are the context in which nurses may or may not provide spiritual care. Research has shown that patient outcomes (e.g., length of hospital stays, failure-to-rescue rates, perception of individualized care) are influenced by structural factors, such as type of hospital, unit size, nurse-patient ratios and model of care used to organize the work (e.g., Aiken, Clarke, Sloane, Stochalski, & Silber, 2002; Aiken, Clarke, Sloane, & Stochalski, 2001; Needleman, Buerhaus, Stewart, Zelevinsky, & Matte, 2006; Suhonen, Välimäki, Katajisto, & Leino-Kilpi, 2007). Therefore, this research sought to explore the relationship between structural or organizational factors and nurses engaging in spiritual care practices.

Characteristics of the hospital. Participants were asked about the type of hospital in which they worked (four response categories, see Table 1) and their type of work unit (20 response options, see Table 1).

Staffing characteristics. Participants were asked about the number of hours they worked in the 2 weeks prior to taking the questionnaire and about their perceptions of their usual workload: "On an average, how many patients do you take care of during a shift?"

Nurses' opinions about spirituality in the work environment. The next group of questions assessed nurses' perceptions of their work environment in relation to spirituality. One, nurses were asked whether they work in an area of nursing where patients tend to be particularly in need of spiritual care. Two, they were asked whether they believed that spirituality comes up often in their personal interactions with patients. Three, they were asked to explore whether they usually feel comfortable when a patient talks about religious issues. In addition, the questions determined how they perceived themselves as well as their colleagues in terms of being comfortable talking about spirituality. Last, nurses were asked whether they perceived their supervisors to be supportive of their providing spiritual care. For the analysis, please refer to Table 2-1.

The Dependent Variable: Nurse Spiritual Care Therapeutics Questionnaire (NSCQ)

The NSCQ is a newly-developed 17-item tool that operationalizes a diverse range of possible nurse responses with regard to spirituality (Taylor, 2008). The instrument measures frequency of providing spiritual care, and the underlying definition of a nurse-provided therapeutic is "Ways of being or actions taken by a nurse with the intent to promote patient health (or a good death) – in this case, spiritual health (best termed

integration or the incorporation of spirituality into all aspects of life)" (Taylor, 2008, p. 154-159). Taylor (2008) assumes that spirituality is about spiritual integration and acknowledges that spirituality includes periods of challenging emotions. The author, therefore, questions that feeling good is a valid indicator of movement towards spiritual integration (Taylor, 2008) and describes a careful process of refining the items to establish construct validity by working with a panel of nursing spiritual care experts. Nine doctorally-prepared nurses were asked to comment on and grade 29 pilot items in terms of their relevance in nursing. Based on their feedback expressed on a four-point Likert scale ranging from "not relevant" to "very relevant," a content validity index (CVI) was established for each item. Taylor (Elizabeth Johnston Taylor, email communication, June 22, 2008) then eliminated all items that received a CVI score of less than "very good" (equivalent to a percentage score of less than .77 panel agreement). This step reduced the scale to 17 items (see appendix) that qualified for further testing.

Reliability testing of the 17 items was conducted with a small sample ($N = 53$) of nurses who volunteered to pilot this instrument. These were nurses who had either completed a curriculum in spiritual care (58.5%) with Dr. Taylor (Taylor, Mamier, Bahjri, Anton, & Petersen, 2009) or who knew someone who had completed this curriculum and invited them to participate. Most in the sample were BSN prepared nurses (49%), followed by 30% who had a Master's degree or higher, and 21% who practiced nursing with an Associate Degree. Each of the 17 items was followed by a five-point Likert-type scale that participants rated in response to the question: "During the past month, with the intent to offer spiritual care, how often have you:...." The response options ranged from never to very often (at least 12 times). It is also important to note that Taylor (2008) in the introduction to the survey refers to a broad conceptualization of patient defined as any person receiving nursing care (e.g., family members). Similarly, the term "illness" being used may well be substituted by health concerns, loss or some other word indicating concern, loss, or a health transition. Preliminary analyses had

yielded a coefficient alpha of .89 for the entire scale. Taylor reported the following statistics for the scale: mean of 50.56, standard deviation of 11.69, and possible range 17 - 85 (Elizabeth Johnston Taylor, email communication, April 16, 2008).

Table 1

Descriptions of Independent Variables

Variable	Measures	Level of measurement	Description
Underwood (2003) Daily Spiritual Experience Scale	spirituality	Continuous: sum score of unidimensional scale	16 questions, 5 point Likert-type scale, sum scores between 16-80. Cronbach's α ranges from .94 to .95.
Koenig, Meador, and Parkerson (1997) Duke University's Religion Index (DUREL)	religiousness	Continuous: 3 sub- scores & a total score: (1) org. rel. activity [ORA] (1item) (2) non-org. rel Activity.[NORA] (1item) (3) intrinsic rel. [IR] (3item)	5 item Likert-type scale, items (1) & (2) scored separately on a 6 point Likert scale. Subscale (3) consists of 3 items scored together on a 5 point Likert Scale. Reliability: Cronbach's α for subscale (3) found to range between 0.75 – 0.88 (Koenig et al.,1997) and 0.90-0.94 according to Sherman et al. (2000). Internal consistency of the total scale has been found to range between a Cronbach's α of 0.87-0.90 (Sherman et al., 2000).
Zinnbauer et al.'s (1997) measures of S & R	(1) Perceptions of the concepts	(1) categorical	Question (1): 5 response categories: S includes R, R includes S, S&R overlap but are not the same, S&R overlap completely, S&R are totally different non-overlapping concepts
Zinnbauer et al.'s (1997) measures of S & R	(2) Perceptions of self r/t S&R	(2) categorical	Question (2): 4 response categories: a) S&R a) & b) collapse as trad. rel group b) nS&R c) S&nR c) non-trad. quest spirituality d) nS&nR d) non-religious/ secular
Age	Age in years	Continuous	Age
Experience	Exp in years	Continuous	# of years working as RN
Gender	Male/female	Categorical	Binary variable
Race/Ethnicity	5 categories	Categorical	White/Caucasian, AA/Black, Hispanic/Latino, Asian/ Pacific Islanders, Others
Highest degree nrsg	4 categories	Categorical	AS/Diploma/BSN/graduate degree in nursing
Education in s.c.	5 categories	Categorical	undergrad. ed./grad. ed./CEU/personal readings/n/a
Religious affiliation	7 categories	Categorical	Protestant (specify), Catholic, Jewish, Islam, non-trad. Christian, Other World Religion, No Religious Preference
Primary role: work	5 categories	Categorical	Staff Nurse, Supervisor/Charge Nurse, Nurse Manager, Nurse Educator, Administrator
CA-RN license	Yes/No	Categorical	Screening question
Bedside nrsg care	Yes/No	Categorical	Screening question
Response to study	3 categories	Categorical	Screening question: email/presentation/other:_____
Org Var 1: Hospital	4 categories	Categorical	MC, Childrens' Hospital, BMC. Community Hospital
Org Var 2: Unit	20 categories	Categorical	Will be collapsed meaningful smaller # of units
Org Var 3: # of h worked in 2 weeks	Work time in hours	Continuous	>70 h/2weeks is considered full time, 40-69h in 2 weeks is considered part time. < 40h does not qualify
Org Var 4: staffing	# of patients/shift	Continuous	Determines workload
Org Var 5: nurses' perceptions of work environment	6 Yes/No	Categorical	(1) Do patients in your work environment seem to be particularly in need of spiritual care? (2) Does spirituality come up often with your patients? (3) Do you usually feel usually comfortable when a patient talks about religious issues to you? (4) Are you comfortable talking about spirituality? (5) Do you think your colleagues are comfortable talking about spirituality? (6) Do you think your supervisors are supportive of you providing spiritual care?

Table 2

Analytical Strategy for Research Question 1

Q1: What are the most common spiritual care practices of nurses in a faith-based acute care setting, and how frequently are they provided?		
Independent Variable [IV]	**Level of Measurement**	**Analytical Strategy**
Nurse Spiritual Care Therapeutics Questionnaire (NSCQ)	Continuous	Univariate descriptive analysis of 17 items of NSCQ with sum score of each item and sum score of one-dimensional scale

Table 3

Analytical Strategy for Research Question 2

Q2: What is the relationship between nurses' spirituality and religiousness and their spiritual care practices in nursing in a faith-based acute care setting?			
Independent Variable [IV]	**Level of Measurement**	**Analytical Strategy**	**Dependent Variable [DV]**
Daily Spiritual Experience Scale [DSE] –main measure for spirituality	continuous	Univariate Descriptive Analysis Bivariate: Pearson r Correlation Multiple Regression Analysis	NSCQ
Duke University's Religion Index [DUREL] – main measure for religiousness	continuous	Univariate Descriptive Analysis Bivariate: Pearson r Correlation Multiple regression analysis	NSCQ
Zinnbauer et al.'s (1997) measures of S & R - secondary measures for S & R (1) Perceptions of the concepts	categorical	Univariate Descriptive Analysis Collapse 5 categories into 2. independent t-test, Multiple regression analysis	NSCQ
Zinnbauer et al.'s (1997) measures of S & R (2) Perceptions of oneself in relation to S & R	categorical	Univariate Descriptive Analysis Collapse 4 categories into 3 and run ANOVA with Tukey post-hoc test for 3 categories Chi square for association between (1) & (2) with collapsed Categories 2x3 Multiple regression analysis	NSCQ

Table 4

Analytical Strategy for Research Question 3

Q3: What is the relationship between personal characteristics of the nurse and nurses' spiritual care practices in a faith-based acute care setting?			
Independent Variable [IV]	**Level of Measurement**	**Analytical Strategy**	**Dependent Variable [DV]**
Age	Continuous/ ratio level	Pearson's r correlation; Multiple regression analysis if significant	NSCQ
Experience	Continuous/ ratio level	Pearson's r correlation; Multiple regression analysis if significant	NSCQ
Gender	Categorical/ nominal	Independent samples t-test; Multiple regression analysis if significant	NSCQ
Race/Ethnicity	Categorical/ nominal	One-way ANOVA with post-hoc Tukey test; Multiple regression analysis if significant	NSCQ
Highest degree in nursing	Categorical/ nominal	One-way ANOVA with post-hoc Tukey test; Multiple regression analysis if significant	NSCQ
Education in providing spiritual care	Categorical/ nominal	One-way ANOVA with post-hoc Tukey test; Multiple regression analysis if significant	NSCQ
Religious affiliation	Categorical/ nominal	One-way ANOVA with post-hoc Tukey test; Multiple regression analysis if significant	NSCQ
Primary role at work	Categorical/ nominal	One-way ANOVA with post-hoc Tukey test; Multiple regression analysis if significant	NSCQ

Table 5

Analytical Strategy for Research Question 4

Q4: What is the relationship between organizational variables of a faith-based acute care setting and nurses' spiritual care practices?			
Independent Variable [IV]	**Level of Measurement**	**Analytical Strategy**	**Dependent Variable [DV]**
Org Var 1: Hospital	categorical	Univariate Descriptive Analysis Bivariate Inferential Analysis with DV: One-way ANOVA with Tukey post-hoc test, enter in Multiple Regression Analysis if one of the groups is significant	NSCQ
Org Var 2: Unit	Categorical	Univariate Descriptive Analysis Collapse units in a meaningful way for adequate cell sizes. Bivariate Inferential Analysis with DV: One-way ANOVA with Tukey post-hoc test, enter in Multiple Regression Analysis if one of the groups is significant	NSCQ
Org Var 3: Number of hours worked 2 weeks prior to taking the survey	continuous	Univariate Descriptive Analysis Bivariate Inferential Analysis: Pearson's r Correlation with NSCQ after eliminating those who worked <40h/2 weeks Multiple Regression Analysis if significant	NSCQ
Org Var 4: Staffing: Number of patients	continuous	Univariate Descriptive Analysis Bivariate Inferential Analysis: Pearson's r Correlation with NSCQ	NSCQ
Org Var 5: Nurses perceptions of work environment	categorical	Univariate Descriptive Analysis Present perception of own comfort level (4) and perceptions of colleagues (5) per unit. Compare comfort level with religious (3) vs. spirit. (4) issues Bivariate Inferential Analysis (4) & (6) with DV: One-way ANOVA with Tukey post-hoc enter in multiple regression if significant	NSCQ

Table 6

Analytical Strategy for Research Question 5

Q5: What are factors that are related to not providing spiritual care in a faith-based acute care setting?			
Independent Variable [IV]	**Level of Measurement**	**Analytical Strategy**	**Dependent Variable [DV]**
Selected IV based on outcomes from main analysis		Logistic Regression	NSCQ Recode into categorical variable providers vs. non-providers

Table 7

Analytical Strategy for Research Question 6

Q6: What type of experiences with the sacred encountered at the workplace have shaped nurses' understanding about the meaning of spirituality in nursing?		
Data	**Type/Typology**	**Analytical Strategy**
Nurses' accounts	A) Spiritually Engaging Experiences: 　(1) Integrative, Confirmatory 　　-Rites of Passage 　　-Bonding Moments 　　-Healing Events 　(2) Non-trad. Quest Type 　(3) Experience of the Sacred in Collectivity 　(4) Counter Culture B) Spiritually Disengaging Experiences 　(1) Cynicism 　(2) Bewilderment 　(3) Humor	Content Analysis using the typology to the left, allows quantifying spiritually engaging vs. disengaging experiences.

Data Management and Analyses

Preliminary Data Analysis

Because this study was conducted by means of an online survey (no paper and

pencil format), data were downloaded from Survey Monkey® to be analyzed with the

Statistical Package for the Social Sciences Version 17 (SPSS®). Frequency distributions

were obtained for categorical variables and measures of central tendency and variability

were obtained for continuous variables. To allow for adequate frequencies in cells used in the bivariate analyses, some variables (e.g., religious affiliation, type of unit) were collapsed into fewer, still conceptually meaningful categories. Data were examined for skewness and kurtosis to make sure that the assumption of normality was justified. Out of range values were removed from the analyses, and missing data were assigned a code. Subsequent frequency distributions were run to determine the rate for missing data, which was addressed in the following ways: Before running any inter-item reliability and factor analyses, missing data for the three scales NSCQ, DUREL, and DSE were imputed using the expectation maximization procedure described by Schafer and Graham (2002). Finally, all continuous variables were entered into a correlation matrix to check for significant relationships among variables. For all inferential analyses, alpha was set at .05.

Testing the Reliability of the NSCQ

Reliability indices show the extent to which something can be measured consistently. One such measure is coefficient alpha or Cronbach's α. This researcher also calculated item and scale means, variances, and standard deviations.

Testing the Validity of the NSCQ

A moderate correlation was expected between the DUREL and NSCQ as well as between the DSE and NSCQ (construct validity). Construct validity also was evaluated based on an exploratory factor analysis (EFA) that detected the clusters of items and identified relationships among items, specifically the (a) discovery of one or more factors/components/or domains that the NSCQ taps, (b) identification of scale items constituting each factor, (c) strength of each item's factor loading, and (d) variance

explained in the original set of variables by identified factors (Mertler & Vannatta, 2005). EFA is a theory building technique used to discover the underlying factor model best fitting the study data. Hence, EFA is a very appropriate method particularly for the early stages of instrument development, as was the case here.

In a first step, the factor analysis (principal axis factoring, unrotated) was conducted. This operation allowed evaluation of the adequacy of the matrices upon which this factor analysis was based and informed a decision about the number of factors extracted in further exploratory work. The decision about the number of factors to be retained also was based on several criteria: (1) eigenvalues > 1, (2) the evaluation of a scree plot (corresponding to number of distinct breaks in the slope of the line), and (3) the percentage of total variance explained (Mertler & Vannatta, 2005). Several tests to evaluate the data matrices were used, among others Bartlett's test of sphericity and Kaiser-Meyer-Olkin (KMO) measure of sampling adequacy.

Multiple Regression Analysis

Multiple regression analysis was used for understanding the effects of several independent variables on NSCQ scores. Possible predictors for the regression model were nurse demographic factors, spirituality and religiousness variables, organizational variables (see Table 2) as well possible interaction effects of some of the independent variables. Outcomes of the bivariate correlations between possible predictors and the dependent variable determined which variables were to be entered into the regression equation. A number of regressions were run to find the best fit. Prior to multiple regression analysis, all independent variables were entered into a correlation matrix and examined for moderate to high intercorrelations to rule out multicollinearity of

independent variables (Mertler & Vannatta, 2005). The regression model was also visualized well in the research graphical model that can be found under Figure 1 on page 16.

