

EXPLORING THE RELATIONSHIPS BETWEEN AND AMONG REGISTERED NURSES'
SPIRITUAL WELL-BEING, SPIRITUAL CARE PERSPECTIVES, AND THEIR PROVISION
OF SPIRITUAL CARE IN ACUTE CARE SETTINGS

BY

BARBARA J. KITCHENER

Dissertation Committee

Dr. Jane Dellert, Chair

Dr. Bonnie A. Sturm

Dr. Donna Ho-Shing

Submitted in partial fulfillment of the
Requirements for the degree of Doctor of Philosophy in Nursing
Seton Hall University
2016

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Dedication

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Abstract

Despite acknowledgment that spiritual care is an essential aspect of holistic nursing care, nurses often feel ill-prepared for, uncomfortable with, and uncertain about providing spiritual care. Studies have indicated that nurses who have a strong sense of their own spiritual well-being and/or a positive perspective [attitude, value, belief] about spiritual care are more inclined to provide spiritual care to their patients. However there is a scarcity of such studies among acute care nurses. This descriptive correlational study aimed to explore relationships between and among acute care nurses' spiritual well-being (SWB), spiritual care perspectives (SCP), and their provision of spiritual care (SC) to hospitalized patients. The Spiritual Variable of the Neuman System Model provided a suitable framework for this study. Data were collected electronically via Survey Monkey[®] over a six week period from a convenience sample of acute care nurses ($n = 130$) through the Academy of Medical-Surgical Nurses. The Spiritual Well-being Scale by Paloutizan and Ellison (1982), the Revised Spiritual Care Perspective Scale by Taylor (2004), the Spiritual Care in Practice Questionnaire by Vance (2001), and a demographic/work-related survey were utilized for data collection. Participants in this study were primarily Christian (33.8%), or Catholic (31.5%), female, (90.8%), Caucasian (73.1%), average age 46.05 years, with a Bachelor's degree in Nursing as their highest educational qualification (61.5%). Most were employed in general medical-surgical units (63%) for an average of 14 years. Pearson's r analyses revealed significant positive relationships between the dependent variable (provision of SC), and the two independent variables—nurses' SWB ($r = .27, p = .002$), and SCP ($r = .63, p = .0001$). These findings indicate that nurses who possess a sense of high SWB, and a positive SCP (attitude) are more likely to provide SC to patients in acute care settings. Spearman Rho tests showed moderate to strong positive correlations

between and among the dependent variable and three demographic/work related variables, namely —commitment to personal spiritual practices ($r_s = .31, p = .0001$), confidence in providing SC ($r_s = .45, p = .0001$), and comfort in providing SC ($r_s = .40, p = .0001$) —signifying that nurses who were strongly committed to their spiritual care practices were also confident and comfortable in providing spiritual care and provided such care frequently to their patients in the acute care setting. Multiple regression analyses demonstrated that SCP was the best predictor of SC practices. The nurses' SCP (attitude) was also shown to have a significant mediating effect between the other predictors and provision of SC. Participants in this study understood that SC may involve non-traditional activities such as active listening and quiet presence. Findings from this study provide evidence that the nurse's SCP is a significant contributing factor to provision of SC among acute care nurses. There are implications and recommendations for further research studies, nursing education, clinical practice, and policy making.

Key Words: Spiritual well-being, spiritual care perspectives, provision of spiritual care, holistic nursing care, spiritual care practices in nursing.

Chapter I

THE PROBLEM

Introduction

A high percentage of Registered Professional Nurses (RNs) employed in the acute care setting are not proficient in providing spiritual care to their hospitalized patients with the comparable ease to which they administer care in the physiological, psychological, developmental and sociocultural domains. Clarke, Cross, Deane, and Lowry (1991) noted that nurses need to address spiritual care as systematically as they do other aspects of patient care. Spiritual care is an essential aspect of holistic care (Baldacchino, 2010; Fulton, 1995; Mitchell, Bennett, & Manfrin-Ledet, 2006; Ross, 1994). While nurses recognize their responsibility to provide holistic care, they also feel ill-prepared for, uncomfortable with, and uncertain about providing spiritual care to their patients (Baldacchino, 2006; Chism & Magnan, 2009; Gallison, Xu, Corrine, & Boyle, 2013; Hodge & Horvath, 2011; Lind, Sendelbach, & Steen, 2011; McBrien, 2010; Milligan, 2004; Shih, Gau, Mao, Chen, & Lo, 2001; Tiew, Creedy, & Chan, 2013; Wong, Lee, & Lee, 2008). These statements are drawn from studies on spiritual care perceptions, perspectives of spirituality, spiritual care competency, provision of spiritual care, spiritual empathy, and spiritual well-being among practicing nurses as well as nursing students at various levels of their educational journey from undergraduate through post graduate (Abbasi, Farahani-Nia, Mehrdad, Givari, & Haghani 2014; Baldacchino, 2006; Chism & Magnan, 2009; Chung, Wong, & Chan, 2007; Giske & Cone, 2012; Milligan, 2004; Stranahan, 2001).

