The effects of spiritual care nursing education on nurses' comfort in the delivery of spiritual care

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THE EFFECT OF SPIRITUAL CARE NURSING EDUCATION ON NURSES’ COMFORT IN THE DELIVERY OF SPIRITUAL CARE

by

Carmen E. Sterling-Fisher

A thesis proposal in partial fulfillment of the requirements for the degree of Master of Science in Nursing

Department of Nursing
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May, 1996
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ABSTRACT

Spiritual care of patients has been an important part of nursing since Florence Nightingale’s days, although the spiritual nature of nursing care is often overlooked in today’s nursing community. According to Highfield (1992) and Lilley (1987), issues regarding the physical and psychosocial aspects of nursing care continue to predominate nursing literature despite the long standing documented value of spiritual aspects of nursing care (Burkhardt and Nagai-Jacobson, 1994; Robinson, 1994 and Ross, 1994), resulting in limited available learning opportunities related to spiritual care. The purpose of this study was to determine the effect of an educational intervention concerning spiritual nursing care on spiritual care knowledge and comfort level in the delivery of spiritual care. Forty-six registered nurses were tested pre- and post-seminar in order to determine the effect of the educational intervention.

Findings revealed high base knowledge and comfort level related to spiritual care. Despite this high level, knowledge increased significantly post-seminar (p<.008). Comfort level was also increased (p=.057), but this increase was not significant. Anecdotal comments from seminar participants supported the findings and reflected interest and excitement about spirituality and nursing.

This study provided evidence of interest in spiritual nursing care among registered nurses. Documentation of objective and subjective findings related to education and spiritual care nursing has the potential to impact nursing education and practice.
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thanks for my son, Nick, who has learned to thrive on macaroni and cheese. You're so often the reason I do what I do.
CHAPTER I

Introduction

The health care environment in the United States is changing. Our population is aging and experiencing new developments and exacerbations of chronic illnesses. Because of the relatively close personal and intimate contact nurses have with clients, nurses play pivotal roles in assisting clients and families experiencing illness and living with the subsequent changes in their lives. Current nursing literature reveals that nurses want to respond to clients and families by supplementing the science and technology with the art of nursing (Donley, 1991; Macrae, 1995; Maraldo, 1990). However, holistic nursing, incorporating the interrelated components of biological, sociological, psychological and spiritual aspects of the human being, while gaining in popularity, often remains ignored in clinical practice. This is especially true in the area of geriatric patient care (Heine, 1992; Peterson, 1985).

Four aspects of the human being, the psychological, sociological, physical, and spiritual, are multidimensional, interrelated and interdependent requiring management in order to maintain an intact, functional system for the client experiencing illness (Dossey, Keegan et al, 1995). This is an ongoing process for clients learning to manage chronic illness (Lubkin, 1990). An instability within either of the physical, social, psychological and spiritual variables can lead to an imbalance in the system and subsequent crisis.

Assisting the client during crises may be very difficult for nurses who cite lack of knowledge, comfort and time in the failure to assess and intervene in the client’s spiritual distress (Cimino, 1992). Unfortunately, although many nurses recognize the need to care
for the whole person, spiritual concerns remain an area often neglected in practice (Labun, 1988; Soeken & Carson, 1986) and nurses’ educational preparation (Highfield & Cason, 1983; Narayanasamy, 1993).

Problem and Purpose

There is relatively little research in the spiritual dimension of nursing as compared to other areas of nursing care. There have been many attempts to define nursing, the nurse-patient relationship, spiritual dimensions of nursing care and the relationships between these variables with little agreement of definitions and finding of relationships. Some studies identified nurses’ reluctance to assess and intervene in the spiritual dimension of individuals, inspite of the desire to practice holistic care (Highfield & Cason, 1983; Labun, 1988; Soeken & Carson, 1986). Although there is limited information about the nurses’ degree of comfort in giving spiritual care (Cimino, 1992), studies indicate a lack of education and awareness of spiritual needs are related to nurses’ attitudes and beliefs about spiritual care (Boutell & Bozett, 1990; Carr, 1993; Harrison, 1993; Johnston-Taylor & Amenta, 1994; Ross, 1994). Additionally, education about spirituality and spiritual care tends to focus on the religious aspects, although meeting spiritual needs require a much broader focus (Highfield & Cason, 1983), indicating inadequate educational preparation related to spiritual care. There is a paucity of studies evaluating the effect of spiritual nursing education on comfort in the delivery of spiritual care. In 1986, Ellis described a spiritual care course that resulted in nurses’ feelings of being better prepared to identify and meet patients’ spiritual needs. Definitions and relationships related to nursing and spirituality have been varied, perhaps because of the confusion and contrast of the nurses’ value systems attempting to move to a holistic
framework from a more physical/medical model and money focused value system. Additionally, a limited body of knowledge relating to spirituality and insufficient spiritual educational preparation has resulted in relative difficulty assessing and intervening in the client’s spiritual needs (Peterson & Nelson, 1985). Therefore, subsequent delivery of physical-focused nursing care continues, in spite of the development of holistic laden nursing theories. Therefore, the purpose and focus of this study was to evaluate the effect of an educational seminar on nurses’ knowledge and comfort in the delivery of spiritual care.

Significance of the Study

Nurses have cited lack of education, formal and informal, as reasons for inadequate assessment and intervention related to patient’s spiritual needs. Additionally, lack of comfort related to the spiritual care delivery has been cited (Cimino, 1992; Highfield & Cason, 1983; and Narayanasamy, 1993). This study is important to help determine if, in fact, education and knowledge had an effect on nurses’ comfort in the delivery of spiritual care. The literature review of this paper centered around spirituality and the chronically ill, terminally ill and elderly because of the relatively high proportions of these groups seeking healthcare and their particular high risk for spiritual distress.

A balance between the physical, psychological, sociological and spiritual dimensions of human beings is essential in order to maintain health. Therefore, it is important for nurses to be aware of the importance of each of the interrelated, interdependent dimensions as well as how to address the needs of clients with regards to each dimension.
CHAPTER II

Review of Literature and Conceptual Framework

Review of Literature

There is limited information directly related to spirituality and nursing education, although there has been significant research and theoretical literature published about spirituality and spiritual care. This section is devoted to the exploration of the concepts of spirituality, spiritual well-being and spiritual distress.

It is important for nurses to be aware of current themes and occurrences because many people in the United States appear to be searching for meaning in their lives. The result is a spiritual awakening in this nation, the first section is devoted to literature related to the concept of spirituality in non-nursing literature.

Spirituality and Spiritual Well-Being in Non-Nursing Literature

Books written as guides for people in search of a sense of greater meaning of the soul or spirit have become very popular in the United States. These books, many of which are or were national best sellers, are offered to help find the sense of the sacred or the purpose that may be missing in people's lives. It is important for nurses to be aware of current popular literature, even though these books or articles are not scientific pieces. Our patients in need of spiritual healing or guiding may be reading this material. A better understanding of popular literature offers alternative perspectives and will help us to understand our patients and their needs better.

In "Hymns to an Unknown God," Keen (1994) set out to explain how we can recapture a sense of the sacred in everything we do every day of our lives. Keen (1994)
quotes Bill Moyers, "Any journalist worth his or her salt knows the real story today is to define what it means to be spiritual. This is the biggest story—not only of the decade but of the century." Authors, such as Dyer have attempted to define spirituality by contrasting the spiritual with the nonspiritual.

Dyer (1992, 1995) described the difference between a spiritual and a non-spiritual person, and ways to develop and tap into the power of the higher self. He also described his beliefs regarding the world of higher awareness where nothing is impossible, including complete physical health. He writes from the perspective of a counselor/therapist.

Chopra's (1989, 1994) ideas are supportive of Dyer's and they have lectured together in the United States. Although Chopra's beliefs stem from his experience as a medical doctor, he states, "We are real magicians all the time... In the very act of perception we take this field of infinite possibilities... and out of it we create material reality." Chopra and Dyer focus on the mind-spirit ability to overcome physical weaknesses. Chopra (1994) also offered seven laws of success. Although he did not define spiritual or spirituality, he claims that if the laws are followed, and we learn to live in harmony with natural law, a sense of well-being, good health, fulfilling relationships and energy and enthusiasm for life will occur.

In contrast to Chopra and Dyer who distinguish between the roles of the spirit and mind, Peck (1978) makes no distinction between the mind and the spirit. He believes there is no difference between the process of achieving spiritual growth and achieving mental growth. He describes the journey of spiritual growth as a long one. In his later work, he sought to explain that we don't have to make this journey alone, but can ask the
force for help in becoming greater than we are in our lives (1993). In 1995 he described a three week trip through Wales, England and Scotland that became an adventure of the spirit and the strife to understand the journey of life, spirituality, faith, and mystery.

Similar to Peck, Schwartz (1995), a journalist, wrote about his own spiritual journey. He described the different philosophies that have developed in the modern consciousness (mind-body) movement as well as his attempts to couple Eastern spiritual traditions with Western psychology. His work offers descriptions into the difference between personality (psychological and emotional based) and essence (spirit based).

While some authors are mind/body/spirit oriented or mind/spirit oriented, others, such as Williamson might be considered more of a pure spiritualist.

Williamson (1993, 1994) sought to interpret “A Course in Miracles” and claimed the spiritual journey is the relinquishment-or unlearning-of fear and the acceptance of love into our hearts. Her books are based on the belief that to be consciously aware of love and to experience love in ourselves and others are the meanings of life. The connectedness of all human beings as children of God is the basis for understanding love and relationships, both individual and global. Relationships are the basis for spiritual exploration by other authors, as well.

Stephen and Ondrea Levine (1995) approach relationships as grounds for spiritual practice. They claim that in relationships we learn and practice techniques for clearing the mind and opening the heart. Spiritual practice therefore offers the possibility of a healing relationship. The relationship between spirituality and healing, in contrast to curing, in modern medicine has been discussed by medical professionals.
Dossey (1993) devoted a book to exploring the use of prayer in the health care setting. He included sections about understanding prayer and healing, factors influencing the efficacy of prayer and research findings related to the use of prayer and healing.

The previous reviews support the belief of a spiritual awakening and search for something beyond the material world that has left many yearning for something more. Moore (1992) believes that many of today's problems, such as addictions, obsessions, violence and loss of meanings are a result of our loss of soul and/or neglect of our soul. In support of the search for something beyond the physical world, he described ways to cultivate depth and sacredness in everyday life.

Our culture has supported and popularized books which guide individuals toward spiritual awakening and ultimate happiness with life. Although nursing has claimed to recognize the importance of the spiritual dimension of the individual, relatively little attention has been given to the subject until recently. Nursing is responding to our culture's spiritual awakening with an influx of information related to spirituality, spiritual well-being and spiritual distress in general as well as to specific patient populations, and nurses' attitudes toward the delivery of spiritual care. The following sections review nursing literature related to spirituality, spiritual well-being and spiritual distress.

**Spirituality, Spiritual Well-Being and Spiritual Distress in Nursing Literature**

Spirituality and spiritual well-being are commonly used although often with different meanings in nursing and non-nursing literature. Although spiritual distress, a nursing diagnosis, has been defined, without clear definitions of spirituality and spiritual
well-being, it is difficult to use. Therefore clear definitions are important so that use and understanding of the terms are consistent among nurses.

**Spirituality**

The spiritual dimension of individuals are integral parts of some nursing conceptual frameworks. Travelbee wrote that “Human beings are motivated by a search for meaning in all life experiences, and meaning can be found in the experience of illness, suffering and pain.” (1966, p.v). She also believed nurses must be prepared to help individuals find meaning in their experiences. Roger’s (1970) Theory of Unitary Man saw the nurse and patient in interactive and complementary systems in the process of constant change. She stressed the importance of the holistic view of human beings in the world. Watson (1985) described people as being possessed of spirit, soul or essence capable of transcending time and space. Neuman (1995) described the spiritual dimension of man in an open system where he interacts with the environment. Consistently, spirituality is considered essential in the maintenance of balance in the human being as a system.

Various nurse authors have defined spirituality, and although most definitions are similar, they are still distinct from one another. Soeken and Carson (1987) defined spirituality as a belief that relates the person to the world, and gives meaning to existence. This belief can be expressed through religious activities such as prayer and worship services, although the entire spiritual dimension of a person is much broader. Ellerhorst-Ryan (1985) identified spirituality as the central philosophy of life which guides peoples’ conduct, and Bugental and Bugental (1984) described spirituality as a force that impels humans forward in living. Similar to Soeken and Carson (1987),
Burkhardt and Nagai-Jacobson (1994) described spirituality as a person’s quest to find meaning and purpose in life. Furthermore, Burkhardt (1994) suggested, based on recent research focused on spirituality of women, that spirituality is a unifying force, manifested in the Self, and reflected in one’s knowing, and one’s doing. In congruence with the previous definitions, Fish and Shelly (1983) identified three spiritual components of an individual as a sense of meaning and purpose in life, a means of forgiveness, and a source of love and relatedness.

Definitions of spirituality usually have an existential (pertaining to issues of meaning and hope) and/or religious foundation. It is not surprising that spirituality and religiosity are often used synonymously, even though they are not the same. Unfortunately, if the nurse’s definition of spirituality focuses primarily on the religious aspects, true spiritual care may be omitted. For instance, patients may not have any particular religious needs, although there may be a need for help related to meaning or purpose in life, the existential portion of spirituality (Emblem, 1992). Spiritual needs are much different than religious practices and affiliations (Moberg, 1971). The 1971 White House Conference on Aging Publication refers to Bolinger (1969) who noted the distinction between “spiritual” and “religious.” He claimed that while the terms are not necessarily opposites, they are not synonymous. A spiritual need may be met by a religious act, such as praying or receiving Holy Communion. Additionally, many spiritual needs are best met by dealing with a physical need, and the spiritual needs of the aging are those of every person and include the need for identity, meaning, love and wisdom. Spiritual needs are often religious in nature and we must take care in showing sensitivity by not imposing our own beliefs, which can lead to antagonism and
withdrawal of the client (Peterson, 1985). It is therefore very important for nurses to be aware of the various definitions of spirituality and to recognize that organized religion may or may not be an element of spirituality. Additionally, awareness of the broader definitions of spirituality may help to alleviate some of the fear and anxiety associated with the religious aspect of spiritual care, since nurses are taught early on not to initiate discussions about religion (Peterson, 1985).

Some nurses have defined spirituality by identifying spiritual needs (Highfield and Cason, 1983; Shelly and Fish, 1988; Stallwood and Stoll, 1975). Some of the spiritual needs identified were any factors necessary to establish and/or maintain a relationship with God (Stollwood and Stoll, 1975), the need for meaning and purpose in life, the need to give love, the need to receive love, and the need for hope and creativity (Highfield and Cason, 1983). This definition requires a relationship with God or other higher being and also an expression of satisfaction with life. The spiritual needs approach gives us an additional dimension not clearly offered by other definitions. Through interviews with patients, nurses, and chaplains, Emblem and Halstead (1993) identified the following six spiritual needs: religious, values, relationships, transcendence, affective feeling and communication. They stressed the importance of all six categories being assessed in order to fully identify spiritual needs of patients.

Burkhardt (1994) further described spirituality as being expressed and experienced in the context of caring connections with oneself, others, nature and God/life force. According to her definition, the self reflects an unfolding life journey that embodies who one is, what and how one knows, and what one does, as well as one’s source of strength and meaning. Connections are those attachments and relationships
that link self to others, nature, self, and God/life force. Her definition implies sharing and attention giving. Granstrom (1985), Nagai-Jacobson and Burkhardt (1989) and Stoll (1989) all agreed that mutual sharing between patient and nurse lead both toward inner harmony and a feeling of contentment. This inner harmony is often defined as spiritual well-being.

**Spiritual Well-Being**

Spiritual well-being is defined by the National Interfaith Coalition on Aging (NICA) as “the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness” (Cook, 1980, p. XIII). Ellison (1983) refers to spiritual well-being as a continuous variable, not being a matter of whether it is possessed or not, but rather how much of it we have and how we can enhance the degree of spiritual well-being we have. He also believed that spiritual well-being is an expression of spiritual health much like our complexion or pulse rate is an expression of our physical health. Hungelmann et al. (1985) define spiritual well-being as an ability to find meaning and purpose of present and future life events. Additionally they describe spiritual well-being as an inner harmony and is manifested by being content with life, regardless of personal failures and illnesses.

Many researchers have studied the relationship between spiritual well-being and various behaviors and attitudes. Studies have shown that high degree of spiritual well-being is positively correlated with high self-esteem, social competence, satisfaction with life (Paloutizian and Ellison, 1982), positive moods (Fehring, Brennan, and Keller, 1987), lower levels of anxiety in adults diagnosed with cancer (Kaczarowski, 1989) and hardiness in patients with AIDS (Carson and Green, 1992). Mickley’s (1992), study of
women with breast cancer showed that women classified as intrinsically religious internalize a religious creed and follow it fully. The intrinsically religious were found to have significantly higher scores on Paloutzian's and Ellison's 1982 spiritual well-being scale than those who tended to use religion to provide security and/or sociability. This group was classified as being extrinsically religious. They also found hope to be positively correlated with spiritual well being, and existential well-being to be the primary contributor to this hope. Spiritual well-being was negatively related to loneliness and depression in chronically ill and healthy adults in a study by Miller (1985).

All studies found were in basic agreement supporting Ellison's (1983, p. 332) claim that spiritual well-being results in feeling "generally alive, purposeful and fulfilled."