Qualitative Research Question

This researcher asked one final open-ended question: "Tell me about an experience at work that greatly influenced your understanding of spirituality, positively or negatively?" A similar question had previously been given to nurses at a tertiary care secular workplace, and two-thirds of the nurses shared an experience with the research team (Grant, O'Neil, & Stephens, 2004). These responses pointed toward the fact that nurses do encounter spirituality/the sacred within a secular organizational context. The question used in this study was, however, the open-ended question above.

The analysis for this question was based on the conceptual typology of the sacred by the sociologist of religion N. J. Demerath III (2000). He differentiated experiences of the sacred in two ways: First, he distinguished between experiences of the sacred that are confirmatory (affirming one's identity, providing support, assurance, and security) versus compensatory (that is providing release/relief from unfulfilling commitments to the sacred by offering alternative ones). Second, Demerath contends that experiences of the sacred are either marginal (outside of mainstream) or institutional (occurring within a culturally like-minded collectivity). The combination of the two distinctions generated the following four types of the sacred as: (a) integrative (marginal/confirmatory), (b) quest (marginal/compensatory), (c) collectivity (institutional, confirmatory), and (d) counter culture (institutional/compensatory). Where experiences follow a confirmatory or compensatory function, they can be classified as engaging encounters with the sacred.

Based on Demerath's typology, Grant (2004) differentiated between nurses' encounters with the sacred at work that are spiritually engaging versus disengaging. Grant further classified disengaging encounters under the following three categories: (a) cynicism, (b) bewilderment, and (c) humor.

Using a directed qualitative content analysis approach the data from Question Six were analyzed (Hsieh & Shannon, 2005). In this approach the initial coding was based on Demerath's typology (2000). Where the data did not fit the categories a new category was developed to better represent the findings within this sample of participants.

Summary for Chapter Three

This chapter provides an overview of the research questions, sampling plan, and the study site. The variables selected for this study have been described with information regarding reliability and validity provided. The measures have been found to have adequate psychometric proprieties to support their use. The process of data collection, data preparation, and data analysis has been outlined. Additionally, the background and method of analysis for the open-ended question has been described. The following chapter will provide a description of the findings of the study.

CHAPTER FOUR

Results

This chapter contains a description of the study findings, and organization follows the research process of recruitment, data collection, data preparation, sample description, findings, and summary.

Recruitment and Response Rate

Recruitment of potential research participants began with this researcher attending nursing management and educators' meetings in the four hospitals to inform staff about the purpose and format of the study. The managers (directors) and educators were asked to post flyers on their respective units and inform their staffs about the study. During data recruitment and collection, a total of 2311 RNs were contacted through the participating tertiary-level health care organization's work email system and invited to participate in the online survey. Reminder emails were sent to non-respondents at three and five weeks after the initial invitation. These reminder emails resulted in additional response waves. After the eight-week period of data collection, a total of 679 responses were downloaded from Survey Monkey and imported via Excel into an SPSS (version 17) data file. Review of the Survey Monkey output showed that nine individuals had opted out of the study, leaving the number of respondents at 670. Thus, 28.9% of the total RN workforce had responded by accessing the survey. Further analysis of the downloaded cases showed that 43 respondents did not meet inclusion criteria, and they were deleted from the data matrix. A review of the remaining questionnaires showed 605 completed, resulting in a net response rate of 26.9%.

The majority of respondents (81.2%) stated that the email invitation at work prompted their participation in this study. Very few responded to the flyers that were posted on the units (2.2%) or because their supervisor (1.6%) or a co-worker/educator requested their participation. The researcher and a team of helpers visited the units with fruits and candies accompanied by a reminder note asking that nurses check their work emails. Forty-five individuals (8.1%) participated in response to talking with the research team. Five participants (0.9%) responded due to presentations given by the researcher, and another five (0.9%) responded out of curiosity. Eleven individuals (2%) noted that their commitment to research or to the topic was their prime reason for responding, and 11 (2%) were prompted primarily by the offer of candy or the raffle. The biggest challenge was to ensure that RNs checked their work emails. The extra measures taken to remind RNs to check their emails for the study invitation likely increased the number of respondents by five to ten percent. Personal interactions of the research team during day and night shifts appeared to have maximized the number of nurses willing to participate.

There were, however, a number of participants who reported difficulties progressing from one section of the survey to the next, and others who said they completed the survey aided by the help desk but still showed up as incomplete surveys for the researcher. It is unclear how many of the incomplete surveys were due to such submitting/receiving problems with the online survey. Chamiec-Case (2006) described similar problems in his online survey where some of the information was downloaded incomplete although the participants, in fact, had completed their surveys. The research team could not rule out that security features of the unit computers caused submission problems.

Preparation of the Data and Variable Recoding

Initial data screening involved reviewing descriptive statistics for each variable in the data set (e.g., frequencies, ranges, *SDs*, and distribution plots). The printouts were reviewed for unexpected values, missing values, and outliers. Where inconsistencies were found, additional cross checks were made. Cases having more than five missing values across all variables were removed ($n = 73$) from the data matrix, leaving a sample of 554 cases. Univariate analysis of the data revealed a moderate skew to the left of the midpoint for the Daily Spiritual Experience Scale (DSE) indicating a fairly spiritual sample. Nurses' Spiritual Care Questionnaire (NSCQ) was moderately skewed to the right, indicating predominantly lower scores for spiritual care practices. The three Duke Religion Index (DUREL) sub-dimensions were recoded so that higher scores reflected higher practice. Analysis of the distributions revealed a moderate skew to the right, indicating a fairly religious sample. Nevertheless, the standard deviations for each of the tools showed adequate variability. There were outliers within the variables of age and experience. These cases were checked and determined to be accurate. Some of the outliers within the variable "number of hours worked" were reevaluated in light of present hospital policy, and a few of these outliers were replaced by missing values.

Missing values across the three instruments (DSE, DUREL, and NSCQ) were imputed using Missing Value Analysis, the expectation-maximization (EM) method described by Schafer and Graham (2002). The number of missing values per variable across the matrix ranged between zero and ten. Hence, no more than ten values per variable were imputed. Items that had the most missing values in the NSCQ were item seventeen with ten missing values, item sixteen with eight, items five and eight with six,

and items eleven and thirteen with five. Within the demographic variables, ten missing values remained across the variables of race and religious preference and three for gender. These all were coded system missing.

Within the demographic variables, a number of recodes were made. For example, a total of 60 individual units had to be recoded into larger work area groups to allow for subsequent comparisons. Table 1 (see after the next paragraph) presents 19 different nursing areas that were reorganized into nine groups for the bivariate analysis. Similarly, hospitals were grouped to make adult versus pediatric versus psychiatric hospital comparisons. The education variable was recoded from six levels into a three-level variable for the bivariate analysis. The continuous variable "hours worked in the last two weeks" was recoded into a three-level variable differentiating between working "full time," "part time," or "over time." Within religious preference, non-denominational Protestants were combined with non-denominational Christians; Jewish and Muslims were grouped with "other religions;" and Latter-day Saints were combined with the "Protestant non-SDA" category.

Throughout the following sections, reference will be made to the tables embedded in the text. Descriptive statistics are shown in Table 8 and 10 for categorical and in Table 9 and 11 for continuous variables. Within these and the tables that follow, variables are organized, where possible, by demographics, nurses' spirituality and religiousness, and organizational variables. Organizational variables represent nurses' work environment (e.g., hospital, unit, area of nursing) and to their perceptions of factors within this environment (e.g., patient needs, supervisor support, nurses' spiritual care comfort level).

Table 8

Descriptive Statistics: Demographic Variables (Categorical)

Variable	N	%
Gender		
Male	73	13.2
Female	478	86.3
Race		
Caucasian/White	261	47.1
Hispanic/Latino	75	13.5
Asian/Pacific Islander	180	32.5
Black/African American	26	4.7
American Indian/Alaskan Native	2	0.4
Educational Background		
Diploma in Nursing	5	0.9
Associate Degree in Nursing	218	39.4
Bachelor's Degree in Nursing	277	50.0
Non-Nursing Bachelor's Degree	12	2.2
Master's and Doctoral Degree in Nursing	27	4.9
Non-Nursing Master's and Doctoral Degree	15	2.7
Hospital		
Medical Center (Adult Care)	294	53.1
Children's Hospital (Pediatric Care)	198	35.7
Community Hospital (Adult Care)	39	7.0
Behavioral Medical Center (Psychiatric Care)	23	4.2
Workload		
Full Time (70-80 h/14 days)	351	63.4
Part Time (<70h/14 days)	135	24.4
Over Time (>80h/14 days)	66	11.9
Work Role in Addition to Patient Care		
None, Patient Care Exclusively	361	65.2
Team Leader/Shift Coord./Relief Charge Nurse	142	25.6
Charge Nurse/ Manager/Supervisor/Director	23	4.2
Educator	17	3.1
Advanced Nursing Practice (APN) role	11	2.0

Variable	*N*	%
<u>Shift</u>		
Day	317	57.2
Night	234	42.2
<u>Work Area</u>		
General Medicine and Rehabilitation	64	11.6
General Surgery	28	5.1
General Pediatrics	36	6.5
Medical ICUs	49	8.8
Surgical ICUs	49	8.8
Pediatric ICUs and Intermediate Care	51	9.2
NICU	75	13.5
Oncology (Pediatrics)	18	3.3
Oncology (Adult, In and Out Patient)	16	2.9
Behavioral Health	22	4.0
Emergency Department (Adult and Pediatrics)	26	4.7
Procedural Services (e.g., VAT, Dialysis)	14	2.5
Pre, Peri and Post Operative Services	26	4.8
Peds Pre and Post Procedure Care and Dialysis	9	1.6
Outpatient Services and Laboratories	6	1.1
Labor and Delivery	36	6.5
ICU Resource and Flight Nurses	16	2.9
Case Management	3	0.5
Advanced Nursing Practice (APN)	2	0.4
<u>Received Education in Providing Spiritual Care</u>		
Yes	362	65.3
No	192	34.7
<u>Obtained Spiritual Care Education through:</u>♦		
Undergraduate Nursing Program	179	49.5
Graduate Nursing Education	22	6.1
In Service (other than orientation)	66	18.2
Completed Continuing Education Units (CEUs)	49	13.5
Personal Reading about Spiritual Care	71	19.6
Other	37	10.2

♦ several participants marked more than one option

Description of the Sample

Nurses' Bio-Demographics

An overview of the participants' demographics is given in Table 9. The sample of 554 Registered Nurses (RN) was on average 39 years old (*SD* 10.89) and had 11 years (*SD* 10.04) of RN experience. They had worked an average of 69.5 hours (*SD* 14.24) during six shifts. Most nurses worked full time (63.4%), 11.9% worked overtime (defined as more than 80 hours in two weeks), and 24.4% worked part time. Most nurses worked the day shift (57.5%) and cared for an average of four patients per shift.

Table 9

Descriptive Statistics: Demographic and Work-related Variables (Continuous)

Variable	Mini-mum	Maxi-mum	Mean	Mode	*SD*
Age	21	67	39.0	25	10.89
RN experience (years)	0	45	11.0	1	10.04
Number of shifts in the last 2 weeks	3	12	6.14	6	1.48
Hours worked in the last 2 weeks	36	122	69.5	72	14.24
Number of patients in one shift	1	30	4.3	2	3.84
RNs' perceptions of work environment					
Patients in need of spiritual care	1	5	3.68	3	0.90
Frequency of spiritual issues	1	5	3.01	3	0.78
Comfort in talking about spirituality	1	5	3.41	4	1.22
Colleagues' comfort with spirituality	1	5	3.19	4	1.09
Supervisor support	1	5	1.93	1	1.09
Comfort with religious issues	1	5	3.71	4	1.03

Please refer back to Table 8 for the descriptive statistics for the categorical demographics. Male RNs constituted 13.2% (n = 73) of the sample. The racial/ethnic profile of the sample generally corresponded to the racial/ethnic profile of the total workforce with 47.1% Caucasian/White, 32.5% Asian/Pacific Islander, 13.5% Hispanic/Latino, 4.7% Black/African American RNs. American Indian/Alaskan Native nurses were represented by only two individuals (0.4%) in this study.

Most RNs (50%) held a Bachelor's degree in nursing. The relative under representation of graduate degrees (7.6%) was the result of the inclusion criterion that required at least 36 hours of direct patient contact in the two weeks prior to taking the survey. Because many of the nursing leaders with advanced degrees did not qualify to take the survey, most participants were RNs (65.2%) who practiced patient care exclusively. Nursing leadership, however, was represented in the study as team leaders/shift coordinators/relief charge nurses (25.6%), and in 9.2% of the total sample they belonged to the diverse group of charge nurses/managers/supervisors/directors, educators, and Advanced Practice Nurses (APN). The four hospitals were represented proportional to their sizes and numbers of RNs: 53.1% worked at the Medical Center, 35.7% worked in the Children's Hospital, 7.0% were from the Community Hospital, and 4.2% were from the Behavioral Medical Center.

Sources of Spiritual Education

Only 34.7% of the respondents had never received education about spiritual care. Of the ones who had received spiritual care education (n = 362), 78% marked the default option and identified one place where they had received education about spiritual care. Of those who marked several sources, 12.2% identified two, 7.2% referred to three sources,

and 2.2% had obtained their spiritual care education in more than three places. Almost half of those who received spiritual care education ($n = 179$) noted that they had received the education in their undergraduate nursing program. By contrast, only 6.1% marked graduate education in nursing; however, 18.2% had received spiritual care education during in-service programs, and 13.5% had taken continuing education units in spiritual care. Reading on their own about spiritual care was noted by 19.6%, and 10.2% named other places that had provided them with knowledge about spiritual care: through church related ministries ($n = 7$), through a pediatric residency program ($n = 12$), through experience or training in specialties like hospice or palliative care ($n = 5$), or through religion classes or a completed theology degree ($n = 6$). Some also wrote that the employing institution provided information about spiritual care to newly hired RNs during orientation ($n = 7$).

Nurses' Spirituality and Religiousness

Nurses' spirituality and religiousness were assessed using a number of tools. The Daily Spiritual Experience Scale (DSE) measured nurses' overall spirituality with a Cronbach's alpha reliability coefficient of .94 in this sample. The Duke Religion Index (DUREL) measured the three sub-dimensions ORA (organized religious activity – 1 item), NORA (non-organized religious activity – that is, private religious practice – 1 item) and the three-item intrinsic religiosity subscale which scored a Cronbach's alpha of .82 in this sample. In addition, nurses were asked to state their present religious preference and their conceptual understanding about spirituality and religiousness. Last, they were asked to identify how they perceived themselves in relation to spirituality and religiousness.

Table 10

Descriptive Statistics: Spiritual/Religious Variables (Categorical)

Variable	N	%
Conceptual understanding of spirituality & religiousness		
Spirituality is the broader concept and includes religiousness	225	40.6
Religiousness is the broader concept and includes spirituality	26	4.7
Spirituality and religiousness are different and do not overlap	18	3.2
Spirituality and religiousness are the same and overlap completely	44	7.9
Spirituality and religiousness overlap partially but are not the same	236	42.6
Defining one's own spirituality		
I am spiritual and religious	394	71.1
I am spiritual but not religious	125	22.6
I am religious but not spiritual	23	4.2
I am neither spiritual nor religious	9	1.6
Religious Preference		
None or prefer not to state	25	4.5
Seventh-day Adventist (SDA - Protestant)	200	36.1
Protestant (non-SDA)	65	11.7
Non-denominational Christian	151	27.3
Catholic	94	17.0
Other Religion (e.g., Buddhist, Muslim)	10	1.8

When describing their conceptual understanding of spirituality and religiousness, the vast majority of the RNs favored an integrated view of spirituality and religiousness. An overview of these conceptualizations is shown above in Table 10. The majority of RNs (42.6%) described spirituality and religiousness as related concepts with shared ground yet distinct conceptual boundaries. This conceptual understanding allows for people to be spiritual outside of a religious framework. The alternative view of spirituality being the broader concept that includes the smaller concept of religiousness

was supported by 40.6% of the respondents. In this view, too, people can be spiritual only or spiritual and religious. This understanding was contrasted by the group of 7.9% who thought that the concepts overlapped completely, and by those for whom religiousness was the broader concept that included spirituality (4.7%). Both of these perspectives assume there is no spirituality apart from religiousness. Only 3.2% of the sample thought that spirituality has no conceptual overlap with religiousness.

When describing their own spiritual/religious profile, 71.1% identified as spiritual and religious followed by 22.6% who saw themselves as spiritual but not religious. A minority of 4.2% identified as religious but not spiritual, and 1.6% identified as neither spiritual nor religious. These numbers represent a fair amount of diversity in the spiritual/religious profile of the sample.