Empirical studies on spiritual care perspectives, and spiritual perspectives were conducted among undergraduate nursing students (Baldacchino, 2006; Ross et al., 2014), palliative care nurses (Ronaldson, Hayes, Aggar, Green, & Carey, 2012), nurse practitioners

(Stranahan, 2001), nurses enrolled in a post graduate degree program (Milligan 2004), nurses working with institutionalized older people (Baldacchino & James, 2010), and oncology nurses (Musgrave & McFarlane, 2004; Taylor, Highfield and Amenta 1994). Chism and Magnan (2009) conducted a study among student nurses to examine their expressions of spiritual empathy and attitudes toward providing spiritual care. It should be noted that while some of these studies examined the nurses' *spiritual care perspectives* (i.e. attitudes, beliefs, and values pertaining to spiritual care) (Taylor et al., 1994), others were more concerned with the nurse's *spiritual perspectives*, which addresses the extent to which nurses consider the impact of spirituality on their lives and on their spiritually related activities (Reed, 1987).

Studies examining the effects of spiritual well-being and spirituality on provision of spiritual care were done among nursing students (Abbasi et al., 2014; Baldacchino, Boneello, & Farrugia, 2010), oncology nurses (Musgrave & McFarlane, 2004), and nurses from various specialties (Fisher & Brumley, 2008). The findings of studies on provision of spiritual care among nurses in acute care settings (Gallison et al., 2013; Ronaldson et al., 2012; Vance, 2001), health care professionals in three large clinics (Tanyi, McKenzie, & Chapek, 2009), and nurses in an acute and chronic hemodialysis setting (Deal & Grassley, 2012) further validate the trepidations nurses experience about including spiritual care in their practice. Empirical studies have also provided understanding of the spiritual care perspectives, spiritual well-being, spiritual care provision, barriers to providing spiritual care and competency among nurses who provide care in hospice, palliative, hemodialysis, and oncology settings (Astrow, Wexler, Teixeira, He, & Sulmasyetal, 2007; Deal & Grassley; 2012; Fisher & Brumley, 2008; McBrien, 2010; Musgrave & McFarlane, 20004; Ronaldson et al., 2012; Ross, 2006; Taylor, Highfield, & Amenta, 1994).

The studies among nursing students and clinicians caring for the terminally ill reveal that individuals with a high sense of their own spiritual well-being and/or positive spiritual care perspectives are more inclined to provide spiritual care to their patients. However, there is a noticeable absence of empirical studies aimed at understanding these variables among RNs in the acute care settings. This is highly disconcerting and cannot be disregarded because RNs comprise the largest segments of healthcare professionals in the acute care setting, and are the primary givers of nursing care assigned to provide care to the “whole person” around the clock. According to a recent *Nursing Fact Sheet* published by the American Association of Colleges of Nursing (AACN, 2015), nearly 58% of RNs currently work in acute care settings. .

There is agreement in the literature that nursing care is not truly holistic if care of the human spirit is not being administered routinely by RNs (Baldacchino, 2010; Burnhardt, & Nagai-Jacobson, 1985; Chung et al., 2007; Hodge & Horvath, 2011; Martsof & Mickley, 1997; Mitchell et al., 2006; Narayanasamy, 2006; Pesut, 2008; Stranahan, 2001; Tiew et al., 2013). Furthermore, the governing agencies and accreditation bodies have stated mandates regarding the relevance of spiritual assessment and spiritual care being incorporated into the patient’s plan of care (AACN, 2008; International Council of Nurses (ICN), 2006; American Nurses Association (ANA), 2001; The Joint Commission (TJC), 2009).

Spiritual care in nursing practice is defined as a complex interpersonal relationship between the nurse and patient that is intended to assist the patient in finding meaning, purpose and fulfillment in the face of illness, suffering, and death through the instillation of hope and encouragement of the patient’s belief and faith in God (or transcendent power), others, nature, art and/or self (Burkhart, Schmidt & Hogan, 2011; Ross, 1994). Burkhart and Schmidt (2012) noted that spiritual care is “not a list of assessment questions and prescribed interventions, but rather a

purposeful monitoring and compassionate responding to patient's spiritual needs toward greater meaning and hope” (p. 3).

Citing several studies, Chung et al. (2007) noted that the most frequent forms of spiritual care offered by nurses included: prayer, use of religious objects, talking with clergy, Bible reading, conveying a benevolent attitude, acceptance and non-judgmental attitude, listening, instillation of hope, touching, and being present. The findings of Milligan’s (2004) study of 59 Scottish nurses enrolled in a “post-registration program” were corroborated by the studies cited by Chung et al. (2007). The aim of Milligan’s study was to describe the perception of spiritual care among the nurses. When asked to give examples of perceived spiritual care that nurses could provide, the most common expressions were “listening” and “being supportive and comforting” (Milligan, 2004). Several responses fell into the category of “assisting in religious observation and meeting religious needs”, and “valuing/ supporting autonomy” (Milligan 2004, p. 166). The participants in this study perceived barriers to providing spiritual care as being insufficient time, inadequate training, and a lack of experience. In a later and much larger study ($n=271$) conducted by Gallison et al. (2013), acute care nurses in a major New York City hospital reported the greatest perceived barriers to providing spiritual care to their patients were: belief that the patient’s spirituality is private, insufficient time, difficulty distinguishing proselytizing from providing spiritual care, and difficulty meeting needs when spiritual beliefs were different from their own.