While the importance of spirituality in regards to the health of the patient or client has been cited, others recognize the importance of nurses' spirituality to the successful delivery of spiritual nursing care. Nagai-Jacobson and Burkhardt (1989) describe processes for incorporating spirituality into clinical practice, and suggest the practice of holistic nursing involves the spirituality of both nurse and client and is transformational for both. Burnard (1987) and Peterson (1987) also stress the importance of nurturing of the nurse's own spirit in order to respond to the spirit in any interaction. Although spirituality and spiritual well being are terms often used synonymously, it must be declared that spiritual well being is actually dependent on one's spirituality. If the spiritual dimension is not acknowledged, nurtured and protected, one's spiritual well being will suffer. When the spiritual dimension is neglected, spiritual distress, the opposite of spiritual well being can result.
**Spiritual Distress**

Spiritual distress is defined as the state in which an individual or group experiences or is at risk of experiencing a disturbance in the belief or value system that provides strength, hope, and meaning to one's life (Carpenito, 1989). Some defining characteristics are experiences of disturbances in the belief system, questions related to credibility of the belief system, demonstration of discouragement or despair, inability to practice usual religious rituals, presence of ambivalent feelings or doubts about beliefs, expression related to no reason for living, feelings of spiritual emptiness, showing of emotional detachment from self and others, expressions of concern, anger, resentment, and/or fear over the meaning of life, suffering, or death. A request for spiritual assistance for a disturbance in a belief system is also a defining characteristic. When sources of hope and strength are not based in reality, despair can result. Hope which is based on reality tends to draw on a person's resources to adapt so life can be meaningful during the present and future time (Stoll, 1979).

Some pathophysiological risk factors include the loss of a body part or loss of a function of the body part, terminal illness, debilitating disease, pain, trauma and miscarriage and stillbirth. Some treatment-related risk factors are abortion, surgery, blood transfusion, dietary restrictions, isolation, amputation, medications and certain medical procedures. Some situational risk factors include the death or illness of a significant other, embarrassment at practicing spiritual rituals, hospital barriers to practicing spiritual rituals, confinement to bed or room, lack of privacy, lack of availability of special foods/diet, beliefs opposed by family, peers, health care providers, childbirth, divorce or other separation from loved ones.
Spirituality, Spiritual Well-Being and Spiritual Distress in the Chronically Ill, Terminally Ill and Elderly

Based on the definition of spiritual distress, persons who are elderly, chronically ill and/or terminally ill are at particular risk for spiritual distress, although crisis is often an opportunity for growth in faith, with resulting greater ability to live life more fully (Stoll, 1979). With the mounting interest and acceptance in the holistic health paradigm describing the interrelated, interdependent relationships of the physical, social, psychological and spiritual aspects of the human being, avoidance of the chronically ill’s, dying’s and elderly’s spirituality may no longer be considered acceptable by the nursing profession (Caine, 1989; Cousins, 1989; Frankl, 1985; Maynard, 1988; and Soeken & Carson, 1987) or health care consumers. Clients are accepting control over the healthcare received and are also more knowledgeable. Additionally, clients may not readily accept fragmented as compared to holistic care from the healthcare system (Maraldo, 1990). The following section examines literature related to the spirituality, spiritual well-being and spiritual distress in the groups who seek healthcare services relatively most often; chronically ill, terminally ill, and elderly clients.

Spirituality and the Chronically Ill

For the purpose of this paper, chronic illness involves attention to the societal and personal issues and concerns experienced by persons with a chronic medical condition. Chronic illness is defined by Lubkin (1990, p. 6) as “the irreversible presence, accumulation, or latency of disease states or impairments that involve the total human environment for supportive care and self-care, maintenance of function, and prevention of further disability.” Chronic illness can result in permanent and progressive limitations
of activities, often leading to undesirable changes in level of independence and lifestyle (Burkhard, 1987; Charmaz, 1983; Connelly, 1987; and Craig & Edwards, 1983; Strauss, et al, 1984). According to Lubkin (1990), clients and their families experiencing new onset or exacerbation of a chronic illness are faced with daily challenges and changes that can affect quality of life. They may be left with many questions and choices related to quality vs quantity of life, life and death, and various treatment choices. Feelings of powerlessness, and perceptions that one’s actions will have no affect on outcome can result in loss of control and hope leading to spiritual distress. Additionally, feelings of loss of hope can result in anger, desperation, bitterness, despair and guilt. This is especially true when the anger is directed toward God (Henderson, 1989). Chronically ill may experience feelings of isolation and loneliness. Spiritual distress from deprivation can develop if the feelings of separation from God, loved ones, social interaction and even superficial personal contact exist (Courville-Davis, 1994).

Persons experiencing fear, hopelessness and abandonment may perceive God as being judgmental. When a person is able to feel hopeful, peaceful and courageous, he/she will tend to perceive a God who is personal, in control and as a giver of meaning to life (Stoll, 1979). God may be considered that which gives highest value and is the focus and purpose of a person’s time and life. God may be a person’s occupation, some physical activity, and even the strength within oneself (Stoll, 1979). The focus of some people’s beliefs is the authority within himself, and they require no help from the outside world (Duncan, 1969). For instance, a physically handicapped individual may not accept inactivity, lack of control and dependence in his/her life, and choose to assume responsibility of his/her own destiny.
According to Bernard (1987), spiritual distress can result when there is an inability to invest life with meaning. For the chronically ill, finding meaning and purpose in suffering while maintaining balance between physical, social, psychological and spiritual self can be a constant challenge. A balance of the system is required in order to obtain optimal personal and family function (Bernard, 1987).

Moore-Schaefer (1995) described the themes prevalent in her qualitative study of six women experiencing chronic illness. They feared the loss of independence, livelihood, and ability to play with their children and friends. They also feared becoming a physical and financial burden on their families. She pointed out how denial of the illness related problems often left room for hope for the future. Some of the women interviewed explained how hope, faith and belief in a higher power brought about personal strength and positive feelings toward life. The spiritual dimension of these women's lives supported their personal strength and hope helping them to endure the physical and psycho-social hardships of chronic illness.

Young (1993) described the relationship between spirituality and the chronically ill Christian elderly. Her findings suggest spirituality increased in importance as people aged. Her subjects described a feeling of well-being as a result of their belief that God knew of their needs. Comfort was found in spiritual practices and the belief that a higher being would always give love. The loneliness of these Christian chronically ill elderly was alleviated or reduced through maintenance of social contact with religious representatives or organizations that offered opportunities to share spiritual feelings.

Seriously and terminally ill individuals are facing many of the same challenges as the chronically ill, although their plight toward meaning and purpose in life may be
shorter, depending on the nature of their disease. The differences between chronic illness and terminal illness, especially the chronic phase of the terminal illness trajectory, are often blurred. In today’s society, the person with a serious and/or terminal illness may still attempt to cope with the demands of life while attempting to maintain health and prevent or adapt to further physical deterioration. The following section describes the relationship between spirituality and the seriously and terminally ill.

**Spirituality and the Seriously and Terminally Ill**

Seriously and terminally ill patients experience illness or problems that endanger life or have significant risk of death. According to Doka (1993), confrontation with a life-threatening illness often leads to an intensified awareness of one’s own mortality thereby bringing life new vitality while turning mundane activities into pleasurable achievements. The person with a life threatening illness may even view the illness as a turning point of life, because there may be a search to find reasons for the illness, the role of suffering, and the meaning of life and death. Doka (1993) described the spiritual issues faced by persons in the prediagnostic phase, acute phase, chronic phase and terminal phase of illness. The prediagnostic phase is a time when existential and spiritual issues are created, and the person seeks answers to the questions raised from within. During the acute phase, the person attempts to incorporate the present reality of the diagnosis into one’s sense of future as well as one’s past. The search for meaning in suffering, chronicity, uncertainty and possibly decline are issues faced by the person in the chronic phase. Meaning in life and death are issues common to the terminal phase.

Spiritual needs and problems are the core of human existence. Finding meaning in the illness, related problems, in life as it was lived and in the remaining days of life,
while finding forgiveness are spiritual needs. Hope to live in a manner the person
decides, and finding relatedness to a supreme or higher being and/or to a religion or
community of faith are other spiritual needs (Kemp, 1994). Similarly, six major themes
found by O'Connor et al (1990) in their study of thirty recently diagnosed cancer victims
were the search for understanding of the personal significance of the diagnosis, looking
at the consequences of the diagnosis, reviewing life, change in outlook toward self, life,
and others, living with the cancer, and hope. These themes are inherent in the existential
concerns of meaning of life, illness, and death which may be referred to as the
"existential plight" occurring within 100 days of the cancer diagnosis (Weisman and
Worden, 1976).

Reed (1987), in a study of 300 adults, found terminally ill hospitalized adult
patients indicated a greater awareness of their own spirituality and the relationship of
their spirituality to the world, than nonterminally ill hospitalized adults and healthy
nonhospitalized adults. She also found a low but significant positive relationship
between spiritual perspective and well-being in terminally ill hospitalized adults.

Montavan Kaczorowski (1989) studied 114 adults diagnosed with cancer in order
to determine if a relationship between spiritual well-being and anxiety existed for persons
confronted with life threatening illness. Her findings were supportive of the theory that
persons with high levels of spiritual well-being have lower levels of anxiety. Benner
Carson and Green (1992) examined the relationship between spiritual well-being,
particularly existential well-being, (those pertaining to life's meaning and hope), and
hardiness in 100 people who had either tested positively for the human
immunodeficiency virus or who had the diagnoses of acquired immunodeficiency
syndrome related complex or AIDS. Their results showed spiritual well-being (religious and existential components) was a predictor of hardiness, although, when analyzed separately, existential well-being was the primary predictor of hardiness. Two other studies support the finding that spiritual well-being, and specifically existential well-being can be predictors of hardiness in AIDS patients (Gavzer, 1988 and Bolen, 1985). Gavzer found hardiness was related to spiritual renewal in long-term survivors of AIDS and Bolen wrote specifically about William Calderon who experienced a spiritual renewal with a subsequent healing of the Kaposi’s sarcoma lesions that covered his body.

While Benner Carson and Green (1992) explored the existential portion of the spiritual dimension, Mickley (1992) explored the role of spiritual well-being, religiousness and hope in the spiritual health of women with breast cancer. Both research groups used the same Spiritual Well-Being Scale by Pauloutzian and Ellison, (1982). In her study of 175 women with breast cancer, Mickley found no difference in hope scores between intrinsically religious and extrinsically religious patients. Hope was positively correlated with spiritual well-being, with the existential well-being component being the primary contributor to hope. Shuler et al (1994) studied the effects of spiritual/religious practices on psychological well-being among inner city homeless women. They found 48% of the women in the sample used prayer as an effect on lessening use of alcohol and/or street drugs. Those women who prayed also perceived fewer worries and fewer depressive symptoms. Ninety-two percent of their sample reported one or more spiritual/religious practices, including praying, attending worship services or reading religious material.
Similar to Mickley (1992) and Benner Carson (1992), Reed sought to compare terminally ill with healthy adults (57 adults in each group) for differences in religiousness while also exploring well-being. She used the Religious Perspective Scale (RPS) adapted from King and Hunt's Dimensions of Religiosity Scales (1975). The RPS measures the extent to which persons hold certain religious beliefs and engage in religiously oriented interactions with others and with God. Reed also used the Index of Well-Being (IWB) which was designed by Campbell, Converse and Rodgers (1976) to measure satisfaction with life, cognitively and affectively, as it is currently experienced. She found both groups scored moderate high levels of well-being. A positive relationship between religiousness and well-being was found in the healthy group, but not in the terminally ill group. This perspective contrasts, in part, with the findings of Young (1993) and Mickey (1992).

As the body ages, alterations occur in every dimension of the human being. Biological changes, some of which result in conditions considered chronic illness, occur. The final phase of life, whether resulting from illness or old age, often involve many changes. When changes occur in either the biological, the psycho-social, the emotional or the spiritual dimension, an imbalance in the entire system results. An understanding of spirituality and spiritual development of the elderly is therefore necessary in order to meet the needs of the elderly.

**Spirituality and the Elderly**

Twelve percent of the population of the United States is now composed of persons older than 65, while this population consumes 36% of the total personal health care expenditures (American Association of Retired Persons, 1990) and by the year 2020,
it is estimated that older adults will consume almost half of the nation's health care services (U.S. Department of Health and Human Services, 1987). Over 40% of acute care hospitals census is over 65. The health care system of the United States is changing dramatically as a result of our aging population, and healthcare providers are being called to provide health promotion and protection interventions (Heine, 1992). A better understanding of the elderly's plight is needed, including an understanding of spiritual issues and spiritual development, in order to meet the needs of the elderly.

Unfortunately, there is a paucity of studies directly related to spirituality and the elderly, and the majority of the studies done are related to the religious aspect of spirituality. Although much of the information related to chronic illness pertains to the elderly, an understanding of spiritual development and life changes is essential.

Spiritual development is an ongoing process that does not end with the advent of old age. In fact, a sense of urgency may even develop as one ages and anticipates death without feeling spiritually intact. Heriot (1992) claims that aging is a spiritual process rather than a physical one because there is no evidence that the spirit succumbs to the aging process, even in the presence of severe physical and mental illness. She describes aging as a time of opportunities for inner growth and continued spiritual development in relation to changes of self and self-perceptions, relationships of self to others, the place of self in the world and the self's world view. Time provides a critical aspect in spiritual development, because it not only dictates the questions but makes the answering of those questions very urgent (Johnson, 1989). This impetus for spiritual development is enhanced by the changes in interpersonal relationships since status in the working world
and materialistic values are often no longer as important as the strength of interpersonal relationships.

Maves (1986) discussed the developmental issues of elderly that may affect their maturing spirituality. Some of these developmental tasks are the discovery of new sources of value, the search for value in simply being alive as compared to achievements, to learn to be single again, to cope with any new physical limitations and to find new outlets for time and energy consumption. Inability to achieve these tasks and others, may lead to poor transition into the new roles as well as feelings that an individual life can make a difference.

Developmental tasks, life changes, adjustments and a search for value in life are closely related to one’s perceptions about the meaning of life. Trice (1986) studied older adults and the common themes related to those things which bring meaning to life. The development of meaningful experiences were found to have resulted from concern for others, helpfulness, action, and positiveness. Three concepts emerged from Heriot’s (1992) study of older adults’ experiences of personal meaning of life across the lifespan. These three concepts are the sources of personal meaning, the meanings associated with those sources of personal meaning, and the outcomes of the presence of personal meaning of life.

Proedehl (1991) reported similar findings to Trice (1986) and Heriot (1992), although the nature of the responses tended to be more global. Proedehl (1991) studied the spiritual dimension of health as perceived and experienced by older adults and found most ideas about spirituality had to do with their beliefs and questions concerned with the self and their orientation to the universe. The major themes included world view,
spiritual process, spiritual feelings and behaviors, religion and church, and spirit and health.

In support of the previous studies related to spiritual health of the elderly, Noble Walker (1992) wrote of nurses’ roles in the provision and enhancement of wellness for elders. She believed spiritual growth, especially self-actualization, may be more central to wellness than any other dimensions of a health-promoting life style. This spiritual growth involves having a sense of purpose in life, experiencing awareness of and satisfaction with self, and the ability to continue to grow and develop personally. The later years are considered a time to establish new goals to direct the rest of life, and also a time that is fulfilled in unique ways.

Johnson (1989) characterized existential spiritual development as the instinctual search for meaning and described the forms this search may take. Although he claimed all forms of spirituality can provide guidance to the elderly during the final phase of life, he focused primarily on the religious aspect of spirituality. The first form is the evangelical form where God is encountered through the word of God, resulting in a passionate belief system. The second form is more charismatic, also noted for it’s serious devotion to God, although God is met through the experience of the presence of the Spirit. The third type, sacramental spirituality contrasts with other types because the presence of God is mediated through prayers, festivals, celebrations and rituals. Unfortunately, the dependency on ritualism for this type, can result in emptiness. The activist form is the fourth type of spirituality where God is found in the world rather than the church. Members of this group may also be members of secular issue oriented groups such as anti nuclear and ecology movement groups. Johnson (1989) believed members
of this group may lack spiritual depth and eventually feel disillusioned. The academic spirituality offers more feeling over intellect. Persons who are academic express their relationship with God through the mind, and awareness of God is mediated through thought. Members of this group are often scholars, theologians, and teachers who Johnson believed may become cold and impersonal. The sixth form of spirituality, ascetic spirituality, is found among monastic orders of priest and nuns who offer their life in prayer for the world. Johnson claimed members of this group may find this form of spirituality an escape from the world. In Eastern spirituality, the seventh form of spirituality, a union with God is sought and God is usually pictured as a part of the person. Therefore, to get in touch with the self is to get in touch with God.

Transcendence within the person often manifests itself in peace and may sometimes result in a withdrawal from the world where faith is strengthened through meditation, fasting and solitude. The eighth and final type of spirituality described by Johnson (1989) is that of holistic understanding. The main setting for worship is corporate or group, although time alone for private worship is valued. Members of this group feel the presence of God through external events of history and nature, human intelligence, theology, intuition and imagination. Life is enriched through periods of silence and keeping open to the inner depths of the spirit.