With regard to religious preference, 4.5% did not have a religious preference or preferred not to state it. Almost half of the sample identified as Protestant (47.8%), and within the Protestants, 36.1% were Seventh-day Adventists, and 11.7% specified another Protestant denomination. Over a fourth of the sample self-classified simply as Christian with no denominational preference. Catholics constituted 17% of the sample, and a small group of 1.8% identified with other world religions such as Buddhism or Islam.

Additional RN spirituality and religiousness measures are presented in Table 11. In personal religious practices, half of the sample ($n = 322$) attended church or religious meetings at least once a week and engaged in private religious activities (e.g., prayer, bible study, and meditation) at least once a day ($n = 321$). The mean scores for organized religious activity (mean = 4.19, $SD = 1.37$) as well as for private religious activity (mean = 4.18, $SD = 153$) were quite high.

Table 11

Descriptive Statistics: Spirituality/Religiousness Variables (Continuous)

Variable	Minimum	Maximum	Mean	Mode	*SD*
DUREL					
Religious Attendance Subscale Score (ORA)	1	6	4.19	5	1.37
Private Religious Activity Subscale Score (NORA)	1	6	4.18	5	1.53
Intrinsic Religiosity Subscale Score (IR)	6	18	15.91	18	2.34
Daily Spiritual Experience Scale					
DSE Total Score	1	6	2.07	1	1.18

Similarly, the two other measures of spirituality – Daily Spiritual Experience Scale and Intrinsic Religiosity Scale – point towards a highly spiritual nurse sample. The mean intrinsic religiosity score of 15.1 implies that participants tend to identify highly with experiencing the presence of the Divine (i.e., God) and that their religious beliefs tend to influence the way they approach life. Nevertheless, there is enough religious diversity in the sample so that those who attend church infrequently (27.7%) and who rarely or never practice religious activities (10.3%) are also represented.

Descriptive Findings of Nurses' Spiritual Care Practices

Preliminary Psychometrics of the NSCQ

Spiritual care practices were operationalized by the 17 items of the NSCQ. Table 12 presents an overview of each of the items and the frequency and percentages for the various response options. In the columns to the far right, the means and the standard deviations for each item are shown.

Table 12

Descriptive Statistics for the Nurses' Spiritual Care Practices Questionnaire

Item	Never 0 times	Rarely 1 - 2	Occasionally 3 – 6	Often 7-11	Very Often > 12	Mean	SD
Asked a patient about how you could support his or her spiritual or religious practices.	149 (26.8%)	222 (40%)	134 (24.3%)	38 (6.8%)	11 (2.0%)	2.17	0.97
Helped a patient to have quiet time or space.	150 (27.0%)	187 (33.9%)	142 (25.6%)	67 (12.1%)	8 (1.4%)	2.27	1.03
Listened actively to a patient's story of illness.	86 (15.5%)	123 (22.2%)	190 (34.4%)	109 (19.6%)	46 (8.3%)	2.83	1.16
Assessed a patient's spiritual or religious beliefs and/or practices that are pertinent to health.	78 (14.1%)	152 (27.4%)	197 (35.7%)	86 (15.5%)	41 (7.4%)	2.75	1.11
Listened to a patient talk about spiritual concerns.	81 (14.6%)	166 (30.1%)	188 (33.9%)	93 (16.8%)	26 (4.7%)	2.67	1.06
Encouraged a patient to talk about how illness affects relating to God—or his or her transcendent reality.	198 (35.7%)	172 (31.2%)	120 (21.6%)	52 (9.4%)	12 (2.2%)	2.11	1.07
Encouraged a patient to talk about his or her spiritual coping.	162 (29.2%)	193 (35.0%)	132 (23.8%)	54 (9.7%)	13 (2.3%)	2.21	1.04
Documented spiritual care you provided in a patient chart.	294 (53.2%)	162 (29.2%)	64 (11.5%)	16 (2.9%)	18 (3.2%)	1.74	0.99

Item	Never 0 times	Rarely 1 - 2	Occas- ionally 3 – 6	Often 7-11	Very Often > 12	Mean	SD
Discussed a patient's spiritual care needs with colleague/s (e.g., shift report, rounds).	218 (39.3%)	202 (36.6%)	100 (18.0%)	29 (5.2%)	5 (0.9%)	1.92	0.93
Arranged for a chaplain to visit a patient.	201 (36.2%)	202 (36.6%)	106 (19.1%)	38 (6.8%)	7 (1.3%)	2.00	0.97
Arranged for a patient's clergy/spiritual mentor to visit.	338 (60.9%)	141 (25.6%)	56 (10.1%)	18 (3.2%)	1 (0.2%)	1.56	0.82
Encouraged a patient to talk about what gives his or her life meaning amidst illness.	233 (42.2%)	166 (29.9%)	102 (18.4%)	45 (8.1%)	8 (1.4%)	1.97	1.03
Encouraged a patient to talk about the spiritual challenges of living with illness.	255 (46.1%)	165 (29.7%)	90 (16.2%)	35 (6.3%)	9 (1.6%)	1.88	1.00
Offered to pray *with* a patient.	228 (41.3%)	168 (30.3%)	103 (18.6%)	36 (6.5%)	19 (3.4%)	2.01	1.08
Offered to read a spiritually nurturing passage (e.g., patient's holy scripture).	388 (70.1)	110 (19.8%)	42 (7.6%)	10 (1.8%)	4 (0.7%)	1.43	0.77
Told a patient about spiritual resources.	184 (33.2%)	201 (36.4%)	113 (20.4%)	49 (8.8%)	7 (1.3%)	2.09	0.99
After completing a task, remained present just to show caring.	36 (6.5%)	97 (17.7%)	150 (27.0%)	167 (30.1%)	104 (18.7%)	3.37	1.16

The NSCQ measures the frequencies of "spiritual care events," which the nurse either initiated or responded to. Because nurses in this setting work either 12-hour shifts (Medical Center, Community Hospital, and Children's Hospital) or 8-hour shifts (Behavioral Medical Center), the introduction to the tool asked participants to think about the last 72-hours at work when filling out the tool.

Exploratory Factor Analysis (EFA) was run according to the specifications of the author of the tool. The one-dimensional solution (extraction method = principal axis) yielded individual factor loadings between .407 and .836 and accounted for 49.5% of the variance. Cronbach's alpha reliability coefficient was .93. Omitting item number 17 (the item with the lowest factor loading) would increase Cronbach's alpha only marginally from .93 to .94. For the present study, it was determined that the full 17-item questionnaire was appropriate.

Additional Spiritual Care Practices

After completing the NSCQ, participants were asked if there were any other spiritual care activities they had provided or would have provided if appropriate. Three-fourths of the respondents said no. Those who said yes (n = 132) were asked to specify their practices in a textbox; most did (n =123). Additional spiritual care practices that several participants noted were prayer, listening, touch, providing inspiration (i.e., through readings or music), caring and presence, talking about God unrelated to illness, massage and humor. Practices mentioned only once or twice and not further specified included mindfulness practices, therapeutic touch, and healing hands. In addition, several nurses stated they would have been prepared to provide more spiritual care than they actually documented in the NSCQ had they seen the necessity for it. For example,

Catholic nurses commented they would have been ready to offer communion to Catholic patients, perform an infant baptism if requested, or bless with holy water if appropriate. Other nurses wrote more generally that they would have been willing to accommodate patients' requests for spiritual practices. Several NICU nurses commented they would have prayed with the parents if they had been present in the last 72-80 hours at work.

Although the NSCQ operationalizes prayer in item 14, a number of participants commented on prayer. Where the NSCQ suggests that nurses initiate prayer with a patient or family, RNs reported patients requesting the nurse to pray with them. Moreover, nurses stated they prayed for their patients "silently" or "independently" with or without letting the patient know about it. Although several NICU nurses said they prayed for their infant patients, this practice is not something they could have documented in item 14 of the NSCQ unless the parents were present and wanted the nurse to pray for them. Last, rather than offering to pray with the patient, some nurses would simply encourage their patients' families to keep praying.

Touch was described as "gentle touch" or "encouraging touch" and was noted in several participants' comments. A pediatric nurse reported she held the hand of a frightened dying child, whereas another nurse held the hand of a child until the child fell asleep. Some mentioned hugs. In one case, the nurse went and visited a former patient on a higher level of care unit and encouraged the patient and family with hugs and prayers. Another form of touch referred to is massage as mentioned by two nurses (without elaboration). Ideas about compassion and caring also were communicated apart from touch with comments like: "be there for them, help them know someone cares,"

"showing compassion," "smile," and "making an effort to show that the patient is cared for in every task."

Listening was operationalized in items 3 and 5 of the NSCQ as listening to the patient's story of illness or to patient's spiritual concerns. Nevertheless, participants brought up: "purposeful listening," "therapeutic listening," "listen attentively," "active listening," or simply talked about being "open to listen." An ICU nurse explained that "most of the time our spiritual care is directly to the family coping with stress, grief, loss, and difficult decisions. It involves a lot of listening and education." Overall, it appears those commenting on listening would like to suggest a less spiritual and more open listening – listening to whatever laments the patient wishes to communicate.

Nurses also implied they provided spiritual care through inspirational music and readings. For example, "singing a patient their favorite hymn or praise song" or "sang spiritual hymns with team members on the unit." More commonly, however, nurses would turn to Christian radio or television broadcasting to provide patients with inspirational music or words. Some nurses would offer readings to lift the patients' spirits: prayer cards, devotional pamphlets, and other short reading materials some of which are provided by the chaplain's department or simply offer a Gideon Bible. Two nurses working in the preoperative holding area have made particular efforts to help patients with their anxiety as they anticipate surgery: One bought several mp3 players with calming hymns patients can listen to if they want while waiting. The other, a professional photographer, brings his lap-top to work and has prepared a slide show with nature pictures and calm music in the background.

Results in Relation to Each Research Question

Results Specific to Research Question One

Question one asked, "What are the most common spiritual care practices of nurses in a faith-based acute care setting, and how frequently are they provided? The response categories for the NSCQ items were 1 (*never = 0 times*), 2 (*rarely = 1 - 2 times*), 3 (*occasionally = 3 - 6 times*), 4 (*often = 7 - 11 times*), and 5 (*very often = more than 12 times*). The Likert scale, therefore, could be dichotomized into *not providing spiritual care* (1) versus *providing spiritual care* (2, 3, 4, and 5). The four items endorsed most frequently had the highest means and were practiced by the following percentages of the sample: (a) After completing a task, remained present just to show caring (93.5%), (b) Listened actively to a patient's story of illness (84.5%), (c) Assessed a patient's spiritual or religious beliefs and/or practices that are pertinent to health (86.0%), and (d) Listened to a patient talk about spiritual concerns (85.5%).

The least frequently endorsed practices were *never* practiced by the following percentages of the total sample: (a) Offered to read a spiritually nurturing passage (e.g., patient's holy scripture) (70.1%), (b) Arranged for a patient's clergy or spiritual mentor to visit (60.9%), (c) Documented spiritual care you provided in a patient chart (53.2%), and (d) Encouraged a patient to talk about the spiritual challenges of living with illness (46.1%).

The overall mean NSCQ score was 36.98 with a *SD* of 12.01. When looking at the modes across the seventeen variables, there are seven items (numbers 8, 9, 11, 12, 13, 14, and 15) where the most frequently chosen response option had been one, which translates into zero practice. For six variables (item numbers 1, 2, 6, 7, 10, and 16), the most

frequently chosen response category was two, which translates into 1-2 times in a 72 - 80 hour period at work. Three categories (items number 3, 4, and 5), however, had *occasionally* (3 - 6 times in 72 - 80 hours at work) as the preferred response category. Last, one item (#17) actually had *often* (7-11 times) as the most frequently chosen response option.

Bivariate Relationships between Nurses' Characteristics and the NSCQ

Research questions two, three, and four explore how each of the following variables may be related to spiritual care practices: nurses' spirituality and religiousness (research question two), nurses' personal characteristics (research question three), and nurses' work environment (research question four). In the following sections, the bivariate relationships between these variables and the outcome variable (NSCQ mean score) will be presented. Binary variables were tested using independent samples t-tests; categorical variables were analyzed using one-way analysis of variance (ANOVA). At the end of the chapter, after presenting all the results each research question will be repeated and answered from a bivariate perspective.

Nurses' demographics and work-related variables were evaluated in relation to their associations with spiritual care practices. Independent samples t-tests were used for the variables gender, shift, and having received education in spiritual care. An overview is presented in Table 13 on the next page. Within those bivariate relationships, working the day shift and having received education in spiritual care both were significantly associated with the spiritual care practice scores.

Table 13

Spiritual Care Practices Questionnaire (NSCQ) Scores by Nurse Characteristics: t-tests for Independent Samples

Characteristic	NSCQ Scores				
	Mean	*SD*	*t*	*df*	*p*
Sex					
Male	37.41	13.24	0.33	549	.743
Female	36.91	11.84			
Shift					
Day	37.92	12.10	2.24	549	.026*
Night	35.61	11.78			
Received spiritual care education					
Yes	38.07	12.22	3.00	552	.003*
No	34.92	11.34			

* statistically significant (*p* < 0.05)

Results of the one-way ANOVAs are presented in Table 14 on the next two pages. Within the variable race, one subgroup (American Indian/Alaskan Native) was too small to be included in the ANOVA. There was no significant relationship between spiritual care practice score (NSCQ) and race/ethnicity, education, work load, or work role. When correlating spiritual care practice mean score with age, years of RN experience, number of shifts worked in the last 2 weeks, number of hours worked in the last 2 weeks, number of patients per shift, no statistically significant relationships were found. Please refer to Table 15 for details.

Table 14

Spiritual Care Practices Questionnaire (NSCQ) Scores by Nurse Characteristics: One-way ANOVA for Categorical Variables

Characteristic	NSCQ					
	N	Mean	*SD*	*F*	*df*	*p*
Race						
Caucasian/White	261	36.35	11.84	1. 446	3/538	0.217
Hispanic/Latino	75	35.35	13.24			
Asian/Pacific Islander	180	38.23	12.11			
Black/African American	26	37.35	15.43			
Am. Indian/Alaska. Native♦	2	48.00	04.24			
Full/part time/overtime						
Working full time	351	36.87	11.86	0. 027	2/ 549	0. 973
Working part time	135	37.10	12.31			
Working overtime	66	37.15	12.27			
Education						
Associate/diploma degree	223	37.70	12.02	1.244	2/ 551	0.289
Bachelor degree	289	36.76	11.80			
Graduate degree	42	34.64	13.23			
Work role beyond patient care						
None, pt. care exclusively	361	36.74	11.60	0.360	2/ 551	0.698
Team leader/shift coord.	142	37.13	12.81			
Nursing leaders	51	38.24	12.70			
Hospital						
Medical Center	295	38.51	11.97	9.032	3/ 550	.000*
Children's Hospital	197	33.59	11.17			
Community Hospital	39	39.97	12.66			
Behavioral Medical Center	23	41.35	12.34			

Work Area (overview)

Adult nursing care	333	38. 69	12.06	13.297	2/551	.000*
Pediatric care	198	33.60	11.14			
Psychiatric care	23	41.35	12.34			

Work Area (detailed)

Medical/ surgical units	206	39.94	11.43	8.175	8/535	.000*
Pediatric care	101	33.33	10.19			
NICU	74	30.92	10.53			
Pediatric oncology	18	44.39	13.69			
Oncology [adults]	16	43.63	12.29			
Behavioral health	23	41.35	12.34			
Interventional services	48	35.96	13.29			
Labor & delivery	36	37.03	11.21			
Emergency room [Adult]	22	32.77	10.45			

*statistically significant (p <0.05 level).

♦ not part of the ANOVA.

Significant differences, however, were found with the variables hospital, area of nursing, and work environment as presented in Table 14 above. Comparisons among the four hospitals and among the three areas of nursing (adult versus pediatric versus psychiatric nursing) revealed that mental health nurses scored significantly higher in spiritual care practices whereas pediatric nurses scored lowest. Post-hoc tests (Tukey) revealed a significant difference between pediatric nursing and both adult and psychiatric nursing. Interestingly, when looking through more differentiated lenses, there were also significant differences within pediatric nurses with NICU nurses scoring lower than pediatric care (general pediatrics and ICU level pediatrics) and pediatric care scoring lower than pediatric oncology nurses. In fact, the highest overall scores in spiritual care

practices were actually attained by pediatric oncology nurses, who as a group scored even higher than mental health nurses.