Numerous factors are associated with the inadequacy of nurses to provide spiritual care to their hospitalized patients. According to Stranahan’s (2001) study of spiritual care perspectives, attitudes, and spiritual care practice among 102 nurse practitioners, 58% of the participants felt that their education was inadequate in preparing them to provide spiritual care. Similar

sentiments were echoed by Chism and Magnan (2009) who studied 223 undergraduate and graduate level nursing students and noted that failures of nurses to provide spiritual care have been associated with (a) confusion about the nurse's role versus that of the chaplain in providing spiritual care, (b) nurses feeling unprepared to meet patient's spiritual needs, (c) lower levels of nursing education, and (d) nurses feeling uncomfortable about providing spiritual care.

Tiew et al.'s (2013) study reiterated Chism and Magnan's (2009) observation that barriers to nurses administering spiritual care included, limited educational preparation, negative attitudes toward spirituality, confusion about nurses' role, perceptions of incompetence, and avoidance of spiritual matters. Pesut (2008) noted that the lack of formal education resulted in spiritual needs being confused with psychological needs. Another well documented barrier to the provision of spiritual care is time constraints—nurses perceive that they do not have enough time to address their patient's spiritual needs. Moreover, they do not perceive themselves to be experts in providing spiritual care (McSherry & Draper, 1998; Pesut, 2008). Despite these challenges, the literature is very clear and consistent that provision of spiritual care is an integral aspect of holistic care and that nurses consider the provision of spiritual care to be within the purview of nursing and a pertinent part of holistic nursing care (Chism & Magnan, 2009; Chung et al., 2007; Gallison et al., 2013; Tiew et al., 2013).

There is evidence to support the hypotheses that the nurse's perception of his/her own spirituality will influence the purposeful assessment and monitoring of the patients' spiritual needs followed by compassionate intervention and integration of spiritual care in response to the spiritual needs identified (Chism & Magnan, 2009; Chung et al., 2007; Ronaldson et al., 2012; Tiew et al., 2013). In a study to evaluate the effects of a spiritual education session on pediatric nurses' perspectives on providing spiritual care, O'Shea, Wallace, Griffin, and Fitzpatrick (2011)

reported that even before 41 pediatric and neonatal nurses participated in a 30 minute spiritual care teaching session, there was a positive correlation between the nurses' perception of their own spirituality and their perspectives toward providing spiritual care. After the teaching session, the correlation between the variables was even stronger.

Chism and Magnan (2009) reiterated the correlation between nursing students' propensity toward providing spiritual care and their heightened sense of spiritual care perspective. The researchers' overarching purpose was to determine the extent to which nursing students' spiritual care perspectives accounted for their expression of spiritual empathy. It was noted that the student nurses' expression of spiritual empathy is a form of spiritual care and is an essential aspect of the nurse-patient interaction. The researchers noted that spiritual empathy occurs when the nurse verbally expresses an understanding of the patient's spiritual concern. The assertion was made that the extent to which a nurse may express spiritual empathy will depend on their own spiritual care perspective; this in turn will depend on the demographics and spiritual characteristics of the nurse. Findings from the study suggested that the provision of spiritual care in nursing practice depended, in part, on nurses clarifying their own spiritual care perspectives. It was also suggested that spiritual care perspective is the best predictor of expressions of spiritual empathy.

Similarly, Chung et al. (2007) studied 61 nurses enrolled in a part time Bachelor of Science (BSN) degree program in Hong Kong and reported that there was a significant correlation between "self" and the understanding and practice of spiritual care. van Leeuwen and Cusveller (2004) also noted the importance of nurses incorporating the awareness and use of self when providing spiritual care.

In a European pilot study of 531 student nurses' perception of spirituality and competence in delivering spiritual care, Ross et al. (2014) revealed that students felt marginally competent to provide spiritual care. Participants who were predominantly Christians reported high levels of spiritual well-being, a positive attitude, and involvement towards providing spiritual care. The study echoed previous findings that the nurse's spiritual well-being was a strong predictor to providing spiritual care. It is also documented that nurses who provide spiritual care also report a greater sense of job satisfaction, heightened spiritual intelligence, and increased empathy towards patients in spiritual distress (Baldacchino, 2008; Burkhart & Schmidt, 2012; Chism & Magnan, 2009; Yang & Mao, 2007).

Furthermore, according to Tovino (2005), 77% of American patients desire recognition of their spiritual needs, values, and beliefs and wanted those considerations to be incorporated into their medical plan of care. Phillips, Paukert, Stanley, and Kunik (2009) indicated that 90% of the general public in the western world expressed belief in a "higher power" and place great value on their spiritual well-being. Lind et al., (2011) drew similar conclusions from their study, noting that patients wanted to have their spiritual needs addressed while hospitalized. However, studies consistently demonstrate that only small percentages of nurses report that they provide spiritual care on a regular basis (Gallison et al., 2013; Ross et al., 2014; Stranahan, 2001; Vance, 2001).