Similar to the academic form of spirituality described by Johnson (1989), Clements (1990) stated the body and spirit interpenetrate one another, and what influences one will influence the other. He also supported the notion that thoughts can affect the body, but neither body, mind or spirit dominate, and aging is not a failure of the body or of the human spirit, but rather a natural occurrence.
As previously stated, spirituality has an existential and perhaps religious components. Salts et al (1991) researched the relationship patterns and role of religion in elderly couples with chronic illness. Her sample consisted of 30 elderly couples with at least one spouse with a chronic illness. She classified the couples as active couples (no caregiving needs), short-term caregiver couples (required caregivers, but expected to be short term), survival couples (both members had some form of chronic illness, and depended upon each other for physical assistance), and live in caregiver couples where a live in caregiver lived in the couple’s home. All couples saw religion as a vital part of their lives. Religion was more of a coping resource for the short term and live in caregiver couples while religious activities predominated the lives of active and survival couples.

Similar to Salts et al (1991), Young (1993) investigated the relationship between spirituality and chronic illness. Young (1993) interviewed 12 Christian adults, between the ages of 65 and 89, with at least one chronic illness to evaluate any relationship between spirituality and chronic illness. She found feelings of well-being and strength to face the challenges of chronic illness came from beliefs that God knew of the informants needs and that God would give His blessings to them and empower them to survive through difficult times. Additionally, she found respondents found a source of comfort in knowing a higher being would always give love. Loneliness and social isolation were decreased with social contact found through religious organizations which offered opportunities for informants to share spiritual feelings with others. They found hope for the future in their beliefs in an afterlife. The contribution of age into the interviewed adults spiritual development was not cited.
Elderly people, like those experiencing chronic illness, experience many changes which may result in changing spiritual needs. Peterson (1985) sought to determine if elderly patients perceived spiritual care as an area for nursing intervention and found support for nursing's involvement in meeting spiritual needs. Unfortunately, the study primarily surveyed for religious spiritual needs. She surveyed 100 hospitalized individuals, and 75% were 65 years old or older. The survey consisted of questions related to significance of their relationship to God, their involvement of religious beliefs and practices, their anticipated response to a nurse asking them about their religious beliefs and their anticipated response if a nurse tried to help them in relating their religious beliefs to attitudes toward their current illness. Fifty percent of the people ages 61-75 and 61% of the people age 76-90 ranked their relationship to God in first or second place. Sixty-seven percent indicated their involvement in religious beliefs and practices affected a great part of their life. Seventy-one percent indicated they would appreciate a nurse asking them about their religious beliefs, and 75% indicated they would appreciate a nurse trying to relate their religious beliefs to their attitudes about illness.

Although most studies and professional writings relate to the individual, the social support network and family of the individual must be considered. Five spiritual tasks for the aging family cited by Fischer (1992) are facing mortality, defining the shape and limits of love and fidelity, struggling with meanings of evil and suffering, seeking forgiveness and reconciliation, and giving and receiving a spiritual legacy. A positive spiritual legacy results in younger members finding hope and a sense of possibility for their own aging. Unfortunately, a spiritual legacy may not always be positive, such as in
the case of a family member who dreads and fears later years. The task is then to grieve, accept and resolve to be tolerant.

Nurses who can support families and individuals through difficult times must be knowledgeable and willing to take risks. Risks are involved since the spiritual dimension of the family and individual is often a mystery which slowly evolves as a result of life's experiences. This mystery contrasts with our science based healthcare system and may be a source of discomfort for some.

In spite of, and maybe because of the mystery, spirituality and spiritual care delivery are growing areas of interest to nurses. Research indicates patients would appreciate nursing interventions to assist them. There seems to be an irony in that nurses recognize the need to care for the whole person, yet addressing spiritual concerns remains an area often neglected in practice (Labun, 1988; Soeken & Carson, 1986). The following section discusses nurses' attitudes and some factors influencing nurses' attitudes toward spiritual nursing care.

**Nurses' Attitudes and Factors Influencing Nurses' Attitudes Toward Spiritual Care**

Cimino (1992) and Campbell (1993) both found a positive correlation between spiritual well-being of nurses and attitudes toward providing spiritual care. Campbell (1993) surveyed forty-nine registered nurses all employed in an acute care hospital in Ohio. Cimino (1992) surveyed 269 registered nurses from various backgrounds in the Commonwealth of Massachusetts. Campbell and Cimino used the same spiritual well-being scale (Paloutizian and Ellison, 1982) and health professional’s spiritual role scale (Soeken and Carson, 1986).
Piles (1990) found a significant relationship between the degree of value or importance the nurse gave to spiritual care and the practice of spiritual care. Eighty-seven percent of the respondents cited lack of time and 70% cited lack of knowledge as obstacles to practicing spiritual care. Highfield and Cason’s (1983) and Sodestrom and Martinson’s (1987) studies cited limited education in spiritual care and limited time with patients as well.

A related study by Highfield (1992) investigated the spiritual health of oncology patients and how well oncology nurses assess spiritual health. Ultimately, the surveys of twenty-one nurses/patient pairs were analyzed. She identified an incongruence between nurse spiritual health scores of patients and the patient’s own spiritual health assessment. Findings also indicated Afro-American and Caucasian nurse respondents rated the spiritual health of patients higher than Asian nurses. She suggested that although nurses may be ready to provide spiritual care (although nurses’ spiritual well-being, knowledge or attitudes toward spiritual care were not tested for), patients may prefer spiritual support from family members, friends, personal clergy, physicians, and others with whom they have ongoing relationships. Additionally, Highfield believed the focus on physical care may negatively impact the nurses’ abilities to adequately assess the spiritual health assessment of patients.

Johnson-Taylor & Amenta (1994) explored attitudes and beliefs toward spiritual care among hospice nurses. The respondents uniformly agreed that patients had spiritual needs and that it was appropriate for nurses to attend to such needs, although attitudes about how a nurse should relate to patient’s spirituality varied. Personal religiosity and
educational preparation were associated with the hospice nurses’ attitudes and beliefs about spiritual care.

Some nurse researchers have examined factors in nurses’ perceptions of patient needs in hopes of explaining the relationship between nurses’ attitudes and behaviors regarding spiritual care. Nurses’ abilities to differentiate between spiritual and psychosocial patient behaviors were studied by Highfield and Cason (1983). One hundred surgical nurses working with oncology patients were surveyed using a religious-existential based instrument. Thirty-five percent indicated limited awareness of spiritual needs or problems. Nurses were asked to classify patient behaviors as either psychosocial or spiritual. Most signs of spiritual health and spiritual needs were assessed as psychosocial health, except for the specific religious oriented needs. Perhaps the synonymous association between spirituality and religion contributed to these responses.

Lilley (1987) studied the relationship between registered nurses’ perception and client perception of human need fulfillment alterations in the client with uterine cancer. Her sample consisted of 15 nurses paired with 15 patients. The human needs explored which most pertained to spirituality were acceptance of self, appreciation, attention, belonging, humor, personal recognition, respect, tenderness, to love and be loved, and the spiritual experience. In contrast to Highfield’s study, this study’s results revealed that the registered nurse sample perceived human need fulfillment alterations similarly to the client with uterine cancer, although nurses, as a group, tended to rank physiological needs as of greatest importance to the patients. The patients, as a group, rated emotional, spiritual, and psychological needs higher. Unfortunately, the studies neglected to
indicate how much time the nurses spent with the patients, since establishment of a trusting relationship is an essential component of spiritual care.

Ross (1994) studied the results of surveys by 655 nurses in Scotland to determine how nurses perceived spiritual needs and care, and how they described giving care in practice. She also sought to determine what factors appeared to influence the spiritual care given to patients. Results indicated that nurses perceived the identification of spiritual needs and the concept of spirituality in terms of the individual’s need for belief, faith, peace, comfort, forgiveness, meaning, purpose, fulfillment, hope, creativity, and giving and receiving love. They tended to view spiritual needs in religious terms. The majority of the nurses considered spiritual care to be a shared responsibility, although half preferred to refer directly to a clergy member. Certain characteristics seemed to prevail in the nurses who were able to give spiritual care at a deeper level. They demonstrated an awareness of the spiritual dimension in their own lives, were personally searching for meaning, had experienced crisis, perceived spiritual care as a part of their role, and/or seemed particularly sensitive and perceptive.

Ross’s (1994) study supports Granstrom’s beliefs that unless nurses confront their own spiritual nature and spiritual quest, they will be uncomfortable in dealing with the patient’s spiritual quest. Granstrom (1985) believed nurses are unaware of their own spiritual quest, and are affected by attitudes about aging, illness and suffering. Much work has been done since 1985 related to spirituality and the spiritual dimension of nursing care in general.

For instance, the degree of importance nurses attach to the spiritual dimension of care was related to the practice of spiritual care in a study by Piles (1990). These results
indicate nurses who value spiritual care are the nurses who provide spiritual care to their patients.

Two studies investigated graduate and undergraduate student nurses’ spiritual well-being and positive attitudes toward providing spiritual care. Soeken and Carson (1986) found students had a high level of spiritual well-being and also those students with a higher level of spiritual well-being expressed a more positive attitude toward providing spiritual care for patients. This was true for both existential and religious well-being. There was no relationship between age and spiritual well-being, age and attitudes or between the years of nursing experience among graduate students and their spiritual well-being or attitudes. Deane and Cross (1987) reported student nurses who had a high level of spiritual well-being also had positive attitudes about providing spiritual care. Religiosity seemed to positively influence attitude about the nurses’ spiritual role and spiritual well-being in this study. Similar to Soeken and Carson’s study, there was no correlation between age and spiritual well-being and attitudes about providing spiritual care.

In summary, the reasons why nurses do and don’t provide spiritual nursing care are varied, although educational preparation seems to be a common theme. Sixty-seven percent of the health educators surveyed by Banks (1980) agreed the spiritual dimension should be a part of professional preparation program in the next 25 years. Nelson (1976) found the graduate students in her study felt educationally prepared to address spiritual concerns of patients, although the hands on experience of giving spiritual care was more important than formal education. Highfield and Cason (1983) found half of the nurses surveyed were uncomfortable in providing spiritual care because they felt educationally
unprepared. One reason offered by Granstrom (1985), an oncology nurse and a minister of faith, is the concept of spirituality needs to be broadened so nurses with diverse beliefs and ideologies can give spiritual care to patients with diverse religious or non-religious orientations. Further education is indicated in order to prepare nurses to provide spiritual care. The following section of the literature review will review the current relationship between spiritual care and nursing education.

**Spiritual Care and Nursing Education**

Although there is a growing interest in spirituality and nursing, a nationally accepted nursing diagnosis and an emphasis in holistic health, there is still a cited lack of spiritual care content in nursing education (Boutell and Bozett, 1990; Carr, 1993; Cimino, 1992; Harrison, 1993; Highfield and Cason, 1983; Narayanasamy, 1993; Ross, 1994; Taylor and Amenta, 1994).

Peterson (1985) indicated many nurses have been taught to avoid religious subjects because of the potential for controversy and misunderstanding. Piles (1986) identified several issues which resulted in nurses having spiritual concerns. Four issues which related to their education preparation are that they were taught to avoid the subject, they lacked educational exposure to theoretical content and clinical practice in spiritual assessment, they lacked recognition of the nurse’s role in the delivery of spiritual care, and they were never exposed to the difference between psychosocial and spiritual needs. Piles concludes that both nursing educators and nurses dedicated to continuing education need to be aware of this lack of educational preparation and provide content in this area.
Although Piles' (1980, 1986) research indicated nursing education had not consistently incorporated spiritual nursing care into the nursing process, various individuals and groups have attempted to develop curriculum incorporating spirituality issues. Although the last thirty years have shown progress in this area, there is still a paucity of information about spirituality and nursing education.

Lewis (1957) developed a series of modules based on objectives which emphasized knowledge of various religious groups and their practices in the United States. Information included sacraments or rites, dietary customs, items of symbolic importance, beliefs of major religious denominations, devotional materials, and particular practices for the terminally ill and dying. Lewis indicated the value, not only of knowledge, but of a nurse's own self awareness, and attitude toward religion in relation to other people, as part of the educational preparation.

Fish and Shelly (1976), in association with Nurses' Christian Fellowship, developed a textbook and workbook after surveying nurses, physicians, chaplains and pastors about spiritual needs, and how they were expressed in health and illness. The text includes case studies, personal reflection questions, personal applications, and goal-setting, in order to integrate professional knowledge with personal growth.

Nurses' Christian Fellowship also published a loose-leaf notebook as a resource book for faculty (1985). Two major sections include teaching paradigms and learning resources. The text and workbook by Fish and Shelly (1976, 1978), other books on spiritual care and needs of children, mentally ill, and ethical considerations, a bibliography are some of the learning resources. Two models were presented in the teaching models. One was an integrated curriculum for a BSN or diploma program of
nursing, and the other was an elective course model illustrated by three secular state universities. Concept papers, case studies, class projects, presentations, lecture and discussion were the teaching methods. Additionally, one class required the students to maintain a personal journal, although there otherwise appeared to be little information related to the spiritual well-being and development of the nurse.

The need for case studies, nursing diagnosis, personal growth and values clarification was included in Forshee’s (1984) paper on teaching spiritual care. Carson and Gerardi (1986) incorporated didactic and small group work as well as art and music into their course at the University of Maryland. Using the Religious Beliefs Questionnaire, they found positive attitudes about God, organized religion, religious practices, and the Bible significantly increased after the course in their student sample. There is no indication of testing of change in clinical practice in this sample.

Buys (1981) and Ellis (1986) based their nursing education staff development courses on Fish and Shelly’s (1976) work, although Ellis utilized mental imagery, prayer, scripture reading and song. The study of spirituality and the incorporation of the human spiritual dimension into nursing education have remained relatively inconsistent, limited and religious focused.

Nelms et al (1993) questioned nursing students about how they learned caring behaviors. Findings indicated nursing students learned about caring from faculty role-modeling in the classroom and clinical settings, as well as from health care staff and nurses in the clinical settings. Additionally, they discovered students were as influenced by experiences acknowledged as caring as they were by behaviors and events they perceived to indicate a lack of caring.
Carr (1993) discussed the integration of spirituality of aging into the nursing curriculum of Saint Anselm College. Required courses for the nursing students include areas of humanities, theology and philosophy, and students are encouraged to incorporate their liberal arts courses into their nursing practice. Some faculty require the student to identify at least one spiritual need in their patient each day of clinical practice, while other faculty require students to keep a journal of spiritual experiences within themselves, and those in relation to older adults. During their sophomore year, nursing students are asked to have a conversation with an older family member about meaningful life experiences. Junior and senior nursing students were required to write detailed nursing care plan for their clients. Assessments included evaluation of the value-belief functional health pattern to help them focus on the spiritual dimension of the patient. Unfortunately, students still tended to focus on religious affiliation and practices. Carr recommends nurses and students become more adept at identifying and meeting the spiritual needs of elderly patients.

An acknowledgment, through action and not just words, about the importance of nursing’s involvement in care of the whole person is essential. The contrast between holistically based care and care actually delivered in our technology focused world is a strong contributor to the healthcare crisis and the confusion about what nurses really do. Continued and committed nursing education about spirituality and nursing, with ongoing evaluation of the affects of the education and communication of those findings, are means of incorporating spiritual care into everyday nursing practice. The focus and purpose of this study was to evaluate the effect of an educational seminar utilizing the
nursing process and Neuman's Systems Model, on nurses' knowledge and comfort in the delivery of spiritual care.

Conceptual Framework

Neuman's Systems Model was the conceptual framework from which this study was based. The spiritual variable is one of the five variables of the client system, within the Neuman Systems Model. It is considered an innate component which permeates the other variables, whether it is ever acknowledged or developed by the client (Neuman, 1995). The nursing process is used as a frame of reference for the model and it's application to nursing practice. The model was used to clarify relationships of variables in nursing care as well as nursing role definitions, which are important to nursing education. It is for these reasons, Neuman's Systems Model was chosen as a framework for this study. The components of the model and their definitions will first be described in order to provide a firm base in which to discuss the model in relation to spiritual care.

Neuman's Systems Model supports holistic concepts by optimizing the interrelationships of the human spirit, mind and body within an ever changing environment and society. Potential stressors are recognized, and the emphasis is on primary prevention of illness with the goals of wellness and balance of spirit, mind, body, and environment.

The client system consists of four circular structures: flexible line of defense, normal line of defense, lines of resistance, and the basic structure. The lines of defense and resistance defend the basic structure. The flexible line of defense is the outermost broken circle surrounding the normal line of defense. It can expand or contract in an
accordion like manner as necessary, and has the ability to be altered rapidly in order to prevent stressor invasions. (Neuman, 1995, pg 26-27).

The client's adjustment to stressor impact determines the normal line of defense which surround the flexible line of defense. The normal line of defense represents the client's current state and the usual wellness level. Five variables determine the effectiveness and strength of the lines of defense: physiological, psychological, sociocultural, developmental, and spiritual. (Neuman, 1995, pg 28).