Another finding was that within adult nursing care, there was no significant difference between general medical/surgical units (mean = 39.50, *SD* = 11.46) and ICU level medical or surgical units (mean = 40.29, *SD* = 11.45). Hence, general and ICU-level units were combined in the one-way ANOVA as presented in Table 9. Similarly, in the Children's Hospital, no significant difference existed between general pediatrics and ICU-level pediatrics. Thus, they were combined into one category "pediatric care." Post-hoc tests (Tukey), however, revealed significant differences between pediatric ICUs (including NICU) and adult medical/surgical ICUs. Furthermore, general pediatrics differed significantly from medical/surgical (including rehab) units, oncology and from mental health nursing.

Last, nurses' perceptions of the work environment and self in relation to the work environment all were significantly correlated with the NSCQ total scores except for the variable supervisor support. These findings are presented in Table 15 on the next page. Moreover, all correlations between the continuous measures of religiousness were significant and positive. The DSE spirituality measure, which was reverse scored, was negatively associated with spiritual care practice as presented in Table 15. In addition to being significantly correlated with the NSCQ outcome variable, all measures of spirituality and religiousness were significantly correlated with each other, and in the expected direction.

Table 15

Correlations between continuous variables and NSCQ

	Nurses' Spiritual Care Practice Questionnaire (NSCQ)	
	r	p
Demographic and Work-related Variables		
Age	.062	.144
Years of experience as RN	.021	.622
Number of shifts in the last two weeks	.046	.278
Hours worked in the last two weeks	-.008	.853
Number of patients in one shift	.037	.392
Nurses' Spirituality and Religiousness		
Daily Spiritual Experience Scale (DSE)	-.343	.000**
Organized Religious Activity (ORA)	.128	.003**
Non-Organized Religious Activity (NORA)	.198	.000**
Intrinsic Religiousness (IR)	.243	.000**
RN Perceptions of Work Environment and Self		
Patients in need of spiritual care	.294	.000 **
Frequency of spiritual issues	.478	.000**
Comfort in talking about spirituality	.185	.000**
Colleague's comfort with spirituality	.116	.006**
Supervisor support	-.069	.106
Comfort with religious issues	.152	.000**

** Correlation is significant at the 0.01 level (2-tailed)
* Correlation is significant at the 0.05 level (2-tailed)

Table 16

Spiritual Care Practices Questionnaire (NSCQ) Scores by Nurses' Spiritual/Religious Characteristics: One way ANOVA for Categorical Variables

Characteristic	NSCQ					
	N	Mean	*SD*	*F*	*df*	*p*
Religious Preference						
None/Prefer not to state	25	31.60	10.06	1.353	5/ 539	0.241
SDA (Protestant)	200	36.97	12.71			
Protestant (non-SDA)	65	36.99	10.65			
Non-denominational Christian	151	38.10	11.99			
Catholic	94	36.16	11.72			
Other Religion♦	10	37.60	13.67			
Conceptual Understanding						
s > r and includes r	225	37.76	12.40	0.789	4/ 544	0.553
r > s and includes s	26	34.31	07.07			
s ≠ r, concepts do not overlap	18	38.83	14.03			
s = r, concepts overlap	44	37.02	12.28			
s & r overlap partially	236	36.43	11.84			
Defining one's own spirituality						
I'm s & r	394	37.65	12. 07	5. 281	2/ 539	0.005*
I'm s but not r	125	37.30	11.36			
I'm r but not s	23	29.39	10.43			
I'm neither s nor r♦	9	23.89	03.95			

*statistically significant (p <0.05 level).

♦ not part of the analysis because N=10.

s = spirituality or spiritual
r = religiousness or religious

In the bivariate analysis, using one-way analysis of variance (ANOVA), religious preference and conceptual understanding of the concepts spirituality and religiousness were not significant (please refer to Table 16 above); however, there were significant

findings depending on how participants self-classified in relation to the concepts. Even when the last category "neither spiritual nor religious" ($n = 9$) was dropped from the analysis, there still was a significant difference between the groups at a $p = 0.005$ level. Post-hoc tests (Tukey) showed there was a significant difference between the spiritual and religious group and the religious but not spiritual group where the spiritual and religious scored significantly higher in spiritual care practices than the religious but not spiritual group. This finding was significant at a $p = 0.004$ level. Similarly, the spiritual but not religious group scored significantly higher in spiritual care practices than the religious but not spiritual group, and this difference was significant at a $p = 0.009$ level.

Bivariate findings specific to research question two. Question two asks, "What is the relationship between nurses' spirituality and religiousness and their spiritual care practices in nursing in a faith-based acute care setting?" In response to research question two, the following conclusions can be drawn: Self-identifying with the spiritual dimension and scoring high in spirituality (as expressed by low scores on the DSE) were significantly correlated with higher scores on the NSCQ. By contrast, it did not matter with which faith tradition or denomination the nurse identified. All three sub-dimensions of the DUREL, however, were significantly positively correlated with spiritual care practice scores; so higher scores in religious attendance, personal spiritual practice, and intrinsic religiosity were all associated with higher scores on the NSCQ. It appears, then, the more spiritual and the more religious RNs are, the more likely they are to engage in spiritual care practices.

Bivariate findings specific to research question three. Question three asks, "What is the relationship between personal characteristics of the nurse and nurses' spiritual care

practices in a faith-based acute care setting? In response to the research question three, none of the classic demographic measures (gender, age, experience, race, or education) was significantly associated with nurses' spiritual care practice scores; however having received education in spiritual care was.

Bivariate findings specific to question four. Question four asks, "What is the relationship between organizational variables of a faith-based acute care setting and nurses' spiritual care practices?" In response, it can be concluded nurses' work environment appears to be strongly associated with nurses' spiritual care practices. Whereas the level of acuity does not seem to matter, there are significant differences between adult, psychiatric, and pediatric nursing with mental health nurses scoring highest and pediatric nurses scoring lowest. When further differentiating the work environment, nurses scored highest in spiritual care if they worked on an oncology unit. Moreover, working the day shift was significantly associated with spiritual care practice scores. Supervisor support was not significant, but perceived patient need for spiritual care, frequency of spiritual issues coming up, and RN comfort with spiritual and religious issues were all significantly correlated with each other and significantly positively correlated with providing spiritual care.

Multivariate Relationships between Nurses' Characteristics and the NSCQ

Based on the interrelationships among the various measures of spirituality and religiousness, it was determined that not all spirituality and religiousness variables could be appropriately used in the multivariate analysis. In fact, Koenig recommends not using all three measures of the DUREL in the same statistical model because of multicollinearity (personal email communication with Dr. Koenig September 29, 2008).

Thus, it was determined best to use ORA (organized religious activity) from the DUREL as the religiousness measure and the Daily Spiritual Experience Scale (DSE) as the spirituality measure. When examining the intercorrelations, these two were the least correlated measures of spirituality and religiousness.

In preparation for the linear regression, a number of categorical variables were recoded as dummy variables; for example, the collapsed version of the variable hospital differentiating between adult, psychiatric, and pediatric nursing was recoded into two dummy variables with adult nursing as the reference group. Both were entered into the regression model.

When examining the work environment variables, it became apparent that patient need of spiritual care and frequency of spiritual issues are highly correlated. Similarly, nurses' comfort with spiritual issues and nurses' comfort with religious issues are highly correlated. Hence, only one of the pairs was entered into the regression. In fact, the variable that correlated strongest with NSCQ was used in the final regression model: RN comfort with spiritual issues, colleague's comfort with spiritual issues, and frequency of spiritual issues.

Overview of the multivariate regression analysis model. The final regression model is illustrated in Table 17 on the next page.

Ordinary least squares regression was conducted to explore which independent variables (Received education in spiritual care, DSE, ORA, RN comfort, Colleague's comfort, Shift, Psychiatric Nursing, Pediatric Nursing, Frequency of Spiritual Issues) would be predictors of RN spiritual care practices as measured by the NSCQ. Multivariate data screening led to the elimination of eleven cases. The remaining 543

Table 17

Summary of the multiple regression

	Unstandardized Coefficients		Standardized Coefficients		
	β	Std. Error	β	t	Sig.
Received education in spiritual care	2.218	.908	.088	2.442	.015
RN spirituality (DSE)	-.225	.038	-.241	-5.869	.000
RN religiousness (ORA)	.133	.347	.015	.382	.702
RN comfort	.422	.382	.043	1.107	.269
Colleagues' Comfort	.268	.422	.024	.637	.525
Shift	.569	.891	.023	.638	.524
Psychiatric Nursing	-1.223	2.175	-.021	-562	.574
Non-Pediatric Nursing	-4.148	.914	-.166	-4.540	.000
Frequency of Spiritual Issues	5.846	.587	.381	9.954	.000

* $p < .05$.

cases met the multivariate assumptions of normality, linearity, and homoscedasticity.

Regression results show an overall model of four predictors (Received education in

spiritual care, DSE, Pediatric Nursing, Frequency of Spiritual Issues), which significantly

predict RN spiritual care practice scores on the NSCQ, $R^2 = .324$, R^2 adj $= .312$, $F(9,533)$

$= 28.322$, $p < .001$.

Multivariate findings specific to research question two. In response to research

question two, spirituality as measured by the DSE was found to be the strongest

significant predictor of the spiritual care practice score (NSCQ) whereas ORA (religious

attendance) was not significant in the presence of the DSE. Thus, the lower the RN DSE

score, the more likely is an RN to engage in spiritual care practices. This understanding,

however, has to be balanced by the recognition that the overall level of providing

spiritual care was not very high. Therefore, it must be noted that even with high

spirituality scores, the overall level of engaging in spiritual care practices tends to be low.

Multivariate findings specific to research question three. In response to research question three, none of the traditional demographic variables qualified for the multiple regression (not significant in the bivariate analysis), but whether the nurse had received education about spiritual care remained a significant predictor in the final regression model.

Multivariate findings specific to research question four. Nurses' work environment and nurses' unit perceptions were significant predictors for spiritual care. More specifically, it is the area of nursing – not being a pediatric nurse – and whether the nurse believes that spiritual issues come up often on her unit that determine involvement in spiritual care practices. When this potential predictor is added into the regression, nurses' comfort level and the perception of the comfort level of colleagues with spiritual issues becomes not significant. Nurses' perception of the frequency of spiritual issues coming up is an even stronger predictor than nurses' DSE score.

Results Specific to Research Question Five:

Factors not predicting spiritual care. Question five asked, "What are factors that are related to not providing spiritual care in a faith-based acute care setting?" The number of participants that had not provided any spiritual care in the 72-80 hours at work prior to taking the survey was *seven.* This number was too small to run any statistically significant analyses. Therefore, the question could not be answered.

Analysis of Nurses' Experiences with the Sacred at Work Specific to Research Question Six

Overview of the analytic process. In the analysis of nurses' narratives pertaining to the question: "Tell me about an experience at work that greatly influenced your

understanding of spirituality, positively or negatively," the researcher in a first, basic step delineated between accounts that reflected engaging versus disengaging experiences with the sacred at work. Second, it was determined which subcategory the narrative would fall under based on Demerath's (2000) typology and the classification of the disengaging experiences by Grant (2004).[1] Third, narratives that could not fit into those already established were categorized and newly defined based on common characteristics. Thus, category A (1) (d) "*nursing as calling* and faith experience" (see Table 14) was newly established. Demerath (2000) had mentioned "work as calling" as an experience of the sacred in collectivity. The narratives in the current study, however, described more personal rather than shared or collective experiences. Therefore, the category was classified as integrative/marginal, thus stressing the function it has for the individual nurse. Fourth, the narratives were classified independently by a second person (oncology nurse holding a master's degree in nursing science). In 9.5% of the cases there were differences in the way narratives had been categorized. Last, cases of disagreement ($n =$ 28) were reviewed again, and a final decision was made as to how they were categorized.

Categories defined. Ultimately, the following categories provided the matrix in which the narratives were classified. The four major categories of engaging experiences with the sacred and their subcategories are outlined below; however, subcategory *Counter-Culture* was not found in this sample.

One, integrative experiences of the sacred:

(a) *Rites of passage.* These are narratives where the nurse is confronted with death, dying and life/spiritual transformations. As the nurse comes to terms with these experiences, personal growth, deeper insight, and understanding of the

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[1] See Chapter Three for overview of Demerath and Grant

human experience of suffering and dying – a form of experience of the sacred "outside of the temple" – occurs.

(b) *Bonding experiences*. These narratives describe a special connection, a special bond between the patient and/or his family and the nurse. The connection does not happen routinely, is special and meaningful to both sides involved, and is, therefore, a type of encounter with the sacred "outside of the temple."

(c) *Healing events*. These are narratives where the nurse either witnesses or actually contributes to physical, mental and/or spiritual healing or restoration to health. As a result, the nurse experiences new insights. As those continue to influence future thinking and actions, they, too, are considered a form of standing on sacred ground.

(d) *Nursing as a sacred calling and faith experience*. This subtype describes narratives in which the nurse experiences the divine in the everyday encounters at work. In the belief system of this group of nurses, there is a sense of purpose and meaning in everything they do, nothing is futile; even challenging situations at work are reframed as opportunities to bring about good through acts of kindness and caring on the part of the nurse. This understanding may not be shared with colleagues and/or patients but gives the nurse strength and courage for the situation at hand. Thus, it is a marginal experience of the sacred for the nurse and has a confirmatory function.

Two, the *Sacred as Quest* reflects a spirituality that seeks new experiences outside of the realm of traditional religion to compensate for a loss of meaning found in traditional encounters with the sacred (i.e., organized religion). Typically, quest type

seekers are somewhat aloof from more traditional forms of spirituality. Their spiritual care practices can reflect their non-traditional quest type of spirituality.

Three, the *Sacred as Collectivity* includes any narrative talking about religious collectivity or institutional collectivity that takes on a sacred meaning. Examples for the latter include a shared bond with co-workers that comes from identifying with an institutional mission statement; it includes drawing actively on and appreciating professional services that deal with the sacred such as chaplains and clergy.

Furthermore, *Sacred as Collectivity* describes any type of spiritual connection between nurses, patients and their families that leads to community or shared religious collectivity during the work encounter. This connection often is based on a shared spiritual/religious understanding; however, the connection is extended when nurses accommodate and facilitate that which is different from their own understanding.

Four, when quest orientation is tied to a collective experience, it is categorized as the *Sacred as Counter-Culture,* category four. Examples include Robert Bellah's (1985) description of radical religious individualism as characterized by "Sheilaism."[2] It may also refer to the diversity of spiritual subcultures emerging within the spiritual quest culture of the baby boomers that has been described by Wade Clark Roof as a "spiritual marketplace" (1999). For nursing, the Complementary and Alternative Medicine (CAM) and New Age movements appear to be particularly influential (Barnum, 2003).

In contrast to the engaging experiences, there is one major category that described disengaging experiences of the sacred. *Bewilderment* seems to capture the response that some nurses had to their encounters with the sacred at work. These nurses appeared

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[2] A form of religious privatism rejecting any claims that a historic church could have on them without necessarily withdrawing formal church membership. For more information check Robert N. Bellah: *Habits of the Heart: Implications for Religion.*

puzzled as to what to do for their patients spiritually and felt uncomfortable about their role as a spiritual caregiver.

Findings for research question six. Of the total sample, 53.4% ($n = 296$) responded to the optional open-ended essay question. An overview of the categories is shown in Table 18. Their comments varied in length and content; however, they fit well with the categories outlined above. Ninety percent of those responding to the essay described engaging experiences of the sacred at work, whereas 6.4% ($n = 19$) expressed a disengaging experience; 3.6% ($n = 11$) stated they never experienced spirituality in the context of a work situation or couldn't think of a personal experience when filling in the survey. One subcategory (four = counter-culture) was not found in this sample of narratives. Furthermore, among the relatively few *spiritually disengaging experiences* ($n = 19$), subcategories 1 and 3, cynicism and humor, were not found. Although humor was referenced, it was not used in a spiritually disengaging context but as a God-given talent to relieve tension and anxiety in a patient.

Data exemplars supporting categories and subcategories. In the following sections, each of the categories and subcategories represented will be summarized and illustrated by original narratives.