Gallison et al.'s (2013) study describing the extent of registered nurses' awareness and preparedness to meet the spiritual needs of the hospitalized patient, and Vance's (2001) exploration of the relationships between acute care nurses' spiritual beliefs, system barriers, and delivery of spiritual care, are among the few studies of RNs in the acute care setting on this very pertinent topic. While studies have been conducted to examine the relationships between

spiritual care provision and the attitude, perspectives, beliefs and spiritual empathy of student nurses at differing stages of their educational trajectory (Chism & Magnan, 2009; Chung et al. 2007; Ross et al., 2014), no studies were found that investigated how acute care nurses' spiritual well-being and spiritual care perspectives might impact their provision of spiritual care.

Overview of Problem

Research findings reveal that there is an inverse, asymmetrical, and concurrent relationship between the hospitalized patient's level of anxiety and the quality of spiritual care given during times of sickness and distress (Baldacchino & Draper, 2001; Chung et al., 2007; Fulton, 1995; Levin, 2001; Phillips et al., 2009). These findings indicate that as the patient's spiritual needs are addressed, the patient will experience reduced levels of anxiety which will enhance shorter recovery time, and consequently, shortening hospital stay, reduce comorbidities such as hypertension and depression, increase patient satisfaction, and increase ability to cope with current illness (Gallison et al., 2013; Levin, 2001; Narayanasamy, 1999; Ross, 1994; Tuck, 2004; Wallace et.al., 2008).

Findings from studies conducted among RNs in hemodialysis (Deal & Grassley, 2012), nursing students at various levels of nursing education (Baldacchino, 2008; Burkhart & Schmidt, 2012; van Leeuwen, Tiesinga, Middel, Post, & Jochemsen., 2008; Chism & Magnan, 2009), and nurse practitioners (Stranahan, 2001) revealed that nurses who provided spiritual care reported a greater sense of job satisfaction, and increased sense of well-being. Respondents in Fisher and Brumley's (2008) study who reported a high sense of spiritual well-being believed that their patients received greater help from their services. Nevertheless, despite these advantages for patients as well as nurses when spiritual care was provided, feelings of incompetence and

uncertainties in providing spiritual care still prevailed among nurses (Greenstreet, 1999; Gallison et al., 2013; Lemmer, 2005; Stranahan, 2001; Vance, 2001).

An ethical dilemma arises within the profession when nurses have a known professional obligation to provide holistic care and most members of the profession are deficient in providing spiritual care. The ANA Code of Ethics (2001, 1.3) denotes that the measure of care given by nurses must enable the patient's spiritual well-being. Pesut (2009) pointed out that, "nurses have an ethical obligation to understand and to incorporate patients' spirituality into plans of care" (p.418). She further noted that the theoretical literature lacks discussions of health care decisions based on the patient's spirituality, and that little attention is given to navigating ethical dilemmas that result when there is conflict between the patients' spiritual beliefs and professional opinions.

The nurse's provision of spiritual care becomes even more critical when the professional code of ethics requires that nurses "promote an environment in which...spiritual beliefs of individuals are respected" (ICN, 2006), and members of the profession are ill-prepared in addressing the rudimentary spiritual needs of their patient based on the individual patient's spiritual belief. Moreover, the need to educate nurses to provide spiritual care has been included as a basic educational requirement as outlined in the most recent Baccalaureate Essentials (AACN, 2008). In seeking to adhere to this requirement, several Colleges of Nursing have either begun to incorporate spiritual care courses in the curriculum or to thread theoretical aspects of spiritual care throughout courses in the curriculum; however, not much is being done to address the spiritual competency needs of practicing nurses in the acute care setting (Burkhart & Schmidt, 2012; Lantz, 2007; Shih et al., 2001).

There are indications that now is the opportune time to implement spiritual care in-service training for registered professional nurses (RNs). These indications include: (a) a

growing consensus among scholars regarding the definition of spiritual care and the related terms (Chung et al., 2007); (b) the governing agencies and accreditation body have stated mandates and requirements regarding the relevance of spiritual assessment and spiritual care being incorporated into the patient's plan of care (AACN, 2008; ICN, 2006; ANA, 2001; The Joint Commission, 2009); (c) the presence of NANDA approved diagnosis for patients in spiritual distress (Ackley & Ladwig, 2006); and (d) the consistency of research findings that there is a perceived lack of competency among nurses in providing spiritual care (Fulton, 1995; Greenstreet, 1999; Gallison et al., 2013; Lemmer, 2005; Narayanasamy, 2006; Philips et al., 2009; Ronaldson et al., 2012; Ross et al., 2014; Stranahan, 2001; Vance, 2001). Moreover, there are reliable instruments for measuring various aspects of the nurse's spiritual well-being and spiritual care perspective, as well as instruments for evaluating the provision of spiritual care (Fisher and Brumley, 2008; Hungelmann et al. 1989; McSherry, 1997; Paloutzian & Ellison, 1982; Reed, 1987; Taylor, et. al., 1994; Vance, 2001).