Neuman (1995) describes the nursing processes of assessment, diagnosis, planning, intervention, and evaluation in terms of stressor prevention and risk reduction. Client assessment includes obtaining information related to biographical information, stressors perceived by the client and/or family, stressors perceived by the nurse, and stressors perceived by the nurse and client. Once all pertinent aspects of client data is prioritized, nursing diagnoses can be assigned. A plan, consisting of goals and outcomes, is then formed based on the previous prioritization of client problems. Interventions to support goals are ordered based on the plan, goals and desired outcomes. Interventions can be initiated any time a stressor is suspected or identified. The goal of primary prevention is to promote client wellness by stress prevention and reduction of risk factors. The goal of secondary prevention is to attain wellness by protecting the basic structure though strengthening the internal lines of resistance. Wellness maintenance is the goal of tertiary prevention. Depending on the situation, reconstitution of the client system is protected or wellness is returned following treatment. Evaluation or reassessment is continuous and interventions are evaluated based on the goals previously set (Neuman, 1995, pg 56-61).
Neuman adapted her systems model specifically to identify elements of spirituality. Although the basic circular structures and roles of those structure remain unchanged, the stressors impacting the system are related to defined spirituality terms. Assessment involves evaluation of appropriate spiritual needs such as love, trust, faith, forgiveness, hope, purpose and meaning in life, and meaningful interpersonal relationships as well as relationships with God or other higher being. Stressors impacting the system are produced when spiritual needs are not met due to maturational factors, situations, and inter-, intra- and extrapersonal factors. These stressors can impact the flexible and normal lines of defense.

Following assessment of spiritual needs, a nursing diagnosis of spiritual distress or spiritual well-being is made. With a diagnosis of spiritual well-being, primary prevention with maintenance of spiritual well-being is the desired goal. Interventions would be anticipatory in nature and designed to educate the client in order to strengthen the lines of defense. The client who is spiritually healthy has his or her spiritual needs met. When spiritual needs are not met, such as when concerns are expressed or manifested by depression, anxiety, fear, guilt, loneliness, hopelessness, powerlessness and diminished self-esteem, the diagnosis of spiritual distress may be appropriate.

Nursing goals based on the nursing diagnosis are developed. Attainment of the normal lines of defense is achieved through secondary prevention goals. Maintenance of the lines of resistance is achieved through goals directed toward tertiary prevention. Some nursing interventions include listening, empathy, vulnerability, humility, commitment, prayer, use of religious literature, rituals, poetry, music, art, and use of clergy (Neuman, 1995).
Achievement of the goals is evaluated by determining if the nursing outcomes have restored spiritual well-being. Reassessment is necessary throughout the nursing process, and especially during the evaluation portion of the nursing process.

The Neuman Systems Model organizes the delivery of spiritual care through its utilization of the nursing process. Although many nurses may not be familiar or comfortable with spirituality in nursing, most are knowledgeable and comfortable using the nursing process in their practices.

In summary, Neuman Systems Model was an appropriate framework from which to develop a curriculum for teaching spiritual care. It was anticipated that organization of the material through use of the nursing process will facilitate understanding of the information provided, and help fill a gap related to nursing education and spiritual nursing care. Provision of the material in an organized, familiar manner will help reduce the variables associated with individual learning capabilities, and enhance the reliability of the nurses' comfort levels post instruction.

Research Questions

1. What are registered nurses comfort levels regarding spiritual nursing care?
2. What is the base knowledge of registered nurses regarding spiritual care?
3. What is the effect of spiritual care nursing education on comfort in the delivery of spiritual care?
4. What is the effect of spiritual care nursing education on knowledge of spiritual nursing care?
5. What is the relationship between knowledge and comfort in nurses' delivery of spiritual care?
6. What is the influence of age, sex, years of practice, nursing specialty, and attendance of religious services on nurses’ comfort in the delivery of spiritual care?

Definition of Major Variables and Concepts

Spirituality was defined as a person’s quest to find meaning and purpose in life (Burkhardt and Nagai-Jacobson, 1994), and a unifying force, manifested in the Self, and reflected in one’s knowing and one’s doing (Burkhardt, 1994). A means of forgiveness, and a source of love are spiritual components of an individual (Fish and Shelly, 1983).

Spiritual Well-Being was defined as an ability to find meaning and purpose of present and future life events, and an inner harmony manifested by being content with life, regardless of personal failures and illnesses (Hungelmann et al, 1985).

Spiritual Needs were defined as any factors necessary to establish and/or maintain a relationship with God (Stollwood and Stoll, 1975) or other higher being, the need for meaning and purpose of life, the need to give love, the need to receive love, the need for hope, creativity (Highfield and Cason, 1983), acceptance and forgiveness (Neuman, 1995).

Spiritual Distress was defined as the state in which an individual or group experiences or is at risk of experiencing a disturbance in the belief or value system that provides strength, hope and meaning to one’s life (Carpenito, 1989). Spiritual distress results when spiritual needs are not met (Neuman, 1995).

Knowledge was defined as the act, fact or state of knowing, awareness, understanding, all that has been perceived or grasped by the mind, learning and enlightenment (New World Dictionary, 1978). For the purposes of this study, knowledge
was related to the assessment, diagnosis, planning, implementation of plan, and
evaluation of nursing care plan in relation to the spiritual dimension of an individual.

Comfort was defined as a sense of ease, quiet enjoyment and lack of worry (New
referred to the nurse’s ability to deliver spiritual care with ease, confidence, and without
worry. Nurses’ comfort in the delivery of spiritual care was measured by the Spiritual
Intervention Comfort Scale developed by Cimino (1992).

For the purpose of this study, nurses were registered nurses licensed in the State
of Nevada, who electively attended a three hour seminar. Based on the State Board of
Nursing’s regulations, these nurses are responsible for nursing care that promotes,
maintains and/or restores health of individuals, families, and communities in a variety of
settings.

Assumptions
1. Nurses are interested in giving spiritual care, as a commitment toward the delivery of
   holistic care.
2. Nurses who attend the seminar possess preconceived ideas, concerns, opinions, and
   fears regarding spiritual nursing care.
3. Nurses who attend the seminar attended for a variety of reasons including, but not
   limited to, interest in the subject matter, support of the researcher and free continuing
   education hours.
4. Nurses will respond to the tests and questionnaire in a truthful and insightful manner.
5. Nurses will understand the seminar format since application of the nursing process to
   nursing care situations is the basis for nursing practice.
CHAPTER III

Methodology

This chapter will describe the research design, sample, measurement methods, procedure, ethical considerations, and plan for data analysis.

Research Design

The study was a descriptive, pretest-posttest quasi-experimental design. Nurses knowledge, through use of the Spiritual Nursing Care Test (SNC), and comfort level regarding spiritual nursing care, through use of the Spiritual Intervention Comfort Scale (SIC), was tested before the seminar in order to obtain baseline measures. A demographic form was completed by the participants. Examples of the demographic form, Spiritual Nursing Care Test and Spiritual Intervention Scale can be found in Appendix A.

Sample

The target population was registered nurses. The convenience sample consisted of registered nurses who electively registered and attended a three hour seminar. Licensure as a registered nurse was the only eligibility requirement. The sample was recruited through advertisements in pamphlets for the seminar which were distributed at five local hospitals, 15 local home health care agencies, and 17 extended care facilities in order to increase the generalizability of the study. Three free continuing education units were offered.
Data Collection

Data was collected a total of seven times from October 28, 1995 through December 21, 1996. The seminar was offered twice at Sunrise Hospital, and one time each at Valley Hospital, University Medical Center, Nathan Adelson Hospice and Southern Nevada Home Healthcare, all in Las Vegas, Nevada. The seminar was also offered once at Lake Mead Hospital in North Las Vegas, Nevada. Each of the cites had comparable conference rooms which comfortably accommodated 20-30 people, except Nathan Adelson Hospice where the seminar took place in the chapel.

Measurement Methods

The data collection instrument consisted of three parts: 1) Background demographic form, 2) Spiritual Intervention Comfort (SIC) Scale, and 3) Spiritual Nursing Care Test (SNC). Each section of the survey was color coded to ease data organization and for variety.

Examples of the SIC, SNC and demographic form can be found in appendix A. The letter requesting permission for use of the Spiritual Intervention Comfort Scale is found in appendix B.

Demographic Data Form

Demographic data was obtained from 13 checklist items which included age, marital status, religious preference, initial education in nursing, highest educational level achieved, employment status, current position, years in nursing practice, current clinical practice, and previous educational experience with spiritual care content. Nominal measurement of this data was done. This form was adapted from work by Cimino (1992). An example of the form is in Appendix A.
Spiritual Intervention Comfort (SIC) Scale

The Spiritual Intervention Scale was developed by Cimino (1992) to measure the degree of comfort nurses have when providing spiritual, religious and existential care as a part of their nursing practice. The 38 item SIC was adapted from a 6 part Likert scale to a 4 part Likert scale. The 4 part Likert scale consisted of “strongly agree,” “agree,” “strongly disagree,” and “disagree.” This change was made because of the confusion the 6 part Likert scale caused a number of colleagues completing the survey to determine clarity of the instrument. The survey consists of forty items including two open ended questions. Scoring on this questionnaire provides ordinal data with higher scores indicating higher degrees of comfort in providing spiritual care. An example of the SIC can be found in Appendix A.

Reliability and internal consistency on the 40 item SIC Scale was established by Cimino (1992). Cronbach’s alpha, used to measure the internal consistency of the tool, of the scale was .94, for religious care items (SRC) was .89, and for existential care items (SEC) was .88. Test-retest reliability was established by Pearson’s Product Moment Correlation with a result of $r=89 \ p<.001$. Reliability of the SIC for this study was also established and scores were comparable to Cimino’s (1992) findings. Reliability coefficients using Cronbach’s alpha of the pre-SIC was .9293, the SRC was .8868 and the SEC was .9183.

Spiritual Nursing Care Test

The Spiritual Care Nursing Test was developed by this researcher to test the basic knowledge of nurses. The test consisted of 25 True/False questions and statements based on the definitions of spirituality, spiritual distress and spiritual care nursing interventions.
described in this study. The SNC was designed to test nurses' knowledge in a time efficient manner. An example of the SNC can be found Appendix A.

The test was distributed to four nursing experts for feedback, clarity and content validity of the test. After split $\frac{1}{2}$ correlation coefficients were obtained for the test, a reliability coefficient of .4847 using Spearman-Brown Prophecy formula was obtained indicating reliability of the tool.

**Procedure**

Instructions regarding the pre and post test obligations were provided on the advertisement form and again the day of the seminar. Nurses were given the Spiritual Intervention Comfort Scale, Spiritual Nursing Care Test and the demographic data form by an uninvolved party before the seminar was delivered. Completed instruments were collected at that time. All surveys and tests were identically numerically coded. Any questions regarding the procedures and obligations were answered.

The approximately three hour seminar was presented, with breaks provided as needed. Examples of the seminar content outline and seminar objectives are in appendix C. Lecture and case studies were teaching methods used in order to meet the seminar objectives. The case study technique was chosen because it is one of the standard nursing education methods of teaching patient care. In a collaborative fashion, participants were asked to apply the nursing process to given patient care situations. Data analysis, formation of a nursing diagnosis, goal definitions, and intervention planning was required. Application of the nursing process is the basis for use of The Neuman Systems Model For Spirituality (Neuman, 1995) and the guide for the presentation of the material of the seminar.
Nurses were asked to complete the Nursing Spiritual Care Test and the Spiritual Intervention Comfort Scale at the close of the seminar, and were given their Continuing Education Certificates. Participants had the opportunity to complete a course evaluation form at the close of the seminar. An example of the course evaluation can be found in Appendix A.

**Ethical Considerations**

The purpose and procedure of the study were written on the advertisements which were delivered, in person or through the mail service, to various health care facilities in Las Vegas. A telephone number with a recorded message was provided for nurses wishing to register. The purpose and procedure was explained on the recording, and once again before the seminar began. Seminar attendance indicated consent. Additionally, information about the study was provided in written form to those in attendance. A copy of this information form is in Appendix C. Confidentiality and anonymity was assured using a coding system, and was indicated. Any participants interested in receiving results of the study had the opportunity to sign a roster.

Approval regarding human subjects rights was obtained from the Department of Nursing and the Institutional Review Board for Biomedical Research at the University of Nevada, Las Vegas prior to advertising or giving the nursing seminars.

**Data Analysis**

Univariate descriptive statistics were done to describe the characteristics of the sample. Frequencies were computed for nurses’ age, marital status, gender, religious preferences, regular attendance of religious services initial educational program in nursing, highest educational level, current employment status, current position, years of
nursing practice, present clinical involvement, area of nursing practice, and previous spiritual care education. Frequencies were also computed for the pre- and post-Spiritual Intervention Comfort Scale and Spiritual Nursing Care Test scores.

Pearson's Product Moment Correlation was utilized to analyze relationships between sample characteristics and comfort and between knowledge and comfort. This method was appropriate because of the interval nature of the data and the normal distribution of the variables in the sample. The level of significance was set at $p<.05$.

Paired T-test was utilized to analyze the effect of an educational seminar intervention by comparing the mean differences between the scores on the Spiritual Intervention Comfort Scale (SIC) and the Spiritual Nursing Care Test (SNC). This was appropriate because of the interval looking nature of the data, and the normal distributions of the variables.
CHAPTER IV

Results

This chapter describes results of the study including characteristics of the sample, and responses to the research questions.

Profile of Sample

The characteristics of the sample population were obtained from the demographic form. The sample consisted of 46 registered nurses in the State of Nevada. Ninety-three and one half percent were female and 6.5% were male. Most of the sample, (26.1%), was between 46 and 50 years old. See table 1 for the frequencies and percentages of the age ranges for this sample.

The marital status of the sample revealed 73.9% were married, 17.4% were divorced, 6.5% were single and 2.2% was widowed.

All seminar participants selected a religious preference. Twenty-two (47.8%), were Protestant, and 32.6% were Catholic. Other seminar participants were Agnostic, Mormon, Atheist, Buddhist or a preference not offered in the demographic data form. Table 1 lists religious preferences and frequencies for the sample.

Forty-five responded to the question asking if they regularly attended religious services. Twenty-five (54%) of the participants said they did and 43.5% said they did not.

Responses related to initial education program in nursing and highest educational level attained were examined next. Forty-five of the participants chose to respond. Eight, 17.4%, began their nursing careers as licensed practical nurses. Most of the
sample, 60.8%, originally obtained a diploma in nursing or an associate degree in nursing and 19.6% were originally prepared at the baccalaureate level.

All nurses originally prepared as a licensed practical nurses furthered their education and became registered nurses. The sample consisted of 15 nurses with a baccalaureate education. Most nurses, 52.2% had practiced nursing from 16 to 30 years. Table 2 further describes the sample’s current education level.

Participants were asked if they worked as nurses, and if so, if they worked full or part time. All of the 45 who responded worked in nursing. The majority of the sample, 89.1% worked full time and 8.7% worked part time.

Specialty areas of nursing practice and current positions in nursing were also examined. Half of the sample, 50%, were home healthcare nurses, and 26.1% practiced in medical surgical areas.

All participants responded to the inquiry about their current position. Sixteen, (34.8%) were home healthcare nurses, and the remaining participants held various nursing positions. Table 3 demonstrates current positions and specific areas of nursing practice of the sample and the frequencies.

Forty-five responded when asked if they had previously attended a spiritual nursing care seminar. Most, 76.1%, had not and 21.7% had.
**Table 1**

**Characteristics of the Sample in Regards to Age and Religious Affiliation**

<table>
<thead>
<tr>
<th>Age</th>
<th>n= 46</th>
<th>Frequency</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>31-35 Years</td>
<td>4</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>36-40 Years</td>
<td>9</td>
<td>19.6%</td>
<td></td>
</tr>
<tr>
<td>41-45 Years</td>
<td>4</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>46-50 Years</td>
<td>12</td>
<td>26.1%</td>
<td></td>
</tr>
<tr>
<td>51-55 Years</td>
<td>8</td>
<td>17.4%</td>
<td></td>
</tr>
<tr>
<td>56-60 Years</td>
<td>6</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>61-65 Years</td>
<td>1</td>
<td>2.2%</td>
<td></td>
</tr>
</tbody>
</table>

**Religious Affiliation**

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Agnostic</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Atheist</td>
<td>1</td>
<td>2.2%</td>
</tr>
<tr>
<td>Buddhist</td>
<td>1</td>
<td>2.2%</td>
</tr>
<tr>
<td>Catholic</td>
<td>15</td>
<td>32.6%</td>
</tr>
<tr>
<td>Mormon</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>Protestant</td>
<td>22</td>
<td>47.8%</td>
</tr>
<tr>
<td>Other</td>
<td>2</td>
<td>4.3%</td>
</tr>
<tr>
<td>None</td>
<td>1</td>
<td>2.2%</td>
</tr>
<tr>
<td>Highest Educational Level</td>
<td>Frequency</td>
<td>Percentage</td>
</tr>
<tr>
<td>------------------------------</td>
<td>-----------</td>
<td>------------</td>
</tr>
<tr>
<td>Diploma RN</td>
<td>10</td>
<td>21.7%</td>
</tr>
<tr>
<td>Associate Degree RN</td>
<td>14</td>
<td>30.4%</td>
</tr>
<tr>
<td>Baccalaureate RN</td>
<td>15</td>
<td>32.6%</td>
</tr>
<tr>
<td>Masters in Nursing</td>
<td>6</td>
<td>13%</td>
</tr>
<tr>
<td>Missing</td>
<td>1</td>
<td>2.2%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Years Practiced as Nurse</th>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>0-5 Years</td>
<td>4</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>6-10 Years</td>
<td>4</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>11-15 Years</td>
<td>2</td>
<td>4.3%</td>
<td></td>
</tr>
<tr>
<td>16-20 Years</td>
<td>8</td>
<td>17.4%</td>
<td></td>
</tr>
<tr>
<td>21-25 Years</td>
<td>8</td>
<td>17.4%</td>
<td></td>
</tr>
<tr>
<td>26-30 Years</td>
<td>8</td>
<td>17.4%</td>
<td></td>
</tr>
<tr>
<td>31-35 Years</td>
<td>6</td>
<td>13%</td>
<td></td>
</tr>
<tr>
<td>36-40 Years</td>
<td>2</td>
<td>4.3%</td>
<td></td>
</tr>
<tr>
<td>41-45 Years</td>
<td>3</td>
<td>6.5%</td>
<td></td>
</tr>
<tr>
<td>46-50 Years</td>
<td>1</td>
<td>2.2%</td>
<td></td>
</tr>
</tbody>
</table>
Table 3