Table 18

Nurses' Spiritually Engaging and Disengaging Experiences (N=296)

	n	*%*
A) Spiritually Engaging Experiences (total)	**266**	**90.0%**
1) Integrative experience of the sacred (total)	143	48.3%
(a) Rites of passage	71	24.0%
(b) Bonding experiences	28	9.5%
(c) Healing events	25	8.4%
(d) Nursing as calling and faith experience	19	6.4%
2) Quest type	10	3.4%
3) Collectivity	113	38.2%
4) Counter culture	0	0%
B) Spiritually Disengaging Experiences (total)	**19**	**6.4%**
1) Cynicism	0	0
2) Bewilderment	19	6.4%
3) Humor	0	0
C) No experience with the Sacred at Work	**11**	**3.7**

A (1) (a) Rites of passage. This category constituted the largest subcategory (*n* = 71) among the integrative experiences of the sacred. In a tertiary level health care system, nurses are confronted with death and dying on a regular basis. It is certainly a prevalent issue on the Intensive Care Units:

> I think the most important experience as an ICU RN is the ability to watch someone die, knowing you have done your best to care for them and provide comfort both physically and emotionally. The biggest challenge I had to learn was to be "ok" with sitting quietly with the family watching the heart monitor and other numbers change and eventually stop. It is important to provide some education and info to the family about the events that are happening that they are "normal" and the common progression of events while knowing that everyone is different and no one knows the exact time involved. The hardest part is being comfortable with silence or just listening and knowing that a presence can be a support or comfort and not talk all the time. Listening to family's stories or

memories and allowing them to talk and grieve in their own way. I think that a supportive presence is maybe one of the most difficult things to provide related to our own need as health professionals to "DO SOMETHING or SAY SOMETHING" at most times. Sometimes there is nothing more to do and nothing more to say, and to remain in that time with a family can be a gift of spiritual support in itself. I didn't think about this or before working in this environment.

The nurse introduced the idea of being a "supportive presence" when someone was dying. Family members or significant others needed the nurse's "emotional and physical support" at this special time. So what does it mean according to this informant to be a *supportive presence* when someone dies in the sterile high tech environment of a tertiary level ICU? This nurse explained how nursing takes on a mediator role between the unfamiliar, possibly fear provoking, high tech environment plus the unknown of the dying process and the people who grieve and try to be strong as they let their loved one pass. The nurse also pointed out that two things do not come easy to a health care professional working in a fast paced environment: being comfortable with not intervening and being comfortable with silence. What the nurse appears to describe is a shift from being actively hands-on involved to being an active but quiet listener. She mentioned allowing the family to share stories and memories and to grieve in their own way. Last, these are insights that the nurse gained through her practice in a busy ICU work setting.

A (1) (b) Bonding moments. These special connections were woven into a large number of accounts; however, this subcategory (*n* = 28) reflects the ones where bonding more than anything else was at the heart of the narrative:

> . . . I had a 15-year-old patient who I took care of very frequently. At first she was hard to take care of because she was very depressed and having a lot of serious complications from her cancer treatment. . . .Her mom would stay a couple hours during the day every so often, and if her dad showed up at night, there was a good chance he would be drunk and/or worried more about himself and say degrading things to her. Needless to say, she had a rough life and cancer made it even rougher. She would cry at least three times before she would go to sleep each

night. We would talk and I could make her happy for a while, but it wouldn't be long before she would cry about her family's absence, her dad's drunkenness/rudeness or having cancer and all the bad things that had occurred since starting treatment. . . .she would specifically ask for me to be her nurse if I was working. It was emotionally difficult to care for her since her mood would swing so quickly (and rightfully so), but I started to enjoy taking care of her. I truly felt like it made a difference to her when I was her nurse. I took extra time to listen, talk, joke and laugh, and just spend time with her. We bonded and she truly needed it. On rougher days, she would ask me if she was going to die or even assert that she was going to die, even if she was doing relatively well. It was so hard to have a response for that. I encouraged her and told her that she was strong and she could fight it. She would reply that it wasn't true and that she wasn't strong. I encouraged her to pray for the strength and try to believe she could get better. It was a mental and spiritual battle that she struggled with and although she started to improve both in physical, mental and spiritual health, she died rather suddenly from aspiration. I had been on a three-day vacation when it happened. On my last day of work before my trip, she had been doing okay, not great but looking as though she might turn it around. . . .It was hard to be away and not to have gotten to say goodbye especially because it was so abrupt and unexpected. It seemed as though maybe she knew all along, and I was so glad I had taken the time to meet some of the spiritual needs she had. I understood then that spiritual nursing care was not just about outreaching in a religious sense. It could be exactly that, but that depends on the person. For this patient it was about spending time talking about her teenage interests, hopes and fears. It was about inside jokes and sharing common interests. She got to feel loved and cared for even if only for a little while. The way her face would light up when I came in and told her I was her nurse that night. You could see her spirit lift, and that I learned was true spiritual nursing.

This account gave insight into the progression of a professional relationship between a pediatric nurse and an adolescent female cancer patient. The patient's situation was characterized by pain and suffering, not only from the cancer and complications during treatment, but also because of difficult life circumstances and lack of familial support. As a result, she was perceived as a challenging patient; for example, she cried a lot, experienced mood swings, fearfulness, and tended to have a pessimistic outlook on life. Initially, the nurse succeeded in cheering her up temporarily. Over time, she noticed the patient requested that she be her nurse. The nurse started to notice that she was able to connect with the patient in a way that was meaningful for the patient. Thus, it also

became meaningful for the nurse to be the patient's primary nurse because she knew how much the girl needed someone who cared about her. Their bonding made the nurse even more invested in this particular case: The sudden, unexpected death triggered a reflection in the nurse on the meaning of spiritual nursing care.

Bonding spiritual care in this case meant "softening the suffering" of this teenage girl, to say it in the words of Family Nursing Specialist, Dr. Lorraine Wright (2008), by making her feel loved and cared for even if it was just for one shift at a time. Although the nurse felt sometimes at a loss for words, she still succeeded in encouraging her patient to be strong and to fight. She also encouraged her to pray; however, the nurse emphasized that spiritual care in pediatric nursing vis-à-vis a teenage cancer patient means connecting by spending time, talking teenage interests, sharing inside jokes and hopes. Spiritual care in this context also meant the willingness on the part of the nurse to take on the challenge of sticking through a difficult patient situation and making a difference.

A (1) (c): Healing events. A group of 25 individuals described healing events. The two central themes in the narrative presented are healing events and spirituality. Nursing in the context of a tertiary level health care system oscillates between death and healing. In pediatric oncology nursing, for example, nurses hope and fight with their patients and their families, but they also mourn the losses:

> Interacting with children as they fight for their lives has greatly impacted my heart and my understanding of spirituality. The human spirit, especially those in children, is resilient beyond imagination, full of hope, life, and determination. My eyes have seen miracles as patients whom the doctors say have no chance keep their spirits uplifted, dig in their heels and fight – and are discharged to the amazement of everyone. One specific 7-year-old little girl is truly alive by the grace of God alone as her doctors were counseling her parents about signing a DNR as there was no more that could be done and the child was suffering. Her parents held to what they believed from God and said no and their daughter is still with us today. There are others whom we have lost, others who wanted so

desperately to live, who fought so hard to end up not making it in the end – those who have tugged on and broken my heart that have actually strengthened my spirit the most. Their courage has humbled me; their desire to live makes me not want to take even the simplest things for granted; their faith has strengthened my own. In caring for these patients my spirituality is what keeps me going as a nurse, knowing that even if the battle is lost and the body dies, the spirit of my little patient returns to God and continues to live on. I personally do not see how caregivers in the field of oncology can function and maintain sanity and a soft heart without spirituality, without a belief in God; without faith. I have a box inside my heart with a huge question mark on it, and it is there that I place my frustration, confusion, and anger when a patient dies. Things that I don't understand, knowing a child suffered severely before dying, seeing the anguish of parents and families as they lose their baby – I just don't get it. But what I do get is that God gets it – He knows why and one day, when it's my turn to die, I'll be able to open that question box and have my questions answered. But then again, I also think that when I am in the presence of God, I won't have to ask at all.

This pediatric oncology nurse shared her joys and tears resulting from her experience at work watching amazing recoveries and tragic deaths. What sustained her is her personal faith even though she admitted there were questions beyond her understanding. The questions did not, however, erode her belief in meaning and a trustworthy God. Why is spirituality important to her? Making meaning of the situation helps her to maintain sanity and a "soft heart" working in these difficult situations.

A (1) (d): Nursing as calling and faith experience. For some ($n = 19$), being a nurse is a divine calling, and what they do professionally is also part of their faith experience. There is virtually no divide between the world of faith and the nurse's everyday life. This view motivates them to do the very best they can in their profession as a nurse because they are representing the love of God here on earth to suffering human beings: "I feel God guided me to this profession and that I do his work caring for those in need. I find this very rewarding and a comfort on days that get a bit stressful."

A (2): Engaging experiences of the non-traditional spiritual quest type. As described above, the non-traditional spiritual quest seeks new meaning or experiences

outside of the framework of traditional religion. The so-called seeker usually identifies

highly with the spiritual dimension while standing more or less aloof or overtly in

opposition to traditional religion:

> My understanding of spirituality versus religiosity has been greatly influenced by
> my extensive work in hospice and now in mindfulness practices with adolescents
> with cutting behaviors. I separate out religious practice with my concept of
> spirituality - spirituality being, I suppose, more of "resonating" with life, the
> experience and understanding of it, and uniting with life as it unfolds. I see
> religion and inherent practice as one's belief system and the choosing then a
> system of beliefs and behaviors that seem reasonable to the individual to provide
> life mapping for the spiritual side. From my hospice life. . . Ushering in family
> members to join in quiet, conscious breathing and prayer as they gave permission
> for the father of the family to leave this life. This was unexpected. . .a home
> health referral had changed in a matter of hours to a hospice referral, and I was
> roused out of a good sleep at home to assist this family to attend to the moment. It
> was a profound moment as the wife struggled to give her husband permission "to
> go." She wept - she wanted him to stay. . .and then, after I asked the family
> members to pace with my deep breathing, I prayed out loud for the family and
> spoke words of gratitude for the dad. . .the wife eventually paced her breathing
> with mine and leaned over her husband, kissed him, and tearfully spoke: "Go on. I
> will join you later." He took his final breath and died. It was an honor to be with
> this family; a privilege to be a part of their most intimate exchange.

The following characteristics in the account of this nurse's intervention suggest a

non-traditional quest or spiritual seeker: One, the nurse's conceptualization of spirituality

represents a connection with the universe; it is highly personal and indescribable. Two, it

also is contrasted with religion, which appears to be merely a framework for manifesting

and understanding the spiritual in the world of shared experiences. Three, the nurse stated

that his or her spiritual understanding had been shaped by mindfulness practices.

Mindfulness, a Buddhist technique, also is part of a cognitive-behavioral treatment

approach called Dialectical Behavioral Therapy (DBT) that was developed for working

with borderline patients (Koerner & Linehan, 2000). Most "cutters" (engaged in self-

injurious behaviors), for example, are considered borderline patients. In this case, it

seems that her use of mindfulness is in the DBT context, rather than in the Buddhist.

Four, in the actual family crisis situation, the nurse uses prayer; however, not enough

information is available to infer to whom she might have been praying. Jesus? Mary?

Vishnu? Ultimately, drawing on professional skills, he or she used deep breathing as a

technique to achieve a calming effect. As a result, the nurse creates an environment in

which the family is able to say their good-byes. Whereas the nurse gives voice to the

deepest needs of the family through prayer, the family is able to master their difficult

task. For the nurse, the perception that the spiritual technique worked well and provided

comfort in the context of this situation made it a spiritually engaging experience.

A (3): Engaging experiences of collectivity. These experiences developed in situations

where nurses connected with their co-workers, other members of the health care team or

with patients/families on the basis of some shared beliefs or experiences.

> I experienced the powerful release of a mom's stored up emotions when a surgeon prayed with her before he took her baby to surgery. She had maintained an upbeat positive attitude every day after finding out her baby had a life threatening heart defect. I was worried about her not coping appropriately and her comfort level to experience her grief. I had spoken with her before, addressing the permission to cry and express her sorrow. As she wept, it was as if God had put His comforting arms around her through this surgeon's words. There was a spiritual connection between the three of us, and a "peace" that surpassed all understanding filled this mother.

A simple prayer offered by a health care professional in an extraodinarily stressful

situation opened the door for a distressed mother to express her pain and fear. By

constraining herself to a positive attitude, she had not permitted herself to express her

sorrow. Prayer created a safe spiritual community where the pain could be expressed and

acknowledged.

B (2) Bewilderment. Nurses' experience of bewilderment can be the result of a misfit between patients' spiritual approaches and the nurses' perspective.

> I work with a lot of very ill and dying infants. Although I believe that God can do all things and healing is part of his will, my medical education holds me back from having faith for healing in some cases. This makes me disconnect from the babies and their families and makes it difficult to relate to their hope or encourage their faith when all medical expertise says the outlook is grim. I feel this is denial, not faith. This greatly affects my ability to provide spiritual care at work.

The nurse described how she disconnected from the patient and family and realized her ability to provide spiritual care was diminished due to his or her own discomfort with the patient's/family's belief system. As the nurse withdraws, there is virtually an absence of therapeutic communication between the nurse and family. As a result, the meaning of the situation from the perspective of the suffering family may not be explored.

Summary of the Qualitative Analysis. Although some nurses stated they have never had an experience at work that affected their spirituality positively or negatively and others were bewildered about what to do with the spiritual at work, the vast majority responded by describing a spiritually engaging experience either on a personal level or as a collective experience. The narratives supported the presence of spiritual themes, acknowledged patients' experiences of distress, pain, and suffering, and showed a variety of ways in which the nurse may respond in an endeavor to be a supportive presence.

Nurses appear to respond to the invitation to enter the realm of the spiritual in situations where they are confronted with patients' distress, pain, and suffering. Rarely would these encounters emerge out of a routine assessment. In their spiritual responses, nurses showed a variety of listening, bonding, and healing behaviors drawing to a greater or lesser degree on their own spiritual heritage and resources. This response could be

rooted in traditional or quest types of spiritualities. Nurses who described disengaging experiences pointed out the difficulties with spirituality they encountered at the workplace. They reported discomfort in situations that may have led them to withdraw or spiritually disengage from their patients. Last, the narratives revealed the spiritual effect encounters with the sacred at work may have on the nurse.

Summary of Chapter Four

Although nurses tended to assess their patients' spiritual beliefs pertaining to health, listened to patients' stories of illness and their spiritual concerns, their overall mean spiritual care practice scores were relatively low; in other words, on average, they had engaged 1-2 times in the past 72-80 hours at work in each of the 17-items of the NSCQ. Factors predicting nurses' spiritual care practice scores centered on nurses' spirituality and religiousness and their work environment. None of the usual demographic variables was significantly associated with nurses' frequency of providing spiritual care. The predictors in the final multivariate model (in order of strength) were: (a) nurses' perception that spiritual issues at the work place came up frequently, (b) nurses' high spirituality scores, (c) nurses not working in pediatric care, (d) nurses having received education about spiritual care in the past.

As diverse as the experiences with the sacred at work might be, 90% of the nurses commenting on an open-ended question shared an experience with spirituality at work that encouraged them to continue to engage with spiritual situations in that context when the situation arose. Although nurses' responses may be influenced by their own type of spirituality, nurses saw themselves in a position to address spiritual issues and to be helpful to individual patients. Where there was a misfit between nurses' and patients'

spiritual orientation, some nurses found themselves disengaging from the spiritual

concerns presented by the patient or family.

CHAPTER FIVE

Discussion

The main goal of this study was to evaluate nurses' spiritual care practices in a faith-based tertiary care setting. Three specific study aims were to (a) describe the types and frequencies of nurses' spiritual care practices, (b) examine the potential effects of nurses' bio-demographic characteristics and their spirituality and religious orientations on their spiritual care practices, and (c) examine the potential effects of organizational variables (e.g., type of hospital, type of unit, workload, nurse-patient ratio) on nurses' spiritual care practices. In addition, an optional open-ended question allowed nurses to describe their encounters with the sacred at work and how those interactions may have affected their views of spirituality, positively or negatively.

This study introduced a new instrument – the Nursing Spiritual Care Questionnaire (NSCQ) – to measure the types and frequencies of nurses' spiritual care practices. The average score was 36.98 (*SD* 12.01) on a scale that could range from 17-85. Factors associated with spiritual care practice clustered around nurses' spirituality and their work environment. In other words, non-pediatric nurses who stated that spiritual issues came up often on their unit, who scored high in personal spirituality, and had received education in spiritual care tended to score higher on the scale than did the others. Moreover, more than half of the sample (*n* = 296) commented on the optional open-ended question at the end of the survey, writing narratives about a spiritual encounter at work. Ninety percent of the narratives were classified as engaging experiences (versus disengaging) with the sacred at work.