Despite these strides in the development of the body of knowledge in spirituality and spiritual care in nursing, and while it might seem that now is the right time to make the quantum leap into providing wide scale spiritual care education for RNs employed in the acute care setting, there is a conspicuous need for empirical studies that explore the relationships between the RN's spiritual well-being and spiritual care perspective and how these variables may correlate with the provision of spiritual care to patients in the acute care setting.

Problem Statement

Studies conducted among nursing students at varying levels of their professional education as well as among RNs employed in providing care for patients in palliative care, hospice, oncology, long term care, hemodialysis, and critical care have indicated that nurses who

have a strong sense of their own spiritual well-being and possess a positive perspective about spiritual care are more inclined to provide spiritual care to their patient (Abassi et al., 2014; Baldacchino, 2008; Burkhart & Schmidt, 2012; Chism & Magnan, 2009; Deal & Grassley, 2012; Musgrave & McFarlane, 2004; van Leeuwen et al., 2008). However, still to be known is whether or not correlations exist between and among these factors (i.e.: nurse's spiritual well-being, spiritual care perspective, and provision of spiritual care) in nurses who are employed to provide direct patient care in the acute care settings.

Research Questions

Overarching Question: What are the relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in acute care settings?

Q1: Is there a relationship between acute care nurses' spiritual well-being and their provision of spiritual care to patients in acute care settings?

Q2: Is there a relationship between acute care nurses' spiritual care perspectives and their provision of spiritual care to patients in acute care settings?

Q3: Are there relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, select demographic factors and their provision of spiritual care to patients in acute care settings? (See Figure 1-1).

Q4: Are there relationships among acute care nurses' spiritual well-being, spiritual care perspectives and select demographic factors? (See Figure 1-2).

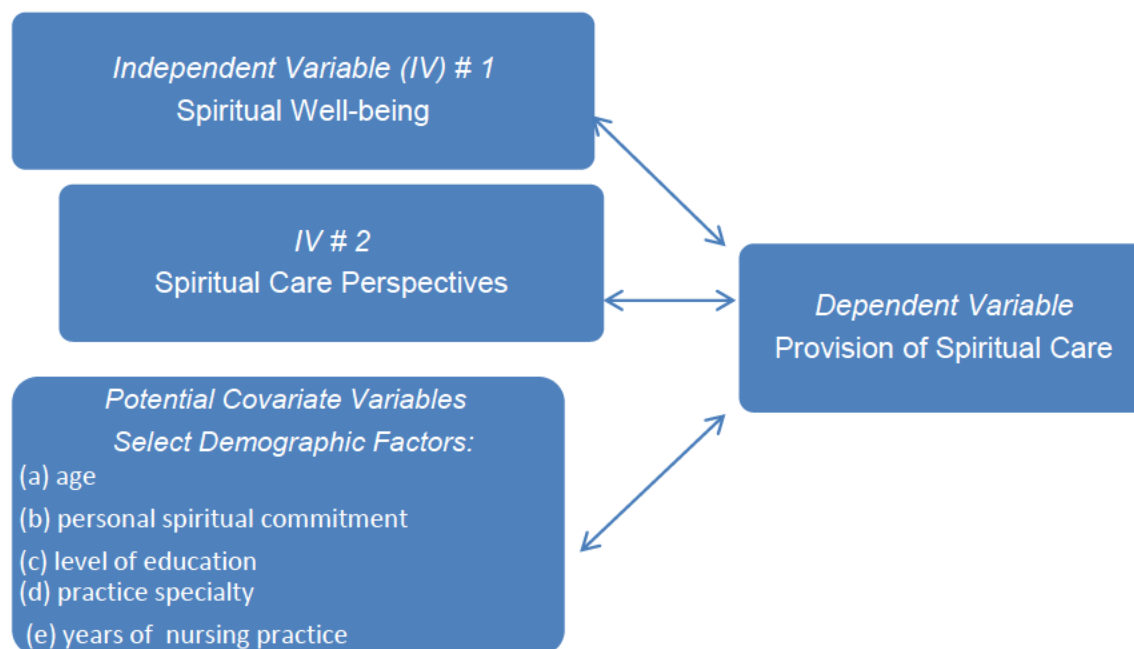


Figure 1-1: Relationships between and among independent and dependent variables.