Area of Nursing Practice and Current Position in Nursing

<table>
<thead>
<tr>
<th>Area of Nursing Practice</th>
<th>Frequency</th>
<th>Percentage</th>
<th>N=46</th>
</tr>
</thead>
<tbody>
<tr>
<td>Medical/Surgical</td>
<td>12</td>
<td>26.1%</td>
<td></td>
</tr>
<tr>
<td>Maternity</td>
<td>1</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Pediatrics</td>
<td>1</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Psychiatric/Mental Health</td>
<td>2</td>
<td>4.3%</td>
<td></td>
</tr>
<tr>
<td>Home Healthcare</td>
<td>23</td>
<td>50%</td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>7</td>
<td>15.2%</td>
<td></td>
</tr>
</tbody>
</table>

Current Position in Nursing

<table>
<thead>
<tr>
<th>Current Position in Nursing</th>
<th>Frequency</th>
<th>Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Administrator</td>
<td>4</td>
<td>8.7%</td>
<td></td>
</tr>
<tr>
<td>Head Nurse</td>
<td>5</td>
<td>10.9%</td>
<td></td>
</tr>
<tr>
<td>Staff Nurse</td>
<td>10</td>
<td>21.7%</td>
<td></td>
</tr>
<tr>
<td>Clinical Specialist</td>
<td>1</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Case Manager</td>
<td>2</td>
<td>4.3%</td>
<td></td>
</tr>
<tr>
<td>Quality Assurance</td>
<td>1</td>
<td>2.2%</td>
<td></td>
</tr>
<tr>
<td>Staff Development</td>
<td>7</td>
<td>15.2%</td>
<td></td>
</tr>
<tr>
<td>Home Healthcare</td>
<td>16</td>
<td>34.8%</td>
<td></td>
</tr>
</tbody>
</table>
Research Questions

1. What are the registered nurses' comfort levels regarding spiritual care?

The SIC scale was used to measure comfort. The highest score attainable, indicating the most comfortable, was 152 and the lowest score, indicating least comfortable was 38 based on the 4 part Likert scale used. The scores ranged from 91 to 143. The pre-test mean scores indicated base comfort levels. The mean was 119.116 and the median was 116.00 with a standard deviation of 13.560. Fifty-four percent of the sample scored 116.00 or above. These findings indicate moderately high comfort levels regarding spiritual nursing interventions for this sample. Three pre-tests were not used in the calculations due to incomplete responses.

![Figure 1](image_url)

**Figure 1.** The midpoint scores for the pre-seminar Spiritual Intervention Comfort Scale are represented.

2. What is the base knowledge of registered nurses regarding spiritual care?

The Spiritual Nursing Care Test (SNC) was used to measure knowledge. The pre-seminar scores therefore indicated base knowledge. The highest score attainable was 25 and the lowest score was 0. The mean score of the 46 participants was 23.659 and the
median was 24.00 with a standard deviation of 1.098. Scores ranged from 20 to 25 (Figure 2). Of the total scores, 84.8% were 23 or above. These scores indicate a high base knowledge related to spiritual nursing care. Two of the participant’s tests were not used in the calculations because of incomplete responses.

![Scores Distribution](scores_distribution.png)

Figure 2. Scores of the pre-seminar Spiritual Nursing Care Test (SNC) ranged from 20 to 25, with the majority of the scores being above 23.

Responses to the open-ended questions support the high base knowledge and comfort levels indicated by the test scores. The first open-ended question asked the seminar participants to list any nursing intervention in the spiritual dimension that they had found effective. The responses, which were placed into 18 categories (Table 4), indicated interventions related to listening and touch were most effective for this sample. The second item asked the participants to write any thoughts or feelings they had regarding the spiritual dimension of nursing care. Thirty-nine (84.78%) of the participants offered responses which were placed into 16 categories. Some of the responses (Table 5) were paragraph length, and cited that spiritual care nursing is important and essential although often overlooked. Responses to the open-ended
questions indicated that the sample was aware of some nursing assessment skills and interventions related to spiritual care and was relatively comfortable with spiritual nursing care. Tables 4 and 5 summarize the responses of both open-ended questions into categories and frequencies.
Table 4

**Spiritual Nursing Care Interventions Found Effective**

<table>
<thead>
<tr>
<th>Response</th>
<th>Frequency</th>
</tr>
</thead>
<tbody>
<tr>
<td>Presence/ “Just being there”</td>
<td>6</td>
</tr>
<tr>
<td>Listening/ Encourage venting</td>
<td>28</td>
</tr>
<tr>
<td>Include the family</td>
<td>1</td>
</tr>
<tr>
<td>Progressive relaxation and imagery</td>
<td>1</td>
</tr>
<tr>
<td>Hugs/Touching/Holding Hands</td>
<td>20</td>
</tr>
<tr>
<td>Nonjudgemental attitude</td>
<td>2</td>
</tr>
<tr>
<td>Smiling</td>
<td>1</td>
</tr>
<tr>
<td>Use of humor/laughing with the patient and family</td>
<td>1</td>
</tr>
<tr>
<td>Empathy/Cry with patient and/or family</td>
<td>4</td>
</tr>
<tr>
<td>Sharing/Risk taking</td>
<td>2</td>
</tr>
<tr>
<td>Tell the truth/dependability</td>
<td>3</td>
</tr>
<tr>
<td>Discuss the process of peaceful dying</td>
<td>3</td>
</tr>
<tr>
<td>Contact chaplain or other clergy member</td>
<td>7</td>
</tr>
<tr>
<td>Read scriptures, sing and/or pray with patient/family</td>
<td>8</td>
</tr>
<tr>
<td>Allowing personal spiritual rituals to be performed</td>
<td>3</td>
</tr>
<tr>
<td>Pray with patient and/or family</td>
<td>6</td>
</tr>
<tr>
<td>Have adequate knowledge about different religions</td>
<td>1</td>
</tr>
<tr>
<td>Writing thoughts and feelings/ Distraction</td>
<td>2</td>
</tr>
<tr>
<td>Response</td>
<td>Frequency</td>
</tr>
<tr>
<td>------------------------------------------------------------------</td>
<td>-----------</td>
</tr>
<tr>
<td>Spiritual health is important to physical health</td>
<td>4</td>
</tr>
<tr>
<td>Smile or hug is good and doesn’t require a lot of time</td>
<td>1</td>
</tr>
<tr>
<td>Not enough time for spiritual care</td>
<td>4</td>
</tr>
<tr>
<td>Uncomfortable talking about religion</td>
<td>6</td>
</tr>
<tr>
<td>Spiritual care is as important as technical care</td>
<td>1</td>
</tr>
<tr>
<td>Uncomfortable talking about death</td>
<td>1</td>
</tr>
<tr>
<td>Empathy is important</td>
<td>1</td>
</tr>
<tr>
<td>A trusting relationship must first be established</td>
<td>1</td>
</tr>
<tr>
<td>Spiritual care is neglected, probably because nurses are</td>
<td>3</td>
</tr>
<tr>
<td>uncomfortable with it.</td>
<td></td>
</tr>
<tr>
<td>It is important/essential and we should do it, although it</td>
<td>15</td>
</tr>
<tr>
<td>is frequently overlooked</td>
<td></td>
</tr>
<tr>
<td>Providing support also gives strength to the nurse</td>
<td>1</td>
</tr>
<tr>
<td>It is important not to criticize the patient’s beliefs or desires</td>
<td>1</td>
</tr>
<tr>
<td>Spiritual=Psychological needs</td>
<td>1</td>
</tr>
<tr>
<td>Many aspects of nursing care is really spiritual care</td>
<td>2</td>
</tr>
<tr>
<td>Is effective in easing anxiety and frustration in patients</td>
<td>1</td>
</tr>
<tr>
<td>Should be stressed in nursing schools and beyond</td>
<td>3</td>
</tr>
</tbody>
</table>
3. What is the effect of spiritual nursing care education on knowledge of spiritual nursing care?

Pre- and post-Spiritual Nursing Care Test scores were compared. An increase in test scores was evident. Twenty-five was the highest score attainable and 0 was the lowest score attainable. The mean of the pre-test was 23.659 and the standard deviation was 1.098. The mean of the post-test was 24.116 and the standard deviation was .626. Figure 3 visually demonstrates and compares the scores of the pre- and post tests.

A paired t-test was used to analyze the effect of the education seminar intervention by comparing the paired mean differences between the scores of the pre- and post-seminar SNC test. Pre-test scores ranged from 20 to 25, and post-test scores ranged from 23-25. Findings (Table 6) indicate a significant increase between pre and post test scores (p=.008).

Figure 3. Pre and post seminar Spiritual Nursing Care Test scores.
Table 6

Comparison: Paired Mean Differences Between Pre and Post Knowledge Test (SNC)

<table>
<thead>
<tr>
<th>Test/Scale</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>DF</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>SNC</td>
<td>-0.4390</td>
<td>1.001</td>
<td>-2.81</td>
<td>40</td>
<td>0.008</td>
</tr>
</tbody>
</table>

*2-tailed t test

4. What is the effect of spiritual care nursing education on comfort in the delivery of spiritual care?

Pre- and post-seminar SIC scores were relatively high (Figure 4). Pre-test scores ranged from 91-143. The pre-seminar SIC mean was 119.116, the mode and median were 116.00 and the standard deviation was 13.560. The post-seminar SIC mean was 120.578 and the standard deviation was 13.55. Post-test scores ranged from 95-150. The trend towards higher scores post-seminar is probably the reason fewer participants scored 140 post-seminar than pre-seminar (Figure 4).

A paired t-test was used to analyze the effect of the educational seminar intervention on comfort by comparing the paired mean differences between the scores of the pre- and post-seminar Spiritual Intervention Comfort Scale (SIC). Findings (Table 7) indicate an increase in comfort which approached significance (p=.057).
Figure 4. Pre- and post-seminar Spiritual Intervention Comfort Scale Results

Table 7
Comparison: Paired Mean Differences Between Pre and Post Spiritual Intervention Comfort Scale (SIC)

<table>
<thead>
<tr>
<th>Test/Scale</th>
<th>Mean</th>
<th>SD</th>
<th>t</th>
<th>DF</th>
<th>p*</th>
</tr>
</thead>
<tbody>
<tr>
<td>SIC</td>
<td>1.5814</td>
<td>5.306</td>
<td>-1.95</td>
<td>42</td>
<td>.057</td>
</tr>
</tbody>
</table>

*2-tailed t test

5. What is the relationship between knowledge and comfort in nurses’ delivery of spiritual care?

Pearson’s Product Moment Correlation was utilized to analyze relationships. There was no significant relationship between knowledge and comfort. The pre SIC and pre SNC correlation coefficient was .1709 with p=.285. The post SIC and Post SNC correlation coefficient was -.0091 with p=.954.
6. What is the relationship between age, sex, years of practice, nursing specialty and attendance of religious services on nurses' comfort in the delivery of spiritual care?

Pearson's product coefficients for the pre- and post-seminar were used to determine correlation coefficients. No sample specifications correlated with comfort in the delivery of spiritual care.
CHAPTER V

Discussion

The purpose and focus of this study was to evaluate the effect of an educational seminar on nurses' knowledge and comfort in the delivery of spiritual care. Comfort and knowledge regarding spiritual care and the effect of the educational seminar will be addressed.

Comfort Level Regarding Spiritual Care

This sample, composed of registered nurses in the State of Nevada, scored moderately high scores on the Spiritual Intervention Comfort Scale indicating moderately high comfort related to the delivery of spiritual nursing care interventions. This sample was a convenience sample of nurses who chose to attend an educational seminar about spiritual care nursing. This interest level is probably related to knowledge and comfort.

Half of the study participants were home healthcare nurses. Home healthcare nurses may possess advanced skills and knowledge in relation to spiritual care nursing due to the nature of their work. Security, privacy, sense of intimacy, and familiarity is inherent in the success of the delivery of spiritual care, and home healthcare nurses have opportunities to develop these qualities because he/she practices within the patient’s environment. Familiarity, friendship, connection, closeness, caring and intimacy is fostered through socialization during home care visits. The hospital based nurse does not often have the opportunities or time to develop the nurse-patient relationship supportive of spiritual care.
More than half of the sample had practiced nursing for 16 to 30 years. The experience level of these nurses may have also contributed to the high base knowledge and comfort levels. These nurses have probably cared for a wider variety of patients and conditions offering the opportunity to incorporate spiritual care nursing into their practice than those nurses with less experience. Also, these nurses are no longer learning the basics of nursing care and time management and may have more time to spend with the patients which is also supportive of spiritual care delivery.

Course evaluations and comments after the seminar indicated that these nurses felt relieved to have their beliefs about nursing and specifically spiritual care nursing validated. Therefore, the course offered some new information to this sample, but functioned primarily as a validation of professional values.

The findings of this study support Cimino’s (1992) results. She found nurses to have a high level of comfort related to the delivery of spiritual nursing care interventions. Few studies have investigated nurses’ comfort in the delivery of spiritual care, and therefore, this study is an important contribution to nursing.

Knowledge Level

High SNC test scores and responses to the open-ended questions provide evidence that base knowledge related to spiritual care nursing in this sample was high. This sample’s high response rate to the request for most effective spiritual care interventions suggests that that they had practiced spiritual care nursing enough to know what was most effective. This once again supports the notion that years of practice and area of practice may influence knowledge and comfort. Responses to the open ended question asking nurses to discuss the most effective interventions related to spiritual care nursing
were similar to those previously found (Cimino, 1992; Shelly & Fish, 1988). The most
effective nursing intervention cited was listening and the encouragement of venting of
feelings. Cimino’s (1992) study indicated the use of touch, holding hands, and praying
with the patient as common interventions utilized by nurses in the Commonwealth of
Massachusetts. This sample’s second most popular intervention related to touch,
hugging and holding hands, however, praying with a patient and other religious oriented
interventions rated lower. Cimino (1992) cited the use of clergy to assist with the
spiritual needs of clients as the second most effective intervention. Highfield (1989) and
Shelly and Fish (1988) were in agreement. This response was cited less frequently in this
sample.

Although other studies have investigated knowledge related to spiritual care
nursing, they had not tested specifically for knowledge. For instance, Narayanasamy
(1993) surveyed a small sample of experienced nurses and found spiritual needs were
often recognized, although nurses were still not educationally prepared to deliver
spiritual care. Lilley’s (1987) sample of registered nurses’ perceived human need
fulfillment similarly to clients with uterine cancer implying knowledge of spiritual care
nursing. Lilley’s findings were not supported by other studies whose authors proposed
the lack of knowledge or awareness related to spirituality and nursing to inadequate
delivery of spiritual care (Highfield & Cason, 1983; Peterson & Nelson, 1985; Sodestrom
& Martinson, 1987), however tests of specific knowledge related to spiritual care nursing
were not done. Highfield (1992) identified an incongruence between nurse spiritual
health scores of patients and the patient’s own spiritual health association. This also
implies nurses’ inadequate assessment skills related to spiritual care nursing. Although
nurses have cited lack of spiritual care nursing education as a cause for not delivering spiritual care (Highfield & Cason, 1983; Peterson & Nelson, 1985; Piles, 1985; Cimino, 1992; Narayanasamy, 1993), findings directly related to knowledge are limited and inconsistent. Therefore, this study builds upon and initiates continued study of nurses' knowledge related to spiritual care nursing.

**Educational Intervention and Knowledge and Comfort**

A statistically significant increase in knowledge, indicating a positive effect of the seminar on knowledge was identified. Comfort levels increased, though not statistically significant (p=.057). Comfort and knowledge were initially high, due to reasons previously postulated, therefore, the findings may not be clinically significant.

Others have studied education and knowledge related to spiritual care nursing, and findings are incongruent. In 1986, Ellis described a spiritual care course that resulted in nurses' feelings of being better prepared to identify and meet spiritual needs of patients. However, comparison between pre and post seminar knowledge and comfort levels were not tested for. Carr (1993) incorporated spiritual care nursing into course work for undergraduate nursing students. In spite of education, students still tended to focus on the religious aspect of spirituality indicating further education needs. Perhaps, the experience level and ages of these two samples and method of teaching and testing contributed to the different findings.

Nurses who attended the seminar and participated in the study also completed a course evaluation. Some of the purposes of this evaluation were to improve delivery and content, to determine if nurses felt the seminar would impact their practice and what type of seminars they would like to attend in the future. The evaluations were very positive in
general. All but two participants agreed or strongly agreed that the seminar would affect their nursing practice. However, each of the two who did not feel the seminar would impact their nursing practice, also wrote that they had enjoyed and benefited from the seminar and would like to attend another on similar subject material. Twelve (26%) commented on their desire to attend more seminars related to spirituality and nursing. Many of the nurses who attended the seminar expressed their feelings related to relief that someone was saying it was alright to acknowledge and care for their patient's spiritual needs. Many also expressed how they hoped they could take the energized, well-being feelings they gained from the seminar back to their work.