This chapter presents an elaboration of the findings for each of the above mentioned areas and contextualizes them in light of the empirical and theoretical literature on nurses' spiritual care practices. Methodological issues will be addressed when discussing the strengths and limitations of the study. Before drawing final conclusions from this study, recommendations will be given for (a) theory development in spiritual care, (b) spiritual care in nursing practice, (c) spiritual care education, (d) research on spiritual care, and (e) tool development (NSCQ).

Comparison of the Findings with the Literature

Assessment

This study provided preliminary psychometric data for a new instrument that assessed nurses' spiritual care practices and the frequencies with which they engaged in 17 different types. Many of the existing studies on nurses' spiritual care have reported on proxy measures for spiritual care, such as nurses' attitudes or perceptions of spiritual care (e.g., McSherry et al., 2002; McSherry, 2006; Reed, 1987; Stranahan, 2001; Taylor et al., 1994). Numerous researchers have studied nurses' attitudes toward spiritual care and explored what is correlated with a positive attitude towards spiritual care (e.g., Lundmark, 2006; Musgrave & McFarlane, 2004a; 2004b; Strang et al., 2002). A consistent finding appears to be that although nurses have a positive attitude towards spiritual care or holistic care, as named by some researchers, the positive attitude does not necessarily relate to actual spiritual care practices (Kristeller et al., 1999; Kuuppelomäki, 2001; Lundmark, 2006; Musgrave & McFarlane, 2004a; 2004b; Scott et al., 1994; Stranahan, 2001; Strang et al., 2002; Tuck, Pullen, & Lynn, 1997; Tuck, Pullen, & Wallace, 2001; Vance, 2001). Although Lundmark (2006a) added some intervention-

related spiritual care questions, for example, "how often do you provide spiritual care?" with the response options *never* to *daily*, there have not been many studies where definition and operationalization of spiritual care for assessment have been published. McSherry (2006) in his tool development blended *perceptions of spiritual care* with *perceptions of spirituality,* and, thus, the tool is again not informative about the actual frequency with which respondents attend to the spiritual in their practices.

Given the absence in the literature of instruments that measure the actual frequency of spiritual care practice, Taylor's (2008) NSCQ, used for the first time in this study, represents progress in the assessment of spiritual care. There remains, however, the challenge of interpreting the results because they cannot be directly compared against other published findings.

Types and Frequencies

Nurses' average spiritual care practice score on the NSCQ was 36.98 (*SD* 12.01). The minimum of the scale was 17 representing zero practice. The maximum of 85 translated into doing each of the 17 practices more than 12 times in the last 72-80 hours at work. Practices that were endorsed most frequently centered around assessment of spiritual beliefs and practices and active listening to patients' illness experiences and spiritual concerns. The most frequently endorsed item, however, was "after completing a task remained present to show caring." These four items likely are to be supported by most nursing scholars, regardless of worldview, as best practice of spiritual care.

As uncontroversial as these items might be from a clinical or theory perspective, from a research perspective, however, how to regard "presence to show caring" is not entirely clear. Its factor loading (in the unidimensional solution) was the lowest, but the

internal reliability coefficient (Cronbach's alpha) would have improved only by a one-tenth if the item had been omitted from the scale. There are possibly two conflicting perspectives around the presence item: (a) the research perspective that suggests "presence to show caring" may not be the best representation for the phenomenon that is being measured (the reason is that the item is endorsed both by those who practice spiritual care and those who do not), and (b) a scholarly/theoretical perspective on the item that holds presence as an effective way of being therapeutic to suffering human beings (i.e., Cavendish et al., 2004; O'Brien, 2003, Taylor, 2002). Nursing is the one profession that is always present in acute care. If that presence is used intentionally, nurses believe it can have a therapeutic effect; however, this specific NSCQ item appears to be located at the conceptual boundaries of another important construct, caring.

Spiritual care practices endorsed least were: (a) reading a spiritually nurturing passage from the patient's holy scriptures, (b) arranging for patient's clergy or spiritual mentor to visit, (c) documenting spiritual care provided in a patient chart, and (d) encouraging a patient to talk about the spiritual challenges of living with illness. Many textbooks on spirituality in nursing suggest that holy scriptures are a meaningful religious symbol or element for religious people (Mauk & Schmidt, 2004; O'Brien, 2003; Taylor, 2002). Reading to a patient from "a patient's holy scriptures," however, where this is not a shared culture – as the wording appears to suggest – it is hard to imagine that this actually happens. If the nurse is not familiar with the reading material, how is he/she supposed to know where to find spiritually comforting passages in the patient's holy scriptures? Thus, emphasizing the fact that this is the patient's holy scriptures may have generalized the item to a degree that practicing clinical nurses do not endorse.

Interestingly, in the open-ended part of the questionnaire, nurses reported they shared inspirational material provided by the chaplaincy department (prayers, selected comforting bible verses) with patients. In the nursing literature, reading scripture with a patient is particularly common in parish nursing (Tuck, Wallace, & Pullen, 2001). Reading scripture appears to go beyond the "spiritual care generalist competency" (Robinson, Thiel, & Meyer, 2007) and may be more common in areas like parish nursing and hospice.

The issue of documentation of spiritual care is also complicated. Experts in the field of spirituality in nursing call for the documentation of spiritual care in the mode of the nursing process (McSherry, 2006), and accrediting bodies look for the documentation of the spiritual assessment in hospital patients' charts (JCAHO, 2004). Nevertheless, apart from information about the presence or absence of a religious affiliation and whether the patient wants to see a chaplain, studies show that even those who profess to provide spiritual care and who do it comfortably do not like to document spiritual insights (Stranahan, 2001). The finding in this study of comparatively low scores in documenting spiritual care confirms what others have observed and critiqued (McSherry, 2006).

Although it is certainly interesting to note that nurses tend not to document spiritual care, from a research perspective the question arises if this item is one of the most important ones representing spiritual care practice. As the NSCQ goes through a refinement process, the author of the tool will likely want the fewest number of "best representations" of the concept to be measured. Because lack of documentation of spiritual care appears to occur in nurses who do and who do not provide spiritual care, the documentation item may be a candidate to be dropped from the NSCQ.

The findings of this study support, on the one hand, that the instrument's content was applicable across different nursing environments. The fact that three-fourths of the participants said there were no other spiritual care practices that they engaged in (beyond the ones mentioned in the tool) can be seen as a basic support of the tool by the clinicians. One-fourth of the respondents, however, stated other spiritual care practices. For instance, respondents described some variations to prayer beyond the one covered by the NSCQ. From a nursing perspective, prayer has been suggested as a way of spiritually supporting patients and their families when appropriate (e.g., DiJoseph & Cavendish, 2005; Taylor, 2002) from the perspectives of oncology care (e.g., Brown-Saltzman, 1997), holistic care (e.g., Dossey, Keegan, Guzzetta, & Kolkmeier, 2000), family nursing (e.g., Wright, 2005) or Christian nursing (e.g., Durfee-Fowler, 2003; Van Dover & Bacon, 2001). An analysis of ideal, typical, and actual spiritual practices of 95 parish nurses showed that praying in conjunction with listening was the most frequently used spiritual practice across the three situations (Tuck, Wallace, & Pullen, 2001). The NSCQ wording for the prayer item suggests a nurse-initiated model. In the narratives of this study, however, nurses mentioned that in some situations, prayer was initiated by the patient or family. More commonly, however, nurses reported that they prayed privately for their patients. Although academicians may argue that nurses' silent prayers are unethical if the patient has not consented to be prayed for, it is possible that silent prayers are much more frequent than nurses' initiating prayer with a patient. For example, the most frequent spiritual intervention Stranahan's (2001) nurse practitioners cited was praying privately for a patient. This private practice was also the case in Dell'Orfano's (2002) clinical project in which the meaning of spiritual care from the perspective of

parents and nurses of brain-injured children was explored. Grant (2004) found prayer to rank fourth as spiritual practice after holding a patient's hand, listening, and laughter as spiritual interventions. Regardless of the ethical discussion surrounding nurses' privately praying for the patients they care for, the act of praying for the patient may translate as a caring, empathetic attitude. It may also be understood as a coping mechanism on the part of the nurse to "maintain sanity and a soft heart" – as one of the respondents stated in the open-ended question – in the face of witnessing patient suffering at the workplace. The fact that nurses' silent prayer for the patient/family emerged clearly from the qualitative data raises the question whether the prayer item could be worded more openly as "how often did you pray with or for a patient?" When interpreting the research finding that the NICU nurses scored lower in spiritual care than all other areas of nursing, the present wording of the prayer item may be relevant in explaining this finding. Because the tool in its present form does not allow nurses to count private or silent prayers as spiritual care practice, this stipulation could be a potential problem for NICU nurses and other pediatric nurses working with small children. That is, as they respond to the NSCQ, they cannot count their prayers for the child or their family as spiritual care unless the parents are present and welcome this form of spiritual support.

In addition, nurses' comments in the qualitative part pointed towards a "more embodied spiritual care practice, for instance, holding a child's hand as the child fell asleep or died. The NSCQ in its present form tends to operationalize spiritual care from a cognitive, communicative perspective. By contrast, some authors have described nursing

as "embodied caring" (e.g., Hamington, 2004; Benner, 2000[3]). Following this understanding, one might ask whether the NSCQ adequately captures the concept of spiritual nursing care in the absence of any "embodied items". Furthermore, the research team wonders whether embodied spiritual care items may be particularly relevant for pediatric nursing more specifically for spiritual care in pediatrics. The absence of embodied items could certainly be an explanation why pediatric and NICU nurses' scores, respectively, were significantly lower than medical/surgical or oncology nurses' scores.

In the literature, descriptions about pediatric spiritual care emphasize spiritual assessment of the child and family with the appeal to respect and maintain family beliefs and practices when the child is hospitalized (McSherry & Smith, 2007). In the United States, as palliative models of care are being advocated to better meet the needs of dying children (55,000/year) and children living with life-threatening conditions (400,000/year) (Calabrese, 2007), there is renewed interest in understanding which spiritual interventions could be helpful to suffering children and their families (Robinson, Thiel, Backus, & Meyer, 2006; Duncan, Spengler, & Wolfe, 2007). Theory-based, concrete descriptions of spiritual care practices for children are rare in the literature; however, they have been described for cancer children by Hart and Schneider (1997). Similar ideas as applied to general pediatric nursing have been outlined more recently by Elkins and Cavendish (2004) and by O'Brien (2003). The need for more relationship-based research, however,

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[3] Benner (2000) warns not to fall into the old dualistic trap when delineating mind, that is, the intellectual part of reasoning in nursing from body, that is, the physical/ skill aspect of nursing care thus buying into the prevalent devaluing of hands-on nursing practice. In their foundational book, "The primacy of caring," Benner and Wrubel (1989) argue that caring through technical proficiency as much as expressive actions may affirm a patient's uniqueness and experience. Both aspects represent "embodied intelligence," which is foundational for caring and the premise for expert nursing care and inductive theory development.

in pediatric end-of-life care with special attention to social and spiritual support has also been articulated (Kane, Hellsten, & Coldsmith, 2004).

Hence, it appears there is a need for more research on models for pediatric spiritual care that sustain children and their families through difficult illness experiences and life transitions. Whereas the need for spiritual care and support in pediatric nursing has been well documented, it is possible that the pediatric dimension of nurses' spiritual care practices has not yet been fully captured in the present form of the NSCQ. It may be that the unique nature of pediatric care requires one or more measures of spiritual practices that more readily capture interventions in this nursing specialty (e.g., touch and inspirational music).

NSCQ Correlates

Nurse demographic factors were evaluated in relation to nurses' practices, and none of the commonly used bio-demographic measures were significantly associated. Lundmark (2006a), comparing the frequency of self-reported spiritual care practice (one item) between registered nurses and nursing auxiliaries, found a statistically significant association where higher educated nurses practiced more spiritual care. Taylor et al. (1995) found a small but significant relationship between number of years in nursing and the spiritual interventions of offering to pray, encouraging prayer, and reading to a patient or bringing reading materials to a patient. By contrast, Vance (2001) did not find any significant correlation between frequency of spiritual care practice and years of experience or education. In Taylor et al.'s (1994) study, attitudes and beliefs about patients' spirituality and the kinds of interventions used by the nurses differed in relation to ethnicity and education. These differences were not found in the present study.

Two nurse work environment related variables, however, were significant. One, in the bivariate analysis, working day shift was significantly correlated with providing spiritual care. This finding, although not found in the literature, makes intuitive sense, because the day shift nurses possibly have more hours of interacting with patients who are awake and with their families than do the night nurses. Nevertheless, in the presence of more powerful predictors, this association was not statistically significant in the multivariate analysis. Second, nurses who had received education in spiritual care were more prone to engage in spiritual care practices than those who did not. This association also was statistically significant in the multivariate model and was not surprising, given earlier findings; for example, in Lundmark's (2006a) study nurses who considered education in spiritual care as important were more at ease in providing such care than those who did not see it as important.

In the last couple of years, countless authors have called for curricular attention to the spiritual in nursing programs (e.g., Callister, Bond, Matsumura, & Mangum, 2004; Greasley et al., 2001; Harrington, 1995; Musgrave & McFarlane, 2004a; 2004b; Stranahan, 2001; Treloar, 2000; Vance, 2001) and have made suggestions about how seminars can be constructed to teach students or to give practicing nurses more skills in this area (e.g., McSherry, 2006; Narayanasamy, 1999; Pesut, 2003; Purnell, Walsh, & Milone, 2004; Rieg, Mason, & Preston, 2006; Smith, 2006; Van Leeuwen & Cusveller, 2004). Recently, a self-study guide has been developed for nurses to acquire more skills in therapeutic communication (Taylor et al., 2009). Moreover, study programs now endeavor also to evaluate whether learning operationalized as change in perspectives and as gaining new skills has, in fact, taken place (e.g., Taylor et al. 2008; Van Leeuwen,

Tiesinga, Middel, Post, & Jochemsen, 2008; Wasner, Longaker, Fegg, & Borasio, 2005). Because received education in spiritual care according to this study has an effect on actual practice of spiritual care, the above educational efforts can be supported.

To assess nurses' spiritual/religious profile, the multidimensional constructs of spirituality and religiousness were measured using several different instruments and dimensions of the constructs as recommended for studies on spirituality (Berry, 2005). Nurses tended to score high in spirituality 2.07 (*SD* = 1.18), organized religiousness 4.19 (*SD* = 1.37), and private religious activity 4.18 (*SD* = 1.53) (all on 6-point Likert scales) and also high intrinsic Religiosity, mean score 15.91 (*SD* = 2.34) on a scale that could range from 6-18. The majority of nurses stated a religious preference within the Christian traditions of faith even if it was not a specific one (e.g., Christian, no denomination: 27.3%). In a number of other studies about nurses' spiritual care in the U.S., samples have scored relatively high on spiritual and religious measures (Taylor et al., 1994; Tuck, Pullen, & Lynn, 1997; Tuck, Wallace, & Pullen, 2001; Tuck, Pullen, & Wallace, 2001; Stranahan, 2001). In this sample, the majority (71.1%) identified with both constructs, spirituality and religiousness. By comparison, in Zinnbauer et al.'s (2001) diverse sample of U.S. Americans, the spiritual and religious group constituted 74%. All but 25 respondents stated a religious preference, and most were Christian.

Whereas respondents in Grant et al.'s (2004) study considered themselves spiritual persons (91%), only 41.6% considered themselves religious persons. The "spiritual but not religious nurses" were also well represented in the current study with 22.6%; however, it was found that most still identified a religious preference, which is not surprising in a faith-based health care system.. Hence, they may not fully represent

the seeker/quest type spirituality that Zinnbauer et al. (2001) and Saucier and Skrzypinska (2006) identified as having very different correlations than the spiritual and religious group as noted earlier. In the qualitative analysis, however, it was shown how a nurse representing the quest-type spirituality may approach spiritual care in non-traditional ways. From a quantitative perspective, there was no difference between both groups that identified with the spiritual in relation to the outcome variable.

Thus, the spiritual and religious nurses and the spiritual but not religious groups scored significantly higher in spiritual care practices. In addition, high mean scores in spirituality were significantly correlated with spiritual care practice in both the bivariate and multivariate analyses. All measures of religiousness (church attendance, private religious practice, and intrinsic religiosity) were significantly positively correlated with spiritual care practices on the bivariate level. On a multivariate level they, however, were not significant.

In earlier studies using the proxy for spiritual care practice (nurses' attitude towards spiritual care), Taylor et al. (1994) discovered a positive correlation between nurses' self-reported spirituality and religiosity and their attitude toward spiritual care. In addition, Lundmark (2006a) was able to show that "private religious practices" more strongly than "belief in God" or "belief in afterlife" influenced the largest number of indicators of attitudes to spiritual care. In the present study, nurses' attitudes to spiritual care were not assessed; however, the findings showed a positive significant correlation between spiritual care practices and both high spirituality and religiousness with spirituality being the stronger of the two associations.