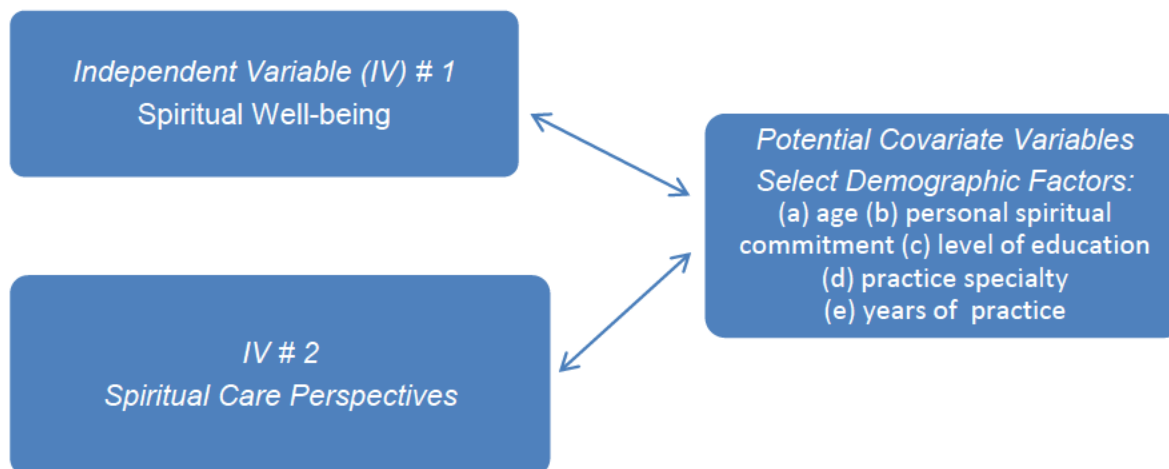


Figure 1-2: Relationships between and among independent variables and potential covariates.

Definitions

Spiritual Well-Being: Spiritual well-being is the gentle exuberance that emanates from the life of one who is engaged in a wholesome relationship with God, self, community, and

environment, and is revealed in a tendency to nurture and celebrate wholeness (Thorson & Cook, 1980 as cited by Chow, 2005). Individuals who exhibit a sense of spiritual well-being are able to add meaning, purpose, and value to life, and derive peace, harmony, and contentment (Doenges & Moorhouse, 1998) despite the difficulties and challenges of life.

In this study, spiritual well-being was operationalized by the score on The Spiritual Well-Being Scale (SWBS). This Scale is a 20-item instrument that was developed by Paloutzian and Ellison in 1982 to measure the general indicators of spiritual well-being. The instrument provides an overall measure of the perception of spiritual quality of life as well as subscale scores for religious and existential well-being (Paloutzian & Ellison, 1982).

Spiritual Care Perspective: Conceptually, spiritual care perspective is defined as the attitudes and beliefs nurses have regarding the provision of spiritual care in nursing (Chism & Magnan, 2009). The concept of spiritual care perspective was operationalized by the revised version of the Spiritual Care Perspective Scale (SCPS-Rv). This tool was developed by Taylor, et al., in 1994 and later revised by Taylor in 2004 to measure the nurse's attitudes toward providing spiritual care.

Provision of Spiritual Care: For this study, provision of spiritual care was conceptually defined as a one-to-one intervention between the RN and patient geared toward addressing the needs of the patient in spiritual distress. Provision of spiritual care is intended to facilitate the patient in finding meaning, purpose, and fulfillment in the face of illness, suffering, and death through the instillation of hope and encouragement of belief and faith in self, others, and God or a power that transcends self. Spiritual care may range from facilitating the patient's request for formal religious activities such as prayers and reading of sacred writings to just listening with an open heart to the patient's concerns (Brown, Whitney, & Duffy 2006). The Spiritual Care in

Practice Questionnaire (SCPQ) Part I, developed by Vance (2001) was used to operationally measure the concept of spiritual care. This instrument measures the frequency of assessment and interventions related to spiritual practice.

Registered Nurses (RNs) in Acute Care Settings: Registered Nurses (RNs) in Acute Care Settings were defined as individuals who possess a current license to practice the profession of nursing, and whose job descriptions require provision of direct nursing care services to adult patients who are admitted to an acute care hospital. RNs who provide critical care to patients admitted to an acute care facility were also included in this definition. It should be noted that within most acute care hospitals there are several critical care units, and that according to the American Association of Critical Care Nurses, thirty seven percent (37%) of all nurses employed in hospitals are critical care nurses. Critical care units include all adult, pediatric and neonatal ICUs, cardiac catheterization laboratories, emergency departments, telemetry, cardiac care, progressive care and post- anesthesia care units (<http://www.aacn.org> – About Critical Care Nursing).

Delimitations

This study was limited to English speaking RNs who were employed full-time, part-time, per-diem, or via agency to provide direct care to adult patients in the acute care setting of multiple health care organizations. RNs employed exclusively in hospice, palliative care and long term care facilities were excluded from this study. These inclusion and exclusion criteria were based on a gap in the literature that alludes to evidence showing that RNs employed in hospice, palliative and chronic care have strong tendencies to routinely provide spiritual care to their patients in end-of-life situations (Ronaldson et al., 2012; Ross, 2006; Taylor et al., 1994).

Basic Assumptions

The study proceeded from three basic assumptions: 1) spiritual care is an essential component of holistic care in so much that nursing care is not truly holistic if spiritual care is not routinely offered; 2) nurses should be able to provide spiritual care with comparable confidence and competence to which care in the physiological, developmental, sociocultural, and psychological domains is provided; 3) an ethical breach occurs when nurses have a known professional responsibility to provide holistic care and spiritual care and it is not provided.

Theoretical Rationale

The Spiritual Domain of the Neuman System Model (Neuman, 1995) (Appendix A) provided an appropriate framework for this study. This model was most fitting because it views the client as an open system consisting of five interrelated domains: physiological, psychological, developmental, sociocultural and spiritual. The Model further offered a careful definition of the spiritual domain, while explaining the relationship between that domain and wellness, insisting that considerations of the spiritual domain are necessary for truly holistic client care. Neuman also underscores the concept of a holistic client approach, with the understanding that spiritual development empowers the client towards well-being by providing spiritual energy for use by the mind and body, explicitly stating that the human spirit controls the mind and the mind controls the body. Additionally, the Model implies that careful assessment of the client's spiritual needs followed by purposeful interventions (i.e., spiritual care) will foster hope, and mitigate anxiety (Neuman, 2002).