Findings of this study, which incorporated the presentation of information in a consistent manner while testing for knowledge and comfort pre and post presentation with a large varied sample, could have the potential to impact nursing by offering objective and subjective findings related to education and spiritual care nursing.

**Relationship of Comfort to Knowledge**

Correlation between knowledge and comfort was not validated in this study. These findings may be attributed to the limited number of items on the SNC, limited range of scores on the SNC and SIC and the low variability demonstrated within each of the tests. Therefore, the high range of scores on the comfort and knowledge tests did not support correlation between knowledge and comfort. The sample size, age range, years of experience, nursing specialty and interest in the topic may be contributing factors to the high scores and low variability between the tests.
In spite of the inability to perform a correlation, this study is an important early step in the investigation of the relationship between knowledge and comfort related to spiritual care.

Factors that Influence Comfort Levels in the Delivery of Spiritual Care

There can be many factors which influence comfort levels in the delivery of spiritual care including but not limited to nurses’ spiritual well-being, attitudes toward spiritual care, practice specialty and previous education. The findings of this study support that practice specialty and years of practice may be a factor in comfort levels in the delivery of spiritual care. However, due to the limited variance in the data collected, no relationship was found between age, sex, years of practice, nursing specialty and attendance of religious services on nurses’ comfort in the delivery of spiritual care.

Responses to the second open ended question (Table 5) which asked about thoughts and feelings regarding the spiritual dimension of nursing care offer some insight into factors which may influence comfort levels. Most agreed that spiritual care nursing is important, although it is frequently overlooked. Other studies (Cimino, 1992; Labun, 1988; Soeken and Carson, 1986) cited similar findings. The next most frequent response was that nurses are uncomfortable talking about religion. Various authors (Highfield and Cason, 1983; Narayanasamy, 1993) have cited the association between religion and spirituality as a possible deterrent in the adequate delivery of spiritual care.

A literature search in CINAHL, medicine, thesis and dissertation abstracts revealed no other studies which tested for the relationships described which further supports the importance of continued data collection.
Limitations of the Study

There were factors which potentially impacted the findings of this study. The sample size was relatively small. Some contributing factors to the small sample size were simultaneous mandatory continuing education at two of the hospitals, and coexisting holiday time (November-December). The sample may have been more varied and larger if nurses were required to obtain mandatory continuing education hours through on site educational experiences. Currently, in the State of Nevada, most of the continuing education hours required for licensure can be obtained through correspondence. Perhaps if more nurses had attended with the primary goal of continuing education hour fulfillment, the scores would have demonstrated more variability. Additionally, although most of the advertisement pamphlets were hand delivered, many nurses claimed to not have seen them or to have found them buried under other papers. After each seminar was presented, the presenter was invited back to the site in order to repeat the seminar for those who could not attend. This was not possible because of time restrictions. This pre-determined time restriction to finish the study contributed to the small sample size and was also a limitation of the study.

Some nurses reviewing the advertisement pamphlet were overheard commenting about how there was no place for religion in nursing. The association of spirituality and religion, a subject often not discussed within the professional setting, may have also accounted for the small sample size. The controversy and misunderstanding about spirituality and religion has been previously cited as a deterrent to spiritual nursing care education by Peterson (1985) and Piles (1986).
The content delivered at each seminar was the same, although due to the interactive nature of the seminar, each had a tone of its own.

This sample was a convenience sample composed of nurses who wanted to learn more about spiritual care nursing. It is assumed that they were therefore aware of and valued the importance of holistic nursing. This may also help to explain the predominately high scores in knowledge and comfort resulting in low variance of scores.

The use of identical pre and post tests and resulting familiarity with the SIC and SNC may have also impacted the study in relation to scoring. The SNC was a short item test with true/false items with a fairly easy nature to them. The nature of the SNC and the small sample size each contributed to low variance of the data. This low variance of the data contributed to difficulty establishing reliability for the SNC at .4847. The Spearman-Brown Prophecy is based on a correlation between two halves of the test. Since the correlation coefficient is effected by the variance of the data, reliability was difficult to establish. Therefore, the findings of this study related to knowledge are reflective of a pilot study indicating a need for further study and perhaps revision of the SNC.

Summary and Implications

This study provided important information related to nursing education and spiritual care. It provided evidence of interest in spirituality and continued education, along with some of the difficulties of studying knowledge and comfort. Continued testing of the SIC and SNC is indicated in order to establish reliability. Furthermore, evaluation of objective data (surveys and tests) as well as subjective data (open ended questions) is necessary in order to study knowledge and comfort in relation to spirituality.
The seminar described in this study, when presented to a large sample, has the potential to impact nursing by offering objective and subjective findings related to education and spiritual care nursing.

It became obvious that nurses were very interested and moved by the nature of the seminar content. The general theme of each of the seminars revolved around nurses’ desires to be able to offer time, care and a part of themselves in their patient care delivery. The theme was also reflective of the frustration in not having this aspect of nursing care valued by the healthcare industry, which tends to focus on the monetary benefits of physical-focused care. Continued presentation of the seminar described in this study offers the opportunities for nurses to openly share their thoughts and feelings related to nursing in general as well as specifically about spiritual care nursing. It also helps to guide nurses toward more clearly defining the roles of the registered nurse which includes, but is not limited to, physical, psychological and spiritual care.

**Recommendations for Further Research**

This study investigating the relationships and effect of knowledge and comfort related to spiritual care can be used to further build upon the body of nursing knowledge. Since the sample was small and can only be generalized to those who attended the seminars, other possible studies are suggested.

1. Studies designed to test knowledge and the relationship between knowledge and personal and professional characteristics.

   Studies designed to test knowledge related to spirituality and nursing would help determine if nurses really do have limited knowledge related to spiritual care nursing. If a knowledge deficit is established, this information could potentially impact nursing
education. Established relationships between sample characteristics would help educators target specific groups for further education.

2. Studies investigating knowledge, comfort and actual delivery of spiritual nursing care.

Studies investigating knowledge, comfort, and actual delivery of spiritual nursing care would help determine if knowledge and/or comfort are the determining factors in the actual delivery of spiritual care.

Also identification of nurses with knowledge, comfort and who actually practice spiritual care nursing, would provide a potential pool of nurses well suited to serve as leaders related to spiritual care.

3. Qualitative studies investigating nurses’ attitudes related to spiritual nursing care.

Much of the valuable information nurses had to offer related to spiritual care was found in the responses to the open ended questions and those comments made before, during, and after the seminar by those in attendance and those who chose not to attend. A qualitative study may help determine trends in nurses’ attitudes toward spiritual care.

4. Studies investigating nursing educator’s attitudes, knowledge and comfort toward spiritual care.

Nursing’s basis is in care of the person viewed as body, mind and soul. Nelms et al (1993) found nursing students learned about caring from faculty role modeling in the classroom and clinical setting. Therefore, educator’s attitudes, knowledge and comfort toward spiritual care, care of the soul, could potentially impact new nurses and therefore their practice.
5. Relationship between spiritual well-being as related to attitudes toward and comfort in the delivery of spiritual care.

This would be a replication of Cimino's (1992) study. Replication of the study would provide additional data about nurses and compare findings of nurses in the Commonwealth of Massachusetts to nurses in other parts of the world. Nurses' spiritual well-being may be as important, if not more important, than nurses' knowledge in determining if spiritual nursing care is actually delivered.
APPENDIX A

SPIRITUAL INTERVENTION COMFORT SCALE

SPIRITUAL NURSING CARE TEST

DEMOGRAPHIC FORM AND

COURSE EVALUATION
SPIRITUAL INTERVENTION COMFORT SCALE (SIC)

Designed and developed by S. Cimino, Ph.D., 1992.

For each of the following behaviors, please circle your response using the following code:

SA= Strongly Agree                      SD= Strongly Disagree
A= Agree                                    D= Disagree

When I am caring for patients, I feel comfortable:

1. asking patients if they want to pray.  SA A D SD
2. when I do not have to discuss death with patients.  SA A D SD
3. asking patients if they want to see a clergyman.  SA A D SD
4. initiating discussions about the meaning of life with them.  SA A D SD
5. discussing the concept of sin with patients.  SA A D SD
6. asking patients not to discuss their feelings of guilt with me.  SA A D SD
7. listening to patients talk about being cheated by God.  SA A D SD
8. asking patients to refrain from reminiscing about their lives and significant life events.  SA A D SD
9. listening to patients talk of heaven.  SA A D SD
10. initiating discussion about dying with patients.  SA A D SD
11. when patients express anger toward God.  SA A D SD
12. initiating discussion about their illness.  SA A D SD
13. praying with patients.  SA A D SD
When I am caring for patients, I feel comfortable:

14. talking of the joys of life with patients. SA A D SD
15. asking patients not to talk of hell. SA A D SD
16. crying with family members of significant others. SA A D SD
17. asking patients if they want to read Scripture. SA A D SD
18. listening to patients discuss the meaning of suffering for them. SA A D SD
19. praying with members of the families or significant others. SA A D SD
20. initiating a conversation about significant people in their lives. SA A D SD
21. selecting Scripture readings for patients. SA A D SD
22. encouraging patients to discuss their hopes. SA A D SD
23. talking to God with patients. SA A D SD
24. showing kindness and concern for patients. SA A D SD
25. discussing Scripture reading with patients. SA A D SD
26. listening to patients discuss their values and beliefs. SA A D SD
27. assisting patients carry out religious practices and rituals of their faith. SA A D SD
28. discussing the concept of forgiveness with patients. SA A D SD
29. having patients discuss their relationship with God. SA A D SD
30. embracing patients. SA A D SD
31. initiating a conversation about God. SA A D SD
32. crying with patients. SA A D SD
33. talking about religious beliefs with patients. SA A D SD
SIC cont.
When I am caring for patients, I am comfortable:

34. crying in front of patients.  
    SA  A  D  SD

35. praying with patients.  
    SA  A  D  SD

36. being at the bedside of dying patients.  
    SA  A  D  SD

37. listening to patients speak of a loving God.  
    SA  A  D  SD

38. discussing with patients about the meaning and purpose of life.  
    SA  A  D  SD

39. Please list any nursing interventions in the spiritual dimension that you found effective.

40. Please include any thoughts or feelings you have regarding the spiritual dimension of nursing care.
SPIRITUAL NURSING CARE TEST

Designed and developed by Carmen Sterling-Fisher, BSN, RN, 1995

Please answer True (T) or False (F) to the following statements:

1. T  F  Spiritual distress results when spiritual needs are not met

2. T  F  A means of forgiveness and a source of love are spiritual components of an individual.

3. T  F  Spiritual nursing care is always religious based.

4. T  F  Spirituality is one’s source or his/her quest to find meaning and purpose in life.

5. T  F  Spiritual distress may be an appropriate nursing diagnosis for the patient who struggles with his/her sense of love and belonging.

6. T  F  Spiritual distress may be an appropriate nursing diagnosis for the patient who wishes to but is unable to attend church.

7. T  F  The patient with a new onset of a chronic illness is at particular risk for spiritual distress.

8. T  F  Spiritual distress may be an appropriate nursing diagnosis when the patient experiences loneliness.

9. T  F  Spiritual care nursing interventions are best carried out after a trusting relationship has been established.

10. T  F  An example of an appropriate spiritual care nursing intervention is the nurse’s response, “You have cancer, there is no hope.”

11. T  F  An example of an appropriate spiritual care nursing intervention is a referral to social services for financial counseling and assistance.

12. T  F  An example of an appropriate spiritual care nursing intervention is the changing of a dressing, while conversing with another nurse in the room.

13. T  F  Spiritual care nursing interventions require non judgmental, attention-giving presence from the nurse.
14. T    F Empathy could be an example of a spiritual care nursing intervention.

15. T    F An example of an appropriate spiritual care nursing intervention is: When a patient asks if he is going to die, the nurse’s response is, “I’ll have to check your chart.”

16. T    F Truth telling may be an example of a spiritual care intervention.

17. T    F The following is an example of a spiritual care intervention: A patient asks the nurse to sit with her. Nurse’s response is, “I am involved in something else right now, but I would like to sit with you for a few minutes. I will be back in 30 minutes.”

18. T    F Active and attentive listening is an example of a spiritual care intervention.

19. T    F The following is an example of a spiritual care intervention: A patient starts to cry after his physician has left the room. He says, “I am afraid of dying.” The nurse sits beside him and holds his hand.

20. T    F Appropriate use of humor is a spiritual care nursing intervention.

21. T    F Allowing and providing the patient the opportunity to pray or meditate are examples of spiritual care interventions.

22. T    F The following is an example of an appropriate nursing spiritual care intervention: A patient starts to cry after his physician has left the room. He says, “I am afraid of dying.” The nurse responds by saying, “I’m sorry. We’re all going to die sometime, though. At least you’ve got some time to get your things in order.” She walks away, as he cries.

23. T    F Praying with the patient, if they desire, can be a spiritual care nursing intervention.

24. T    F Allowing the patient to reminisce about his/her life can be a spiritual care nursing intervention.

25. T    F Referral to pastoral care can be a spiritual care nursing intervention.
YOUR BACKGROUND
This section requests information about your background. Please check off and fill in a response for each statement that best characterizes you.

1. What is your age? ______
2. What is your marital status?
   ____ Single
   ____ Married
   ____ Divorced
   ____ Widowed?
3. What is your gender?
   ____ Female
   ____ Male
4. What is your religious preference?
   ____ Agnostic
   ____ Atheist
   ____ Buddhist
   ____ Catholic
   ____ Hindu
   ____ Jewish
   ____ LDS (Mormon)
   ____ Muslim
   ____ Protestant (specify denomination)
   ________________________________
   ____ Other
   ____ None
5. Do you regularly attend religious services? Yes____ No_____ 
6. What was your initial educational program in nursing? (FOR RNs ONLY)
   ____ LPN/LVN
   ____ Diploma
   ____ Associate degree
   ____ Baccalaureate degree
   ____ Masters degree
   ____ Doctorate
7. What is your highest educational level now?
   ___ Diploma
   ___ Baccalaureate degree
   ___ Doctorate
   ___ Associate degree
   ___ Masters degree
   ___ LPN/LVN
8. What is your employment status?
   ___ Full time in nursing
   ___ Part time in nursing
   ___ Unemployed
   ___ Full time not in nursing
   ___ Part time not in nursing
   ___ Retired
9. What is your current position in nursing?
   ___ Administrator
   ___ Certified Nurse Practitioner
   ___ Head Nurse/Nurse Manager
   ___ Researcher
   ___ Staff Nurse
   ___ Case manager
   ___ Clinical Specialist
   ___ Faculty Member
   ___ Quality Assurance
   ___ Staff Development
   ___ Home healthcare nurse
10. How many years have you practiced nursing? ______
11. What is our area of nursing practice now, full or part time?
    ___ Medical Surgical/Adult Health
    ___ Pediatrics
    ___ Maternity
    ___ Psychiatric-Mental Health
    ___ Community Health
    ___ Occupational Health
    ___ School Nursing
    ___ Home Healthcare
    ___ Other
    ___ None
12. Are you currently continuing your education in nursing? ___yes ___no
    If yes:
    ___ Toward Associate’s Degree
    ___ Toward Baccalaureate Degree
    ___ Toward Masters Degree
    ___ Toward Doctorate
    ___ Other:
    ___
13. Have you ever attended a seminar or class about spirituality and nursing? ___yes ___no
    If so, when? ________________
COURSE EVALUATION

1. THE COURSE OBJECTIVES WERE MET.
   Strongly agree   Agree   Disagree   Strongly Disagree

2. THE COURSE PRESENTATION WAS CLEAR AND ORGANIZED.
   Strongly agree   Agree   Disagree   Strongly Disagree

3. QUESTIONS WERE ANSWERED IN A MANNER INDICATING UNDERSTANDING OF THE TOPIC.
   Strongly agree   Agree   Disagree   Strongly Disagree

4. I WOULD ATTEND ANOTHER SEMINAR PRESENTED BY CARMEN, EVEN IF I HAD TO PAY FOR THE COURSE AND CEUs.
   Strongly agree   Agree   Disagree   Strongly Disagree

5. THIS SEMINAR WILL AFFECT MY NURSING PRACTICE.
   Strongly agree   Agree   Disagree   Strongly Disagree

6. THIS INFORMATION WAS NEW TO ME.
   Strongly agree   Agree   Disagree   Strongly Disagree

7. THIS SEMINAR WAS WORTH MY TIME.
   Strongly agree   Agree   Disagree   Strongly Disagree

8. MY PRIMARY REASON FOR ATTENDING THIS SEMINAR:

9. WHAT WAS MOST BENEFICIAL ABOUT THIS SEMINAR?

10. WHAT COULD BE DONE DIFFERENTLY TO IMPROVE THIS SEMINAR?

11. PLEASE LIST ANY ADDITIONAL COMMENTS INCLUDING ANY SEMINARS YOU WOULD LIKE TO ATTEND IN THE FUTURE?
APPENDIX B

PERMISSION LETTER AND CORRESPONDENCE
I hereby grant Carmen E. Sterling-Fisher permission to adapt the Spiritual Intervention Comfort Scale for her study and permission to publish the results of the research using the scale.

Permission granted

Sarah Cimino, Ph.D.

July 26, 1995

Date
Dear Applicant:

This letter is to serve as official notice that you are approved as a provider for Continuing Education beginning August 22, 1995 and expiring July 31, 1996.