In addition to nurses' spirituality, work place also was associated with NSCQ scores. There are a few studies that compared nurses from different specialties in regard to their attitudes about spirituality/spiritual care or spiritual care practices. Taylor et al. (1999) compared hospice and oncology nurses and concluded that both groups of nurses delivered spiritual care infrequently. Tuck, Pullen, and Wallace (2001) compared mental health and parish nurses asking for an ideal, typical, and recent spiritual care intervention. Although the spiritual/religious profile of both groups of nurses did not appear to differ, parish nurses named/delivered twice as many interventions across the three situations. Vance (2001) exploring differences within the acute care setting, found a significant correlation between areas of specialty and frequency scores of providing spiritual care, suggesting that clinical specialty is a potential correlate of spiritual care delivery.

Grant et al. (2004) from a sociological perspective offers a different take: Although nurses agreed there was something spiritual about the care they provided, the researchers also wanted to know if nurses' work environments allowed them to act according to their spiritual beliefs. That is why they asked nurses about their agreement with the statement, "My job provides many opportunities to put my spiritual beliefs into practice." Interestingly, pediatric ICU nurses followed by mental health, trauma, and oncology nurses scored highest agreeing with the statement (77%, 75%, 75%, and 72%, respectively). Only 58% of the NICU nurses agreed with the statement, and lowest agreement was found among ER nurses (38%).

The present study represents an extension of knowledge in that actual differences in frequencies of providing spiritual care were compared across units. Statistically significant differences were found in the bivariate analysis between mental health and

NICU, between pediatric care/NICU and pediatric oncology, and between pediatric and medical/surgical nursing where pediatric care/NICU consistently provided less spiritual care. This finding also was supported in the multivariate analysis and is somewhat surprising given Grant et al.'s (2004) findings. Whereas in this as well as Grant et al.'s (2004) study, lower scores were found in "Interventional Services," which included the OR, and higher scores in mental health and oncology nursing, there is a big gap between this study's finding that being a pediatric nurse is a predictor for providing less spiritual care and Grant et al.'s (2004) finding that pediatric ICU nurses are the ones most inclined to act upon their spiritual beliefs.

At the present time, this researcher attributes the statistically significantly lower scores of pediatric and NICU spiritual care scores to the way the NSCQ measures spiritual care. From evaluating the issues in palliative pediatric nursing, there is nothing that leads this researcher to assume that pediatric nurses face less spiritual distress in their patients (and patients' families). There is no evidence in the literature that pediatric nurses are less inclined to meet their patients' spiritual needs than do nurses in adult or mental health care; therefore, the reason for the present study's finding that not being a pediatric nurse is associated with higher spiritual care practice scores needs to be elucidated through future field exploration, instrument development (or refinement), and other research strategies.

In addition to nurses' work environment, this study drew attention to nurses' perceptions of the work environment and themselves in relation to it. Nurses' perceived comfort level with spirituality had been successfully used in Taylor and colleague's (1994, 1995, 1999) and Lundmark's (2006a) studies. Grant et al. (2004) had added the

perception of one's colleague's comfort level with spirituality and found that nurses tended to perceive themselves as comfortable but did not believe their colleagues were comfortable with spirituality. The implication of such a finding in a secular hospital is that spirituality may not be an issue talked about among colleagues even if it does come up with the patient. In this study, however, on a 5-point Likert scale, nurses tended to see themselves (mean = 3.4; SD = 1.22) as well as their colleagues (mean = 3.2; SD = 1.09) more comfortable than uncomfortable with spiritual issues. Their level of comfort was even higher when patients presented them with religious issues (mean = 3.7; SD = 1.3).

It is not surprising that nurses who are committed to a faith tradition are comfortable relating to the needs of religious patients. This may be the group of patients that they provide spiritual care to most easily. Even higher than their comfort level is their perception of spiritual needs in their patients (mean = 3.69; SD = 0.9), and most note that spiritual issues come up occasionally (mean = 3.01; SD = 0.78). On a bivariate level, all of these perception questions were significantly positively correlated with spiritual care practice.

A finding from another study may offer interpretive assistance about the relationship of frequency of spiritual issues coming up and actual spiritual care practices. Kuuppelomäki (2001) had found a striking difference in the way Finnish nurses perceived terminally ill patients' spiritual needs: One half of the nurses said that terminally ill patients expressed their spiritual needs often, and the other half said that the same group of patients expressed their spiritual needs rarely. Reflecting on this finding, there appears to be a difference in nurses' perceptions about recognizing cues for spiritual needs or even spiritual distress.

This observation led this researcher to hypothesize that nurses who recognize those cues more often are more prone to act in response to those needs than nurses who tend not to recognize the cues. The survey question "In your patient interactions, how often do spirituality/spiritual issues come up?" is one that asked for nurses' subjective appraisal of the frequencies of such cues. It was assumed that the response would not be so much driven by the objective work environment but rather by nurses' perceptions of spiritual cues. Interestingly, this question turned out to be the strongest predictor of spiritual care practices in this sample. In the multivariate analysis, it explained more variance than any other variable, including nurses' spirituality score. It would be interesting to know whether this factor would fare equally well in another sample in another setting.

In the multiple regression model, 32.4% of the total variance was explained largely due to four predictors. Nurses' comfort level with spiritual issues that had been an influential predictor in Lundmark's (2006a) model and colleague's comfort level that had also been significant in the bivariate analysis were not significant when entered simultaneously with other variables. The same was true for "working day shift." Thus, the predictors of nurses' spiritual care in this sample are related to nurses' perceptions of the frequency of spiritual issues coming up at the work place and nurses' spirituality, nurses not working in a pediatric work environment, and nurses' status about past education in spiritual care.

Study Limitations and Strengths

The study used an online-survey approach and invited one health-system's RN workforce of 2311 nurses to participate with an email that had the link to the survey. It

was not possible to refine the email list in such a way that only nurses who had provided a minimum of 36 hours of direct patient care received the email. However, 29% of the total population responded to the email invitation by accessing the survey. This is a return rate of almost 30%, which is considered a typical return rate for online surveys. One of the challenges was to get nurses to check their work emails for the invitation. Therefore, the research team followed up with personal visits to the units distributing candy and reminder notes. The candy and a raffle for 25 twenty dollar gift cards to be given away among those completing the survey served to motivate participants who were not particularly interested in the study. After 8 weeks of study time, it was determined that more reminder emails, candies, and visits to the units would not be appreciated. The net response rate was 26.2%.

The facts that nurses were contacted through the institution's work email system and were allowed to fill in the survey while at work were conducive to a better response rate. However, the sample may have been skewed somewhat towards younger age groups, because the older RNs often are not computer literate and avoid the computer. About 22 participants were lost due to not finishing the survey, and 43 were discontinued by the system because they did not meet the eligibility criteria. Nevertheless, the composition of the final study sample reflected very closely the number of nurses in the different hospitals, the proportions between male and female nurses in this facility, as well as the ethnic and religious profile of the total workforce. Thus, the research team concluded that the final sample was a good representation of the total workforce in this facility. The final sample size after data cleaning was $N = 554$, a very solid sample size for the kinds of statistical procedures employed. With such a sample size, the study is

definitely classified among the larger studies that have been conducted in the area of spiritual care in nursing.

Because the study was conducted in one large non-profit, faith-based health care system, comparisons of nurses' practices across the different specialties were possible. Grant et al. (2004) recently explored from a sociological perspective how spirituality and spiritual care were perceived and practiced by nurses in a secular tertiary care health care system. A major critique of his had been that studies in nursing about nurses' spiritual care have usually analyzed nurses *apart* from their organizational context. Thus, he and his colleagues concluded, "such studies provide little information about the possibility of creating a culture of spiritual care within a hospital and its entire nursing staff" (Grant et al., 2004, p. 268).

This health care setting with its four different hospitals shared the same Christian, wholistically[4]-oriented mission statement allowing for spirituality to be integrated at the workplace, if appropriate. So what is the evidence of such a *shared organizational culture*? Whereas Grant et al.'s (2004) study site was in the process of closing the chaplaincy department to save money and explored whether nurses were willing to take on the role of spiritual care givers, the present study's facility has a specific chaplain assigned to each unit to visit patients regularly. Thus, nurses do not have to request the chaplain to come to their unit; rather they naturally cooperate with chaplains who check in on a daily basis. In addition, a chaplain is on call 24 hours-a-day. Nurses also stated in the narratives they felt spiritually supported in their work through the work of the chaplains, and some felt inspired to pay more attention to the spiritual through the care of

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[4] When referring to this health-system's wholistic orientation, the spelling is derived from "whole" and reflecting the mission statement of the institution: "To make man whole."

some physicians. Other supporting evidence that wholistic care may reflect a shared institutional understanding also can be derived from the response to the item of how supportive the nurses perceived their immediate supervisors to be when they provided spiritual care. Seventy-two point two percent of the nurses perceived their supervisors to be very supportive or supportive; 21% were neutral, and 6.8% perceived them as unsupportive or very unsupportive. Hence, there appeared to be a cooperative identity in this particular health care system where attention to the spiritual was not simply assigned to one profession but was a cooperate task.

These shared similarities in the organizational work context possibly reduced the complexity of influencing factors that may be associated with nurses' spiritual care practices. Consequently, it was possible to study these factors more clearly (i.e., the potential effects of nurses' bio-demographics, spirituality and religiousness, and other work environment related variables). Limiting the generalizability of the findings to nurses' spiritual care in a faith-based tertiary care health care system appears reasonable.

Overall, the findings from this study may be most generalizable to spiritual and religious nurses of mainstream Christian faith traditions. Because the spiritual/religious profile of these nurses generally reflects the one of the general American population (Zinnbauer et al., 1997), there may actually be a fairly good fit between the spirituality of the nurses and the patients they care for. Clearly, the study does not allow for inferences about non-spiritual and non-religious nurses who were underrepresented in this study.

Although measuring actual spiritual practice over a defined period of time rather than nurses' attitudes towards spiritual care is an advance in research, it must be acknowledged that nurses evaluated their practice in retrospect from memory. They had

not documented their practices shift by shift or day by day, so their responses likely are approximations only. Furthermore, although the NSCQ measures spiritual care events, it does not capture how much time one spends on each "encounter," nor is it a measure of intervention effectiveness.

Recommendations

Implications for Theory Development in Spiritual Care

Conceptually, there is an intersection between spiritual care and the caring concept, which demands further analysis. Caring and a trusting relationship with the patient appear to be antecedents of spiritual care (O'Brien, 2003). Without these, spiritual care is not possible or may not be understood as benevolent behavior towards the patient. In this study, the NSCQ conceptualized "presence to show caring" as a spiritual care intervention. The fine and frequently blurred line between what is "caring" and what is "spiritual caring" remains an area of conceptual (and theoretical) concern.

Drawing on the work of psychologists of religion (Pargament, 1997; Zinnbauer, 1997) and sociologists of religion (Demerath, 2000; Grant et al., 2004), this study has shown what kind of spiritual identities can be found in a tertiary-care level, faith-based health care system and the kind of spiritual care practices that these may lead to. Differentiating between spiritual identities that are integrated (the individual identifies as both spiritual and religious) and those that only identify as spiritual but reject the religious dimension is theoretically and empirically well supported in the literature (Demerath, 2000; Saucier & Skrzypinska, 2006; Zinnbauer, 1997). Although in the quantitative comparison of these groups in relation to the outcome variable, differences were not substantial (likely because the two groups were too similar in the context of this

study), future research in a different setting may be able to show the differences in preferences for spiritual care practices more clearly. Should the author of the NSCQ include more spiritual care practices that are within the New Age tradition and that are being used in other studies (e.g., Grant et al., 2004), differences in approach to spiritual care practices likely will be apparent. In the qualitative part, however, organized around the typologies of the sacred, a different pattern was shown when the spirituality of the nurse followed a quest-type spirituality.

Implications for Spiritual Care Nursing Practice

The findings of this study are most informative about the spiritual care practices of nurses who self-report as both spiritual and religious. Second, the study results may be representative of spiritual care practices that occur in nurses employed by a faith-based, tertiary care environment. Within this study's health care environment, over half a million patients per year are seen, many of whom are severely ill, facing invasive treatments or are dying. It is interesting to note that nurses in this sample endorsed presence to show caring more than any other of the 17 items; second, they listened actively to the patient's story of illness; third, they assessed spiritual and religious beliefs pertinent to health; and, last, they listened to a patient talk about spiritual concerns. The nurses in this sample care for a broad spectrum of patients with diverse spiritual orientations although many in this cultural context are religious or have a religious heritage on which they draw in difficult life circumstances. It is also informative to note that the most overtly religious practice reported by these nurses was the use of prayer. During the study period (reflecting on the past 72-80 hours at work), 41.3% never prayed with a patient, whereas 48.9% had prayed with patients between 1-6 times. About 10% of

the RNs had prayed with patients more than 6 times. This comparatively small subset of the sample likely was to integrate prayer into their nursing routine, offering to pray with those patients or families who accept prayer and not praying with those who decline.

The nurses' narratives revealed a practice of engaging and connecting with patients; positive experiences appeared to motivate the nurses to be a supportive presence in the next situation. It would be interesting to learn what reciprocal effects provision of spiritual care has on both the provider and the receiver of the intervention.

Implications for Spiritual Care Education

The four-factor predictor model for nurses' spiritual care in this study revealed nurse and workplace related factors: Nurses' perception about the frequency of spiritual issues coming up, nurses' spirituality score, nurses not working in pediatric care, and nurses' status about past education in spiritual care. Clearly, nurses' status with education in spiritual care can be most effectively addressed through education. It also is possible that nurses attending workshops or courses on spiritual care sharpens their awareness for signs and symptoms of spiritual distress and provides them with communication strategies of how to listen for underlying spiritual pain. Thus, through educational intervention, the nurse may become more aware of spiritual issues, recognize the cues more readily, and respond more often with spiritual care.

Implications for Spiritual Care Research

Future research will have to test what type of educational measures really change spiritual care behavior in the nurse or empower the nurse to be even more supportive and attuned to listening. Those effective educational measures would in turn draw attention to what is being taught in courses about spiritual care in nursing. Future research will have

to explore whether the finding about pediatric nursing – a relevant predictor in this model – is real or is tool-related, as this researcher has concluded, and whether frequency of spiritual issues coming up and received education in spiritual care can also predict spiritual care practices in a different setting and sample.

The NSCQ in its present form has allowed for some cross nursing specialty comparisons of nurses' spiritual care practices within the organizational culture of one health care system and yielded some interesting results. The observation, however, that pediatric nurses and within-pediatrics NICU nurses scored lowest of all nurses raised the suspicion that spiritual care practices relevant to the pediatric environment particularly with smaller children and in the context of life-threatening diseases may not have been fully captured by the NSCQ. It is possible that more embodied forms of spiritual care like touch may be missing on the present version of the NSCQ leading this group of nurses to score lower than everybody else. There may be a need to study more about nurses' ways of providing spiritual care to children and their families through qualitative research methodologies. Of particular interest is the NICU environment and units where the children are still too small to talk about spiritual issues with their parents and nurses. It would be interesting to capture more accurately how spiritual care is practiced in these contexts. In oncology and palliative pediatrics, it is possible that guided spiritual imagery is being used (Brown-Saltzman, 1997), for example, as an intervention to help children cope with the effects of chemotherapy. Other more child specific spiritual interventions described in the literature are reading from the child's favorite book or a children's bible and surrounding the child with religious symbols that are meaningful and reassuring to the child (O'Brien, 2003).

The question also arises how the emerging theme of "praying silently for the patient" might affect the nurse. Future research should explore whether there is a relationship between nurses privately praying for patients and their overall coping with stressful clinical experiences and between privately praying and their level of empathy or burn-out. A large percentage of nurses, when asked about a spiritually meaningful encounter at work, gave an experience that was spiritually engaging. Future research ought to explore in more detail what factors contribute to both spiritually engaging and spiritually disengaging care.

Implications for Tool Development (NSCQ)

The NSCQ has the potential for contributing to theory development in spiritual care because it is the first rigorously developed instrument that systematically operationalizes spiritual care, making it possible to measure practices across environments of nursing. This research study has made some contributions to further the development of the existing tool.