In seeking to gain an understanding of the relationships among the nurse's spiritual well-being, spiritual care perspectives, and provision of spiritual care, the assumptions posited by Neuman provided the theoretical foundation for an evaluation of the nurse's perspectives on the

provision of spiritual care as well as ensured a supportive underpinning for exploring the link between the RN's spiritual well-being, spiritual care perspectives, and the provision of spiritual care. The Model provided a suitable lens for exploring the nurse's viewpoints regarding the provision of spiritual care in relation to his/her spiritual well-being and spiritual care perspective, allowing for the careful assessment of the patient's spiritual needs and for the integration of purposeful intervention. Drawing on other aspects of the Neuman System Model was not needed or directly relevant to this study.

Significance of Study

The need for spiritual care is a basic human requirement irrespective of one's age, life situation, spiritual development, ethnicity, socio-economic status, or cultural background (Ronaldson et al., 2012; Ross, 2006; Stranahan, 2001; O'Shea et al., 2011). So basic is the need for spiritual care as an intervention for patients in spiritual distress that the major healthcare accreditor (TJC, 2009), and the prominent professional nursing associations and councils—nationally and internationally (AACN, 2008; ICN, 2006; ANA, 2001) have insisted on the spiritual assessment of all patients and the inclusion of spiritual care into the patient's plan of care.

The need for spiritual care comes to the forefront whenever and wherever people are faced with cataclysmic disasters (Shih et al., 2001). This need is apparent in the outcry for prayer, declarations of national days of prayer, lighting of candles, outpouring of human caring, kindness, tokens of love and material gifts from neighbors, friends, government official, private and religious sectors. In recent history such applications were evident in the face of catastrophes such as the 1999 Columbine Shooting, the 9-11 attacks on the World Trade Center in 2001, the earthquake of 2010 in Haiti, the tsunamis that killed thousands in Japan (2011) and Indonesia

(2006), the 2012 Newtown massacre of 20 school-aged children in Connecticut, the Boston Marathon bombing of 2013, and the April 2015 Nepal earthquake that killed over 9,000 people.

Concurrently, over the past two decades there has been a resurgence of the consensus among nurses and other healthcare professionals that spiritual care is an important component of basic holistic care (Burnhardt & Nagai-Jacobson 1985; Chism & Magnan, 2009; Chung et al., 2007; Deal & Grassley, 2012; Hodge, 2006; Lantz, 2007; Mitchell et al., 2006; Ronaldson et al., 2012; Ross, 2006). However, despite The Joint Commission's (2009) requirement for a spiritual assessment of all patients, and notwithstanding organizational mandates for the provision of spiritual care in various healthcare settings, it is evident that many healthcare professionals have not been well-informed regarding the practical application of providing spiritual care to their acutely ill patients (Giske & Cone, 2012; Ross, 2006; Tiew et al., 2013; van Leeuwen et al., 2008). This is particularly true of nurses who were employed in the acute care setting (Gallison et al., 2013; Ronaldson et al., 2012; Vance, 2001). While many studies on spiritual care and the related topics have been conducted among RNs who provided care to patients who were chronically, critically or terminally ill, there remains a dearth of empirical studies that explore the linkages among acute care nurses' spiritual well-being, spiritual care perspective, and their provision of spiritual care to patients in the acute care environment.

Studies have consistently indicated that as patients' spiritual needs were addressed, patients experienced better outcomes and required shorter lengths of stay in hospitals (Burkhart et al., 2011; Levin, 2001; McSherry & Jamieson, 2011; Ronaldson et al., 2012). Considering that the average cost per inpatient day in the USA ranges from \$1,628.00 to \$2,088.00 (Gordon, 2014), shorter length of stay for hospitalized patients related to purposefully addressing their spiritual needs could result in a significant reduction of healthcare spending. Furthermore, for

this same reason, since the early 1990s, health maintenance organizations (HMO) have also taken a keen interest in the matter of spiritual care (Hilts, 1995).

With full acknowledgement of the benefits and significance of spiritual care to patients, and fortified with knowledge from empirical studies aimed at exploring the relationships between acute care nurses' spiritual well-being, spiritual care perspective, and their provision of spiritual care, nursing scholars and researchers may be better able to develop educational programs and competencies geared at equipping acute care RNs with the skills and confidence needed to incorporate spiritual care in routine patient care.

Chapter II

REVIEW OF THE LITERATURE

This chapter presents an overview of the Spiritual Variable of the Neuman System Model and discusses how this Model provided a framework for studying the nurse's spiritual well-being, spiritual care perspectives, and the provision of spiritual care in the acute care environment. A review and critique of research studies related to the variables are provided.