An application for re-approval will be mailed to you sixty days in advance of expiration date. If you should have changes in your address or continuing education coordinator in the interim, please contact our office in writing with an update.

Thank you

Sincerely,

NEVADA STATE BOARD OF NURSING

Don Rennie, M.S., R.N.
Associate Executive Director for Licensure

The mission of the Nevada State Board of Nursing is to protect the public health, safety and welfare by implementing the Nurse Practice Act, thereby facilitating safe and effective care in the State of Nevada.
APPENDIX C

SEMINAR CONTENT OUTLINE

SEMINAR OBJECTIVES,

STUDY INFORMATION FORM
SPIRITUAL CARE NURSING

COURSE OBJECTIVES AND OUTLINE

COURSE OBJECTIVES

By the end of this seminar, participants will be able to:

1) Define spirituality, from their own perspective and also from those of authors of nursing literature.

2) Differentiate between existential and religious spirituality.

3) Identify spiritual needs and assess for spiritual distress in patients.

4) Identify appropriate spiritual care nursing interventions.

5) Utilize the nursing process, through case study exercises, as a guide to assess spiritual integrity, and plan appropriate interventions.

COURSE OUTLINE

1. Welcome, instructions, and pre-test.

2. Discussion of concepts of spirituality, spiritual well-being, and spiritual distress.

3. Nursing assessment of spiritual integrity-
   - Who is at risk for spiritual distress?
   - What to look for? What to listen for?
   - What to say? What to do?
   - How to assess?

4. Long and short term plans

5. Spiritual care nursing interventions

6. Case studies- putting it all together- We’ll do two, if there is time

7. Summary-
   - Comments
   - Post-test
   - Evaluation/Distribution of CEU certificates
SEMINAR PARTICIPANT:

THIS SEMINAR IS PRESENTED FREE OF COST TO ALL PARTICIPANTS. YOU WILL BE AWARDED THREE CONTACT HOURS UPON COMPLETION OF THE THREE HOUR SEMINAR. THIS SEMINAR IS PRESENTED AS PART OF A RESEARCH PROJECT ENTITLED, "THE EFFECT OF SPIRITUAL CARE NURSING EDUCATION ON NURSES' COMFORT IN THE DELIVERY OF SPIRITUAL CARE." ATTENDANCE OF THIS SEMINAR INDICATES CONSENT TO PARTICIPATE IN THIS RESEARCH STUDY. ATTENDANCE, AND PRE- AND POST-TESTS ARE THE ONLY REQUIREMENTS FOR THE STUDY.

YOU WILL BE ASKED TO COMPLETE A PRETEST AND A POST TEST AT THE CLOSE OF THE SEMINAR. EACH TEST SHOULD TAKE NO MORE THAN 10 TO 15 MINUTES OF YOUR TIME. EACH TEST IS CODED IN ORDER TO MAINTAIN CONSISTANCY, BUT TO PROTECT YOUR ANONYMITY, THE TESTS WILL NOT HAVE YOUR NAME ON THEM. THESE TESTS SCORES ARE ESSENTIAL TO THE SUCCESS OF THIS RESEARCH PROJECT.

THANK YOU FOR ATTENDING!

CARMEN STERLING-FISHER, BSN, RN

Inquiries should be addressed to:

Carmen Sterling-Fisher, BSN, RN
Graduate Student of Nursing
Department of Nursing
University of Nevada, Las Vegas
4505 Maryland Parkway
Las Vegas, NV 89154-1017
APPENDIX D

HUMAN SUBJECT RIGHTS
September 22, 1995

Ms. Carmen Sterling-Fisher
6001 Desert Sun Drive
Las Vegas, NV 89110

Dear Ms. Sterling-Fisher:

The Department of Nursing Human Subjects Rights Committee met and approved your proposal "The effect of spiritual care education on nurses' comfort in delivery on spiritual care" with the following recommendation. The Committee requests you make the change before submitting to the University Human Subjects Rights Committee.

On the participant information form, please clarify the use of the coding, i.e. that it is to match the pre forms to the post forms and note that names will not appear on the forms.

You have a study that should result in very useful information on spiritual care. The Committee wishes you well in completing it. If any of the above is not clear or you wish to discuss the recommendation please do not hesitate to call me.

If you make any major change in your project please notify the Committee.

Sincerely,

Margaret Louis, RN PhD
Chairperson
Human Subjects Rights Committee
Department of Nursing, UNLV
Title of Project: The effect of spiritual care education on nurses' comfort in delivery of spiritual care

Investigator: [Signature]

After reviewing this proposal, the members of the Department of Nursing Human Subject's Rights Review Committee have indicated below their approval/disapproval of this proposal.

Signature of Committee Members

Approve  Disapprove

The above named project is hereby approved/disapproved (circle one).

Date: Sept. 22, 1995
DATE: October 19, 1995

TO: Carmen Sterling-Fisher (NUR)  
M/S 3018

FROM: Dr. William E. Schulze, Director  
Office of Sponsored Programs (X1357)

RE: Status of Human Subject Protocol Entitled:  
"The Effect of Spiritual Care Nursing Education on  
Nurses' Comfort in the Delivery of Spiritual Care"

OSP #501s1095-075e

The protocol for the project referenced above has been reviewed by  
the Office of Sponsored Programs, and it has been determined that  
it meets the criteria for exemption from full review by the UNLV  
human subjects Institutional Review Board. Except for any required  
conditions or modifications noted below, this protocol is approved  
for a period of one year from the date of this notification, and  
work on the project may proceed.

Should the use of human subjects described in this protocol  
continue beyond a year from the date of this notification, it will  
be necessary to request an extension.

cc: Susan Rush Michael (NUR-3018)  
OSP File
APPENDIX E

PRESENTATION OF LITERATURE SUPPORTING THE SPIRITUAL NURSING CARE SEMINAR
Spiritual Nursing Care

The Spiritual Care Nursing Seminar was developed after thorough review of literature related to many aspects of human spirituality. The seminar was structured based on the nursing process, and the following section describes aspects of spiritual nursing care assessment, diagnosis, planning, interventions and evaluation discussed during the seminar.

Spiritual nursing care is a part of holistic care delivery. When spiritual care is omitted in nursing care plans, untreated spiritual distress and unsuccessful patient outcomes can result (Courville-Davis, 1994). By giving care systematically through the use of the nursing process, the delivery of spiritual care and the meeting of spiritual needs can be ensured (Peterson and Nelson, 1987). The nursing process is an organized, systematic method of delivering nursing care where the unique human response of a person or group to an actual or potential alteration in health is the focus. The five steps of the nursing process are assessment, diagnosis, planning, implementation and evaluation (Alfaro, 1986). Spiritual nursing care will be described through discussion of the steps in the nursing process.

Assessment

During the assessment step of the nursing process, data about the patient is gathered and validated to determine the difference between fact and fiction. Patterns of health and disease are then identified by organizing or clustering the data. Additional data is then gathered, if needed, in order to describe more clearly what the data means (Alfaro, 1986). A spiritual assessment is done initially and continuously and consists of data, based on the definitions of spirituality and spiritual distress, related to religious
preference and significance of religious practice and rituals, concept of deity, source of
hope, purpose, and meaning, and correlation between health and spiritual beliefs
(Conrad, 1985; Corrine et al, 1992; Forbis, 1988; and Stoll, 1979).

Assessment can be obtained through observation of the client’s behaviors and
environment. Nonverbal and verbal expressions of fear, doubt or despair may indicate
spiritual distress (Forbis, 1985). The immediate environment such as religious artifacts
and objects, and relations with others may help the nurse to assess those things of value
to the patients. This information is most easily obtained by the home health care nurse
and other health care providers who have opportunities to visit the patient within their
own environment. Hospitalized patients may also have certain important pieces with
them, as well, such as a crucifix, rosary or pieces of jewelry. Assessments must be
confirmed since these articles may have been brought in by someone else and hold little
value for the patient, or may simply be good luck pieces with no religious or spiritual
significance for the client.

Information obtained from an interview, whether formal or informal, is best
obtained after a trusting relationship between the nurse and patient has been established
(Peterson and Nelson, 1987). Stoll (1979) recommends spiritual assessment is best done
after the psychosocial assessment, once a certain comfort level has been obtained by both
nurse and patient.

The patient’s ability to see, hear and move are just some of the important physical
status assessments that must first be done in order to test the appropriateness of certain
nursing interventions (Forbis, 1985; Peterson, 1985; Peterson and Nelson, 1987). The
patient’s level of cognitive function is also important. Their ability to read (and in what
language), relationships with family and others, and perception of self and body image must also be assessed (Peterson, 1985; Peterson and Nelson, 1987). Other areas for assessment include the patients goals, if any, their interest in reaching these goals, and any experience with intervention techniques, such as imagery, reminiscence, or music therapy, and their understanding of the purposes for the interventions must also be assessed (Dossey et al, 1995). It may be helpful to collaborate with the patient's family or others to ascertain what issues give or gave the patient's life meaning, purpose and hope prior to the physical or mental deterioration (Peterson and Nelson, 1987; Ross, 1994).

Community assessment is also important. Low income, racism, unemployment, violence, homelessness, and drug use may lead to feelings of hopelessness and helplessness. Some poor coping mechanisms used are illegal drug use and alcohol consumption, while stronger sources of strength and coping in the community are the 12 step programs such as Alcoholics Anonymous, Al-Anon, and Narcotics Anonymous (Corrine et al 1992). Assessment within the culture of the patient is also very important. When a nurse is a member of the same culture as the patient, some barriers may be lowered lending to a more complete understanding. A nurse who is not familiar with such practices and rituals such as Voodoo and Esperitismo, for instance, may find it difficult to adequately assess a patient's risk for spiritual distress.

The assessment process can also be a therapeutic experience for the patient. The process of being listened to without judgment can be healing (Burnard, 1988; Forbis, 1985), especially if the person is not searching for answers, but only to be listened to (Burnard, 1988). Egan (1986) recommends appropriate use of body language in order to
facilitate open communication. It is recommended to sit facing the person who is talking, keep arms and legs uncrossed, thereby maintaining an open position, lean slightly towards the person who is talking, maintain reasonable eye contact, and relax. These are also ways for nurses to make it possible and easy for patients to give some verbal or nonverbal hint of their openness to discussing the spiritual aspects of care (Peterson, 1985). Peterson (1985) viewed the entire process of the delivery of spiritual care, assessment and intervention, a responsibility of nursing and a privilege to be a person to share the intimacies of another’s life.

The following are some questions which may be used during the interview process in order to assess the spiritual aspects of religious preference and significance of religious practices and rituals, concept of deity, source of meaning, purpose, and means of forgiveness, source of love and relatedness, source of hope and strength, correlation between health and spiritual beliefs, affective feeling, and category of transcendence (Conrad, 1985; Emblem, 1993; Forbis, 1988; Peterson and Nelson, 1987 and Stoll, 1979). Some of the questions can be in the interviewer’s mind, and assessed for indirectly.

Religious preference and significance of religious practices and rituals

What religious practices are significant to you when you are not ill? This questions also helps to determine any religious preoccupation that sometimes comes with illness or exacerbation of illness. What do these practices mean to you? What do these practices mean in light your life history and immediate stresses? Do you feel your faith is helpful to you? If yes, will you tell me how? What religious books or symbols are helpful to you? (Corrine et al, 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Stoll, 1979)
Concept of deity

What does God mean to you? Who is your God? Who or what holds the greatest power to you? A person’s response may be religious oriented or may be focused more on the external world, such as an occupation or one’s own abilities (Corrine et al, 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Stoll, 1979).

Sense of meaning, purpose and means of forgiveness

Some questions related to meaning and purpose in life may be very painful, although the problem is dealt with somehow (Peterson, 1985). Some may deny the situation and refuse to face the questions. Another person in the same situation may reorganize their system of beliefs and change their attitudes toward life, while others may rely on previous and existing philosophies of life. Some potential interview questions and concerns are as follows:

What keeps you going? What gives you zest for life? The answer may be as simple as a chance to smoke another cigarette or a chance to see family members, again. How do you deal with guilt? Explore whether the patient relives past experiences or behaviors in his mind. Is there anger? This may be from the inability to forgive oneself and therefore not tolerate anything that resembles criticism. In situations when you hurt someone else, how do (did) you seek reconciliation? In situations where someone else hurt you, how do (did) you forgive? Is there anything which disappoints you now? Is there anything about your past which you find disappointing? (Carr, 1993; Corrine et al, 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Ross, 1994; Stoll, 1979)
Source of love and relatedness

Feeling love and relatedness may be very difficult during times of aloneness, such as during hospitalization. Certain testing procedures may be dehumanizing and humiliating resulting in a risk of diminished self-worth and spiritual distress (Peterson, 1985). Some potential interview questions and concerns are as follows:

Does the patient have the ability to feel loved, valued and respected by others? Patients with mental illness often are deficient in this area. Do they have visitors, and if so, who visits? How does the patient react during the visits? Who do they talk about? Are there photos or other memorabilia around? Who is the most important person to you? When do you feel most loved? (Corrine et al, 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Stoll, 1979)

Sources of hope and strength

What is the relationship between the person's hope and coping capacity? What kind of hope has he and is it past, present, or future oriented? Is the hope grounded in reality or is it unrealistic? (Corrine et al, 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Stoll, 1979)

Corrine et al (1992), in their discussion of spirituality and women, recommended to look at spirituality as a journey and search for the patient's meaning in life, growth, change, healing and hope. Assessment of past sources of strength and coping will aid the nurse in determining potential nursing interventions related to the use of past spiritual resources. For instance, questions such as, "How did you cope with the loss of your child?" and "Where did you find the strength to do what you did?" may be appropriate.
Correlation between health and spiritual beliefs

Has being sick made a difference in your practice of praying or any other religious practices? What has bothered you most about being sick? What has bothered you most about what is happening to you in your life now and in the past? Has being sick made any difference in your feelings about God or practicing your faith? Has being sick made a difference in your personal belief system? Is there anything that is especially frightening or meaningful to you now? (Corrine et al. 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Stoll, 1979)

Affective Feeling

What feelings do you experience with your illness? How might I, or anyone else help you to become more at ease about-(the feelings they've identified)? What do you think about the most? What bothers you most about your present circumstances? Is there anything you try not to think about? Are you disappointed in or about anything? (Carr, 1993; Corrine et al, 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Stoll, 1979)

Transcendence

What is the most helpful to you in mentally moving to an experience that is more enjoyable than the present moment? How might I or anyone else help you focus on happier moments? (Corrine et al, 1992; Peterson, 1985; Peterson and Nelson, 1988; Forbis, 1988; Stoll, 1979)

Nursing diagnosis is the step following assessment in the nursing process. The nursing diagnosis discussed in the following section is spiritual distress.
Diagnosis

The diagnosis of spiritual distress is made after actual or potential problems and/or the cause or etiology of the problem are identified based on a thorough assessment. The diagnosis step is also the time to determine which problems can be treated independently by the nurses, and which problems may require the assistance of another health care professional or other referral, such as to a clergy member (Alfaro, 1986). A person’s spiritual condition may not be a problem or deficit, but rather provide stability and constancy in the midst of a life with many changes and other turmoil associated with health crises (Corrine, 1992). An example of a nursing diagnosis which reflects a strength would be “religious beliefs and client’s stable beliefs in his purpose and meaning in life provide a sense of spiritual integrity.” In this case, the patient’s spiritual integrity is used to identify usual life-styles and coping patterns, one purpose of the nursing diagnosis (Alfaro, 1986).

Spiritual distress is defined as the state in which an individual or group experiences or is at risk of experiencing a disturbance in the belief or value system that provides strength, hope, and meaning to one’s life (Carpenito, 1989). Additionally, a struggle with a sense of love and belonging may also indicative of spiritual distress. Some defining characteristics are the experiences of disturbances in the belief system, questions related to the credibility of belief system, the demonstration of discouragement, disappointment or despair, inability to practice usual religious rituals, presence of ambivalent feelings or doubts about beliefs, expression related to no reason for living, feelings of a sense of spiritual emptiness, showing of emotional detachment from self and
others, expressions of concern, anger, resentment, and/or fear over the meaning of life, suffering, or death. A request for spiritual assistance for a disturbance in a belief system is also a defining characteristic. When sources of hope and strength are not based in reality, despair can result. Hope based on reality tends to draw on a person's resources to adapt so life can be meaningful during the present and future time (Stoll, 1979).

Some pathophysiological risk factors include the loss of a body part or loss of a function of the body part, terminal illness, debilitating disease, pain, trauma and miscarriage and stillbirth. Some treatment-related risk factors are abortion, surgery, blood transfusion, dietary restrictions, isolation, amputation, medications and certain medical procedures. Some situational risk factors include inability to attend to activities of daily living, such as drive, the death or illness of a significant other, embarrassment at practicing spiritual rituals, hospital barriers to practicing spiritual rituals, confinement to bed or room, lack of privacy, lack of availability of special foods/diet, beliefs opposed by family, peers, health care providers, childbirth, divorce or other separation from loved ones (Carpenito, 1989).

The diagnosis of spiritual distress is based upon the assessment findings. Some examples of nursing diagnosis are:

Spiritual distress related to client's feelings of remorse about the way he has lived his life- particularly drug abuse.

Potential for spiritual distress due to recent death of spouse.

Spiritual distress related to patient's guilt over disappointment with God in spite of lifelong faith in God.
Planning is the step of the nursing process following diagnosis. The plan of action is made in order to reduce or eliminate the problem and promote health (Corrine et al, 1992).