The findings suggest some future research and development be done on the NSCQ. The relatively low mean score of spiritual care practice (NSCQ) and the fact that 7 items had the response option *never* and 6 items *rarely* as the most frequently endorsed response category raise the following questions: (a) Should some of the items be dropped from the tool (e.g., documenting the spiritual care provided) or have the wording adjusted (reading from another's spiritual scriptures)? (b) Should the frequencies suggested by the anchor points be adjusted to avoid skewed distributions and to reflect more accurately what truly is *never, rarely, occasionally, often,* and *very often* in the perspective of clinical nurses? (c) Should the operationalization be reduced to either numbers (0 times,

1-2 times, 3-6 times, 7-11 times, more than 12 times) *or* words (the subjective understanding of the nurse as to how often they engage in spiritual care practices: *never – rarely – occasionally – often – very often*) to avoid possible confusion for an individual?

Prayer was a dominant theme in the qualitative analysis, and it appeared in 155 of 296 comments. Silent prayer of the nurse was mentioned in several accounts, and the question is whether this practice constitutes a spiritual care event that can be incorporated into the tool.

Conclusions

This study gave insight into the way that spiritual and religious nurses approached spiritual care in a faith-based, tertiary health care system. The study is unique because it provides actual frequencies of spiritual care provided and describes spiritual care events and their correlates. Nurses' encounters with spirituality at work were captured by narratives and reflected a spiritually engaging experience in 90% of the cases and a spiritually disengaging experience in the remaining 10%.

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APPENDIX A

Institutional Review Board Exempt Notice

INSTITUTIONAL REVIEW BOARD
Exempt Notice

OFFICE OF SPONSORED RESEARCH • 11188 Anderson Street • Loma Linda. CA 92350
(909) 558-4531 (voice) • (909) 558-0131 (fax)

IRB# 58282

To:	**Winslow, Betty W**
Department:	**School of Nursing**
Protocol:	*Relationship between nurses' spirituality, religiousness, personal and organizational factors and their spiritual care practices in faith-based tertiary care medical facility*

Your application for the research protocol indicated above was reviewed administratively on behalf of the IRB. This protocol is determined to be exempt from IRB approval as outlined in federal regulations for protection of human subjects, 45 CFR Part 46.101(b)(2).

Stipulations:

Please note the PI's name and the IRB number assigned to this IRB protocol (as indicated above) on any future communications with the IRB. Direct all communications to the IRB c/o the Office of Sponsored Research.

Although this protocol is exempt from further IRB review as submitted, it is understood that all research conducted under the auspices of Loma Linda University will be guided by the highest standards of ethical conduct.

Signature of IRB Chair/Designee: _R. L. Rigsby_ Date: 10/28/08

Loma Linda University Adventist Health Sciences Center holds Federalwide Assurance (FWA) No. 6447 with the U.S. Office for Human Research Protections, and the IRB registration no. is IORG226. This Assurance applies to the following institutions: Loma Linda University. Loma Linda University Medical Center (including Loma Linda University Children's Hospital. LLU Community Medical Center). Loma Linda University Behavioral Medicine. and affiliated medical practices groups.

IRB Chair:	**IRB Administrator:**	**IRB Specialist:**
Rhodes L. Rigsby, M.D.	Linda G. Halstead, M.A.. Director	Mark Testerman
Department of Medicine	*Office of Sponsored Research*	*Office of Sponsored Research*
(909) 558-2341, rrigsby@ahs.llumc.edu	*Ext 43570, Fax 80131. lhalstead@univ.llu.edu*	*Ext 43042. Fax 80131. mtesterman@llu.edu*

APPENDIX B

Informed Consent

Loma Linda University School of Nursing
Graduate School

Relationship between nurses' spirituality, religiousness, personal & organizational factors & their spiritual care practices in a faithbased tertiary care medical facility.

Informed Consent Document

You are being invited to participate in a research study conducted by Iris Mamier, as part of her PhD program at Loma Linda University School of Nursing. The study focuses on spirituality and spiritual care as you see and experience it in the clinical setting where you work. The purpose of this study is to examine factors associated with nurses' spiritual care practices in a faith-based tertiary care setting.

You are invited to participate in this research because you are a registered nurse in one of the four hospitals of LLUAHSC. If you have worked 36 hours or more as a Registered Nurse in direct patient care in the last two weeks you qualify to participate. Your participation is voluntary and includes the completion of an online survey. This takes no more than 10-15 minutes. You may withdraw at any time without any negative consequences and your decision will not affect your current or future relations with Loma Linda University and LLUAHSC.

Risks and Benefits of Being in the study
The study potentially contributes to a better understanding of nurses' spiritual care in acute tertiary care. In addition to fostering the professional knowledge base the inventory of your professional practice may make you aware of things you are doing beyond JCAHO requirements without always being aware of them. In addition, there is a chance of winning one of twenty-five $20 gift cards. Therefore, all email addresses of those completing the survey will be entered into a raffle. We hope that at least 350 RN's will participate in this research leaving you with a good statistical chance to be a winner. - There is a small chance that some of the questions may make you feel slightly uncomfortable; however, the questions are no more personal than any questions you typically ask in a nursing assessment with a patient.

Confidentiality
Results of the study will be reported across all participants. None of the information you give will be traced back to you personally as data will be coded under a random identifier and be reported in aggregate.

Contacts & Questions
You may ask any questions you have about this study by contacting the study researcher, Iris Mamier at spiritualcarestudy@llu.edu or EXT85941 or Dr. Betty Winslow, dissertation chair, (EXT45447, email: bwinslow@llu.edu), LLU School of Nursing.

1. Do you agree to participate in the Spiritual Care Survey?

◯ Yes - Start Survey

◯ No Thank-you - Exit Survey

Loma Linda University
Adventist Health Sciences Center
Institutional **Review Board**
Approved _10 l-28 l08_
#_53282_ Chair _R J Rigsby mo_

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Online Survey

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2. Inclusion Criteria

Thank you participating. The first three questions will determine whether you meet the inclusion criteria for this study:

* 1. Are you a CA licensed Registered Nurse?

○ Yes

○ No

* 2. In the last two weeks of working, have you provided at least 36 hours of direct patient care?

○ Yes

○ No

* 3. In which of the following hospitals do you work primarily? Please choose one!

○ I do not work at an LLU facility

○ I do not work in a hospital

○ LLU MC

○ LLU East Campus

○ LLU Children's Hospital

○ LLU BMC

○ Other LLU hospital or facility (please specify)

[   ]

Spiritual Care of Patients - Final

3. Demographics

This is to collect information about you and your experience as a Registered Nurse.

* 1. What is your age?

Years of age ☐

* 2. For how many years have you cared for patients as a RN?

Number of years ☐

3. Gender:

◯ Male

◯ Female

4. Race/ethnicity:

◯ Caucasian or White

◯ Hispanic/ Latino

◯ Asian/ Pacific Islander

◯ Black/ African American

◯ American Indian/ Alaskan Native

* 5. What is your educational background? (mark all that apply):

◯ Diploma in Nursing

◯ Associate Degree in Nursing

◯ Bachelor degree in nursing

◯ Non-nursing bachelor's degree

◯ Master degree in nursing

◯ Non-nursing master's degree

◯ Doctoral degree in nursing

◯ Non-nursing doctoral degree

Spiritual Care of Patients - Final

✳ 6. In addition to your patient care what other work role do you have?

◯ none, patient care exclusively

◯ I a team leader/ shift coordinator/ relief charge nurse

◯ I am a charge nurse

◯ I'm a director of patient care/ manager or supervisor

◯ I an educator

◯ I have an advanced practice (APN) role in nursing

7. What is your work unit number or name?

[_____]

8. How many shifts have you worked in the last 2 weeks?

Number of shifts [_____]

✳ 9. About how many hours have you worked in the last 2 weeks?

Number of hours
worked: [_____]

10. On average, how many patients do you take care of during one shift?

Number of patients: [_____]

11. Which shift do you work primarily?

◯ Day

◯ Night

12. Have you ever received education in providing spiritual care?

◯ Yes

◯ No

Spiritual Care of Patients - Final

13. If you marked "Yes" on Question 12, where did you receive the education about spiritual care (if more than one applies, please check "other" and indicate which selections apply to you.)

○ In my undergraduate nursing program

○ In my graduate nursing program

○ In service, other than orientation

○ I've completed continuing education units in spiritual care

○ I've done some reading on my own about spiritual care

○ Other (please specify)

[   ]

14. What is your present religious preference?

○ Protestant-SDA

○ Protestant-Other Denomination (please specify denomination in comment box below)

○ Protestant non-denominational

○ Christian – no denomination

○ Catholic

○ LDS/ Mormon

○ Jewish

○ Muslim

○ Other religion (please specify using comment box below)

○ No religious preference

Specific denomination or religion:

[   ]

Spiritual Care of Patients - Final

15. What prompted you primarily to respond to this online survey? (one answer only)

- ( ) E-mail invitation at work
- ( ) My supervisor asked me to
- ( ) A flyer I saw at the workplace
- ( ) An ad I saw
- ( ) A presentation about this study
- ( ) Talked with the researcher
- ( ) Other (please specify)

[   ]

Spiritual Care of Patients - Final

4. Spiritual Care

Please mark how often you used each of these therapeutics (or interventions). If you work 12 hour shifts, please consider the last 72 hours of work as the basis for your rating; if you work 8 hour shifts, please report on the last 80 hours.
Note that the word "patient" is used here in a broad sense. Interpret it to mean any person receiving your nursing care (e.g., family members as well as patients). Also, the term "illness" is used. You may need to substitute health concern or loss or some other word referring to the hospitalization experience. There are no right or wrong answers. Using a therapeutic infrequently could result from your determination that it was not appropriate for the circumstances.

1. During the past 72 (or 80) hours of providing patient care, how often have you:

	never (0 times)	rarely (about 1-2 times)	occasionally (about 3-6 times)	often (about 7-11 times)	very often (at least 12 times)
Asked a patient about how you could support his or her spiritual or religious practices	◯	◯	◯	◯	◯
Helped a patient to have quiet time or space for spiritual reflection or practices	◯	◯	◯	◯	◯
Listened actively for spiritual themes in a patient's story of illness	◯	◯	◯	◯	◯
Assessed a patient's spiritual or religious beliefs or practices that are pertinent to health	◯	◯	◯	◯	◯
Listened to a patient talk about spiritual concerns	◯	◯	◯	◯	◯
Encouraged a patient to talk about how illness affects relating to God—or whatever is his or her Ultimate Other or transcendent reality	◯	◯	◯	◯	◯
Encouraged a patient to talk about his or her spiritual coping	◯	◯	◯	◯	◯
Documented spiritual care you provided in a patient chart	◯	◯	◯	◯	◯
Discussed a patient's spiritual care needs with colleague(s) (e.g., shift report, rounds)	◯	◯	◯	◯	◯
Arranged for a chaplain to visit a patient	◯	◯	◯	◯	◯
Arranged for a patient's clergy or spiritual mentor to visit	◯	◯	◯	◯	◯
Encouraged a patient to talk about what gives his or her life meaning amidst illness	◯	◯	◯	◯	◯
Encouraged a patient to talk about the spiritual challenges of living with illness	◯	◯	◯	◯	◯
Offered to pray with a patient	◯	◯	◯	◯	◯

Spiritual Care of Patients - Final

Offered to read a spiritually nurturing passage (e.g., patient's holy scripture)	○	○	○	○	○
Told a patient about spiritual resources	○	○	○	○	○
After completing a task, remained present just to show caring	○	○	○	○	○

2. Are there any other spiritual care therapeutics that you have provided (or would have provided if appropriate)?

○ Yes

○ No

If yes (please specify):

[   ]

Spiritual Care of Patients - Final

5. Conceptual Understanding of terms

1. Spirituality and religiousness are somewhat related concepts to spiritual care. In your view, which of the following statements best describes how the concepts of spirituality and religiousness are related to one another?

◯ Spirituality is a broader concept than religiousness and includes religiousness.

◯ Religiousness is a broader concept than spirituality and includes spirituality.

◯ Spirituality and religiousness are different and do not overlap.

◯ Spirituality and religiousness are the same concept and overlap completely.

◯ Spirituality and religiousness overlap but they are not the same concepts.

2. Which of the following statements best defines your own spirituality and religiousness?

◯ I am spiritual and religious.

◯ I am spiritual but not religious.

◯ I am religious but not spiritual.

◯ I am neither spiritual nor religious.

Spiritual Care of Patients - Final

6. Personal Spiritual Experience

The list that follows includes items you may or may not experience. Please consider if and how often you have these experiences, and try to disregard whether you feel you should or should not have them. In addition, a number of items use the word 'God'. If this word is not a comfortable one, please substitute another idea that calls to mind the divine or holy for you.

1. You may experience the following in your daily life. If so, how often?

	Many times a day	Every day	Most days	Some days	Once in a while	Never or almost never.
I feel God's presence.	◯	◯	◯	◯	◯	◯
I experience a connection to all life.	◯	◯	◯	◯	◯	◯
During worship, or at other times when connecting with God, I feel joy, which lifts me out of my daily concerns.	◯	◯	◯	◯	◯	◯
I find strength in my religion or spirituality.	◯	◯	◯	◯	◯	◯
I find comfort in my religion or spirituality.	◯	◯	◯	◯	◯	◯
I feel deep inner peace or harmony.	◯	◯	◯	◯	◯	◯
I ask for God's help in the midst of daily activities.	◯	◯	◯	◯	◯	◯
I feel guided by God in the midst of daily activities.	◯	◯	◯	◯	◯	◯
I feel God's love for me, directly.	◯	◯	◯	◯	◯	◯
I feel God's love for me, through others.	◯	◯	◯	◯	◯	◯
I am spiritually touched by the beauty of creation.	◯	◯	◯	◯	◯	◯
I feel thankful for my blessings.	◯	◯	◯	◯	◯	◯
I feel a selfless caring for others.	◯	◯	◯	◯	◯	◯
I accept others even when they do things I think are wrong.	◯	◯	◯	◯	◯	◯
I desire to be closer to God or in union with Him.	◯	◯	◯	◯	◯	◯

2. In general, how close do you feel to God?

◯ Not at all close

◯ Somewhat close

◯ Very close

◯ As close as possible

Spiritual Care of Patients - Final

3. How often do you attend church or other religious meetings?

◯ More than once a week

◯ Once a week

◯ A few times a month

◯ A few times a year

◯ Once a year or less

◯ Never

4. How often do you spend time in private religious activities, such as prayer, meditation, or Bible study?

◯ More than once a day

◯ Daily

◯ Two or more times a week

◯ Once a week

◯ A few times a month

◯ Rarely or never

5. In my life, I experience the presence of the Divine (i.e., God)

◯ Definitely true of me

◯ Tends to be true

◯ Unsure

◯ Tends to be not true

◯ Definitely not true

6. My religious beliefs are what really lie behind my whole approach to life

◯ Definitely true of me

◯ Tends to be true

◯ Unsure

◯ Tends to be not true

◯ Definitely not true

Spiritual Care of Patients - Final

7. I try hard to carry my religion over into all other dealings in life

○ Definitely true of me

○ Tends to be true

○ Unsure

○ Tends to be not true

○ Definitely not true

Spiritual Care of Patients - Final

7. Spiritual Care and the Work Environment

1. On your unit where you work, are patients generally in need of spiritual care?

◯ Never

◯ Rarely

◯ Occasionally

◯ Often

◯ Very often

2. In your patient interactions, how often do spirituality/ spiritual issues come up?

◯ Never

◯ Rarely

◯ Occasionally

◯ Often

◯ Very often

3. In general, how comfortable are you talking about spirituality in the workplace?

◯ Very uncomfortable

◯ Somewhat uncomfortable

◯ Neither uncomfortable nor comfortable

◯ Somewhat comfortable

◯ Very comfortable

Spiritual Care of Patients - Final

4. In general, how comfortable do you think most of your colleagues are in talking about spirituality in the workplace?

○ Very uncomfortable

○ Somewhat uncomfortable

○ Neither uncomfortable nor comfortable

○ Somewhat comfortable

○ Very comfortable

5. How supportive are your immediate supervisors when you provide spiritual care?

○ Very supportive

○ Somewhat supportive

○ Neither supportive nor unsupportive

○ Somewhat unsupportive

○ Very unsupportive

6. In general, how comfortable are you when patients talk about religious issues?

○ Very uncomfortable

○ Somewhat uncomfortable

○ Neither uncomfortable nor comfortable

○ Somewhat comfortable

○ Very comfortable

Spiritual Care of Patients - Final

8. Optional open ended question

Please take a moment to think about the following question, then share your experience in the comment box below!

1. Tell me about an experience at work that greatly influenced your understanding of spirituality, positively or negatively?

Spiritual Care of Patients - Final

9. Thank-you

Thank you for participating in this survey! Your contribution to this study is much appreciated!