Planning

Once the diagnosis for potential or actual spiritual distress is made, the next step in the nursing process is planning. The planning phase consists of priority setting, establishment of goals, prescription of nursing interventions and patient activities. Documentation of the plan on the nursing care plan is also required (Alvaro, 1986).

Goals are individualized based on patient needs and their immediate concerns (Peterson and Nelson, 1987) and are aimed at fostering integrity, promotion of interpersonal bonding and enhancement of personal quests for meaning in life (Clark et al, 1991). An example of a long term goal, if a patient’s spiritual development is found to be a strength, would be to continue the direction of the patient’s spiritual development. An example of a short term goal would be to assist in meeting the patients needs according to the direction of the patient. Specific nursing interventions are then prescribed based on goals and would be patient or family directed.

The nurse must be familiar and capable of carrying out any planned nursing intervention. Special and/or additional education may be required, in the arts of meditation, imagery, music therapy and reminiscence therapy, for example.

Implementation of interventions is the next step of the nursing process. The intervention step of the nursing process involves the actual implementation of the nursing goals set in the planning phase.
Implementation and Interventions

Interventions are directed toward the continued collection of information about the patient and determination of new problems, if applicable, as well as how the patient is responding to the nursing interventions. This information is communicated in the nursing careplan (Alfaro, 1986).

Soeken and Carson (1987) view the nurse’s Self as the most effective tool within the context of a caregiving relationship because spiritual care occurs over time, requiring a trusting relationship. Use of one’s Self, meaning one’s time and full attention, can be a means of healing, support and affirmation of another (Courville-Davis, 1994). Dossey et al (1995) uses the term presence to describe the nurse’s being with the patient and describe the physical, psychological, and therapeutic presence. Physical presence implies body to body contact, and can be achieved during routine tasks. Psychological presence implies mind to mind contact where the nurse uses himself or herself as an intervention tool meant to meet the client’s need for comfort, help and support. Although the nurse’s use of Self would involve each of these, therapeutic presence, the nurse’s presence in relationship to the patient as a whole being in which resources of the body, mind, emotions, and spirit are used, is essential to use of Self. Any of the three categories of presence requires the nurse to be totally in the moment with the patient. Use of Self through presence allows the nurse to be free of personal needs, such as the need to be a good nurse or say the right thing, and opens the corridor to true healing (Dossey et al, 1995).

Spiritual care is delivered with the intent of “life giving” and is delivered in a nonjudgemental, supportive manner (McLaughlin and Shilling, 1994). The nurse
delivering spiritual care must be diverse and open to options as needed and requested by
the patient. These were a few of the findings of a pilot study of a committee organized to
deliver spiritual care in a hospital in Albany, New York. The multidiscipline committee
was formed to evaluate how to best address the spiritual needs of patients, families, and
staff. A patient information pamphlet was designed and distributed in order for patients
to be aware of the committee, and to let them know it was alright to discuss spiritual
needs with nurses and other health care professionals. Each unit had two nurses trained
to follow through on patient requests. Unfortunately, patients seldom used the spiritual
care phone number on the pamphlet and problems existed due to the inconsistent follow
up methods on the spiritual needs of patients. There was also inconsistent
communication between the nurses on the units. The committee formation led to a few
unexpected benefits. Initially, members were cautious about their own spiritual
concerns, but over time found a strong sense of personal and professional spiritual
growth. Their ability to work as a team improved, and they eventually became more
open and autonomous. They found the delivery of spiritual care as a reciprocal process
(McLaughlin and Shilling, 1994).

Clark and Heidenreich (1995) posed three open ended questions to sixty three
CCU patients regarding events which had created hope, meaning or purpose and what
nurses could due to contribute to these feelings. Three themes of nursing interventions
emerged. The establishment of trusting relationships, the provision of an in depth
spiritual assessment, and the conveyance of technical competency were requests of
patients. Additionally, many felt nurses should act as facilitator among family members,
clergy and other health care providers.
Clark et al (1991) questioned 15 adult Judeo-Christian Caucasian patients about any event during their hospitalization that contributed to their sense of well-being and provided hope for recovery. Approximately one third of the respondents claimed the nurses’ presence and caregiving activities such as attention giving, answering of questions, as well as their upbeat and encouraging attitude contributed most. When asked about the experiences, situations or relationships which would have helped their sense of well-being and hope during their hospitalization, nurses were cited as being important for demonstrating caring, compassion and empathy. Also cited were nurses’ risk to become emotionally involved and to share feelings with them and their families. Trust was fostered through a caring attitude, technical competence, touch and attention to the patient’s and family’s needs.

Other interventions promoting spiritual growth are availability, time to spend with the client and family, truth telling and answering questions, sharing of familiar experiences, and humor (Stiles, 1990).

Hall and Lanig (1993) investigated how self-professed Christian nurses perceived they integrate the religious aspect of spiritual care into their nursing roles. The degree of spiritual integration into nursing roles and comfort in the delivery of spiritual care was dependent on age and years holding personal beliefs and values. They also found spiritual caring occurred more often with colleagues and peers than with patients. Educators and preceptors tended to deliver fewer of the interventions to their students and peers, a factor attributed to the fear of imposing personal beliefs and values on others.
Hamer, a sufferer of myasthenia gravis, wrote of the most appropriate spiritual care nursing interventions. She suggested patients in crisis need nurses who offer hands, hugs, and words of comfort, as well as the ability to perform in a technically competent fashion. Interventions such as listening, talking, touching and laughing, when are appropriate were suggested. She recommended nurses should pray and witness with patients, and speak “the Lord’s language of love” as the needs of the sick are tended to.

Corrine et al (1992) suggested interventions for the female patient to become more relaxed and at ease with herself. Patient education about these interventions may be an appropriate plan. Activities such as sitting quietly, reading something meaningful, writing a letter, meditating on a loved one who may have died and engaging in self dialogue were some suggestions. Other practices which may bring about decreased anxiety and an increased sense of safety include the creating or performing a meaningful ritual and walking in a quiet place. In addition to guiding patients toward their own interventions, particular nursing interventions aimed at decreasing feelings of absence and emptiness include listening and accepting disturbing feelings in order to facilitate the expression of anger or sadness. It is also recommended for nurses to seek out community resources for patients, such as 12 step programs, priests, chaplains and other clergy men who may be available to see patients.

Reminiscence, the process of life review is another nursing intervention (Conrad, 1985; Forbis, 1988). This nursing intervention not only allows the patient to safely reminiscence, but requires the nurse to facilitate the process through appropriate questions, comments, and responses which carry the process in a particular direct. One basic premise of reminiscence therapy is that before events can be turned into meaning,
they have to be experienced. Therefore to reminisce offers a chance to give new
meaning or renew old meanings (Sherman, 1991). Other outcomes of reminiscing and
life review are adaptation to changes in life styles, improved coping skills, such as with
grief and depression from personal losses, enhanced levels of self-esteem, in the face of
declining physical and intellectual abilities, improved socialization skills, and a sense of
belonging and identity in the world (Coleman, 1986; Sherman, 1991). Reminiscence of
past religious ceremonies or rituals, milestones and significant life events can be
spiritually therapeutic (Conrad, 1985; Forbis, 1988).

Reminiscence therapy is an example of an intervention to help the patient
reconnect with life events. It helps them to assign meaning to life events, whether
pleasant or not. Writing diaries and journals are other examples of interventions directed
toward life review and cleansing. Diaries and journals are safe places for patients to
express fears, anger and any other feelings freely. Letter writing, while possibly being a
way to review one’s life, may also be an intervention toward maintaining and renewing
relationships, as well as proceeding toward forgiveness, if applicable (Dossey et al,
1995).

Story telling is another means of remiscing about successes, failures,
disappointments, sources of ride and plans. When someone reminisces with someone
who is present and concerned, whether it be a nurse or not, the patient’s values, hopes
and openness to the review process may take on new meanings (Dossey et al, 1995).

Recollection of times when the patient felt meaning and purpose in their life may
help to bring about renewed feelings of meaning and purpose. Questions directed toward
the changes which have occurred since the time when there was meaning and purpose
may be helpful. The nurse may expect responses such as the occurrence of illness, loss of job, friendship or a change in spiritual practices. Appropriate interventions include to help them discover ways to reinstate those elements in their lives which brought about feelings of meaning and purpose. The nurse may intervene with the patient who is unable to recall a time when they experienced meaning and purpose by supporting them as they face these feelings and encourage them to look for a source of meaning and purpose. Peterson and Nelson (1987) caution that these feelings are often very painful and this nursing intervention requires skill and team involvement. An assessment for suicide potential should be consider in the patent who expresses hopelessness and despair.

Music may intensify the patient's ability to reminisce. Music may hold special meaning and/or help foster uplifted spirits (Conrad, 1985) and foster a state of relaxation and openness (Benning and Savery, 1973). Music therapy is classified as a behavioral science concerned with the use of specific kinds of music to affect changes in behavior, emotion, and physiology. The use of music therapy can help reduce stress, pain, anxiety, and feelings of isolation (Schulbert, 1981). Music has proven useful in the treatment of many health problems (Aldridge, 1993; Bolwerk, 1990; Bruscia, 1992; Elliott, 1994; Frank, 1985; Guzzetta, 1989; Kerkvliet, 1990; Lucia, 1987; Prinsley, 1986; Schoor, 1993; Tyson, 1989; Updike, 1990; White, 1992; Zimmermann, 1988; Zimmerman, 1989). It has also been used to reduce stress and pain in hospitalized patients (Halpern and Savery, 1985), such as during childbirth, counseling, and physical therapy with multihandicapped children. Depending on the etiology of spiritual distress, music therapy is an intervention that may meet the goals of relief of spiritual distress or may compliment other
interventions used (Dossey et al, 1995). Music can also help patients to develop a more keen sense of self awareness, develop new ways of association, approach and consider current and past life events, become more creative, clarify of personal values, and cope with any variety of situations (Hampl, 1979). Increased awareness and creativity to aid in problem solving can be achieved when appropriate music is used to produce alpha and theta brain waves (Dossey et al, 1995).

Music thanatology, is a form of music therapy, but has some distinctly differentiating characteristics. This field of music therapy uses music to heal and aid patients toward a peaceful death. Death is recognized as a spiritual process and an opportunity for growth. The goals are solely palliative to address the needs of the dying, to aid in healing of the soul or inner life and not necessarily the body. Specially trained therapists use the media harp and their voices, to implement music thanatology. Music thanatology involves serious inner work for the caregiver with physical, emotional, mental and spiritual personal devotion, and affects the whole team of caregivers, patients and families (Schroeder-Sheker, 1994).

Creative movement, an intervention which may be coupled with music therapy, allows feelings of personal wellness to develop at a comfortable pace as one engages in personal expression through body movements (Boots and Hogan, 1981). Centering, in which an individual focuses inward on his or her own physical reality and engages in simple body movements, is a principle of relaxation lasting from three to ten minutes. A warm-up session follows the relaxation exercises, and can be done actively or passively, depending on the patient’s needs. The warm-up exercises, to establish internal boundaries and give patients an awakened sense of self-awareness, begin with upper
body movements and eventually involves movement of the lower body. Exercises can be done individually or in pairs, if desired. Visualization or imitation of purposeful movements, such as walking, enhance the benefits of the exercise. The rhythmic breathing, relaxation techniques and principles of body movement along with music, imagery, and nonverbal self-expression associated with creative movement promotes health, integration of self, positive self-image, and nutrition for the human spirit (Boots and Hogan, 1981).

Forbis (1988) suggested prayer as a key element in meeting spiritual needs and offering hope as a way to overcome loneliness. Forbis (1988) and Conrad (1985) agreed that shared prayer can be a source of strength as well as an affirmation of caring. Enhanced feelings of belonging and connection can result from prayer and the belief that our personhood is part of something much larger (Kahn and Saulo, 1994). Saudia et al (1991) studied the relationship between health locus of control and helpfulness of prayer as a direct-action coping mechanism in patients prior to having cardiac surgery. Findings suggested prayer was perceived as a helpful, direct-action coping mechanism in 96% of the sample, although no relationship was found between health locus of control and helpfulness of prayer.

Meditation offers some of the same results as prayer, although meditation is a receptive exercise, where prayer, affirmation and visualization are active processes. Medication requires quieting the mind and focusing on the present while releasing fears, worries and doubts (Dyer, 1992; Coleman, 1988; Kahn and Saulo, 1994;). People who meditate have been found to be calmer, more focused, and productive, while relying less on external events for happiness (Benson and Proctor, 1984).
There are a variety of meditation methods including breath meditation, where attention is focused on breathing, mantra medication, where a significant word or phrase can be used, music enhanced meditation and group meditation. Sacred places where people have prayed or meditated are often environments saturated with calm and peaceful feelings, bringing about peaceful and calm feelings (Kahn and Saulo, 1994).

Imagery is a process of mentally visualizing one’s external reality. Imagery involves all the senses, but primarily the visual sense to promote healing and relaxation. The patient can structure his or her own personal images to create the most soothing responses, or the nurse can guide the patient (Kahn and Saulo, 1994). Tone of voice and pacing must convey calmness, reassurance, openness, and trust. Therapeutic imagery is an intervention appropriate for treatment of spiritual distress and to promote spiritual well-being through relaxation, diminished feelings of isolation, increased personal value, and decreased perceptions of powerlessness and hopelessness (Dossey et al, 1995).

Rees (1993) examined the effectiveness of guided imagery in reducing anxiety and depression and increasing self-esteem in new mothers during the first four weeks postpartum. They found a decline in anxiety and depression and an increase in self-esteem in both the experimental and control groups over the four weeks, although the experimental group had more of a decline in anxiety and more of an increase in self-esteem than the control group. Thompson and Coppens (1994) examined the effects of guided imagery on anxiety levels and movement of patients undergoing nonemergency magnetic resonance imaging (MRI). The experimental group who listened to a guided imagery relaxation tape before their MRI scan and used guided imagery during their
scan, had lower levels of state anxiety than the control group. Less movement in the experimental group was also reported.

Use of humor, another nursing intervention, can ease tensions and open the avenue to discussions about serious and anxiety provoking subjects, while diminishing discomfort and promoting physical and emotional well-being (Groves, 1991; Dossey et al, 1995). When one is able to laugh at himself or herself, forgiveness for mistakes and failures is permitted, and vulnerability, which often strengthens a relationship is exhibited (Groves, 1991; Ruxton, 1988). Appropriate humor also allows articulation of ideas or feelings which, without humor, would be difficult if not dangerous to express (Nahenow et al, 1986).

Humor also facilitates learning, because when student (or patient) and teacher (or nurse) are both relaxed and open to exchange information in a caring environment, an element essential in spiritual nursing care delivery (Groves, 1991, Watson and Emerson, 1988). Tensions are eased with smiling, and relaxation promotes learning (Watson and Emerson, 1988).

Haig (1986) cited some destructive aspects to the use of humor in therapeutic situations. The patient may use humor to deny, repress or suppress conflicted areas of concern. Hostility may be concealed as the patient tries to gain acceptability from the nurse. The nurse may use humor as a way of attacking the patient in an manner which is not obvious. Sarcastic behavior is an example. Humor, if used excessively or before the relationship is mature, may lead the patient to doubt whether he or she is being taken seriously. Although the use of humor can be therapeutic, care must be taken to use this intervention without inadvertently causing harm.
Peterson and Nelson (1987) directed their paper toward the delivery of spiritual care to patients with psychiatric problems, although the interventions suggested are applicable to many. In order to guide the patient toward feelings of forgiveness, they recommended the nurse point out contradictions in the patient’s own beliefs, such as if they are able to forgive others, but not themselves. Referral to clergy or other health care providers may be helpful.

Patients expressing the lack of love and relatedness in their lives may have difficulty believing in their own worth and value, and have trouble maintaining long term relationships (Peterson and Nelson, 1987). Caring about and listening to the patient who expresses the lack of love in their lives is often the best intervention, because listening is an offering of worth and an expression of dignity and respect.

Intervening with the patient who experiences spiritual delusions requires care and often a referral to someone prepared to meet the patient’s needs. Pasquali et al (1985) recommend the conveyance of acceptance of the need for the delusion while expressing your own disagreement with the delusion. They also recommend to avoid arguments and instead incorporate reasonable doubt as a more appropriate intervention. When possible, connect the belief to the patient’s feelings and to respond to the essence or core of the delusion. Peterson and Nelson (1987) recommend any discussion about God or spiritual beliefs be done in a very concrete fashion, because delusional patients have trouble thinking abstractly.

Spiritual nursing interventions can take a variety of shapes. Thorough assessment of patient needs and desires, along with the nurse’s competence in teaching and
delivering the interventions are essential for success of treatment. Evaluation of the plan of care and nursing intervention is the next step of the nursing process.

**Evaluation**

The evaluation step of the nursing process is assigned for the nurse, health care providers, patient, and family, when applicable, to determine the effectiveness of the plan of care. Progression of long and short term goals are evaluated along with the effectiveness or ineffectiveness of nursing interventions prescribed and carried out (Alfaro, 1986). For instance, in the patient whose spiritual development was found to be a strength, it would be essential to evaluate if interventions were successful in promoting the direction of the patient’s spiritual development. Evaluation about the patient’s needs being met would also be evaluated. Any changes in the patient’s condition would contribute to the ongoing assessment and the nursing process.

This appendix has provided information regarding the nursing process and it’s use in the delivery of nursing spiritual care.
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