A search of the theoretical and conceptual nursing and health care literature was conducted through the library of two major universities using the databases EBSCO, Proquest, Med-Line, Cumulative Index for Nursing and Allied Health (CINAHL), and Google Scholar. Initially, the following search terms were used: "spirituality in nursing," "spiritual care in nursing," and "spiritual care in healthcare." The yield from these terms presented numerous peer reviewed articles and systematic reviews on a wide array of related subjects such as theoretical descriptions and discussions on spiritual care among nurses, social workers and medical doctors who are employed in hospice care, palliative care, long term care, critical care, and behavioral health environments. Few empirical articles were located, and no studies related to spiritual care in the acute care setting were found. A refinement of the search using the key terms "spiritual well-being of nurses," "nurses attitudes towards spiritual care," "acute care nurse's perspectives of spiritual care," "spiritual perceptions among nurses," and "provision of spiritual care" yielded a large volume of theoretical and empirical articles on those subjects; however studies done among nurses employed in the acute care setting were scant. A total of 64 empirical studies published from 1985 to 2014 are included in this review of the literature.

Development and Major Assumptions of Neuman System Model

The Neuman System Model is based on principles derived from von Bertalanffy's General System Theory. Inherent in the General System Theory is the concept that all elements within an organization are interacting, and that open systems are identified by repeated cycles of input, throughput (process), and output (von Bertalanffy, 1968). "Based on the open systems theory, variables are interrelated and organized in various patterns that serve as sources of system input and output alike" (Neuman, 2002, p. 11). Neuman viewed the client as an open system consisting of five interrelated variables or sub-systems—namely, physiological, psychological, developmental, sociocultural, and spiritual. She asserted that the term "the client as a system" can be used to represent an individual, a family, group, community, social issue, or "even the universe" (Neuman, 2002, p. 11).

Other major concepts of the Neuman Systems Model were drawn from Neuman's own philosophical beliefs and clinical nursing experiences as well as various philosophical perspectives. These include: (a) Gestalt theory which indicates that through the process of homeostasis an organism can maintain equilibrium and health; (b) philosophies of deChardin regarding the wholeness of life, and Marx, suggesting "that the properties of parts are determined partly by the larger whole within dynamically organized systems" (Freese, 2002, p. 300); (c) Selye Stress Theory which defines stress as the nonspecific response of the body to stressors, noting that stressors do produce tension which may be positive or negative; and (d) Caplan's conceptual model which explicates the primary, secondary and tertiary levels of prevention.

Neuman further conceptualized that each subsystem within the *client system* is surrounded by concentric rings, referred to as the *flexible line of defense*, the *normal line of defense*, and the *lines of resistance*. These lines serve to protect the *basic structure* or *core* [i.e.

the client system] from stressors, thus maintaining a state of wellness within and between the previously mentioned five interrelated subsystems (physiological, psychological, developmental, sociocultural and spiritual). Wellness in each subsystem is viewed on a “continuum of available energy to support the system in an optimal state of system stability” (Freese, 2002, p. 306).

Spiritual Domain of the Neuman System Model

The spiritual domain (Appendix A) was added to the Model in 1989, and later expanded and clarified in 1995 (Fulton, 1995). Neuman viewed the spiritual domain as an innate component of the client system that may or may not be acknowledged or developed by the client (Neuman, 1995). The Model established that the spiritual domain permeates all other domains of the client system and exists on a continuum from complete unawareness (and even denial of one’s spiritual domain) to a highly developed spiritual understanding that supports optimal wellness, and may ultimately have an impact on the wellness and illness outcome of the client (Neuman, 1995).

In providing a theoretical explanation for the spiritual domain, Neuman (1995) presented the proposition that each person is born with a spiritual energy force within the spiritual subsystem. Using the analogy of the *seed* which contains an enormous energy potential to represent the spiritual energy force which is housed within the spiritual domain, she explained that the spiritual domain lies on a continuum from dormant or undeveloped to recognition and highly developed. The spiritual domain that is well recognized and highly developed can bring a positive energy force with the power to positively influence one’s state of mind and body. Similarly, the underdeveloped or unrecognized spiritual domain will convey a vague or negative energy force with the power to negatively influence the individual’s state of mind and body.

With suitable environmental catalysts such as timing, warmth, moisture and nutrients, the *seed* will burst forth with transforming energy into a living form and, as it becomes nourished and developed, will offer itself (to others) as sustenance, generating power to help others to the extent that its own positive energy source is maintained (Neuman, 1995). Neuman explained that like the seed, the “human spirit combined with the power of the Holy Spirit” (Neuman, 2002 p. 16) when catalyzed by either joyful or critical life events, will burst forth with transforming energy that is manifested through recognizable physical and mental expressions such as empathy, kindness, harmony, contentment, understanding, compassion and love (Neuman, 2002). As the individual’s thought processes are positively affected, the mind and body are nourished and sustained through positive use of *spiritual energy empowerment*. Neuman referenced studies which have demonstrated “that joyous thoughts enhance the immune system” noting that “the opposite is also true with a negative outcome for the body” (Neuman, 2002, p. 16). In a summary of well documented empirical studies, Levin (2001) presented several evidence based findings which demonstrated that individuals whose spiritual domain is even slightly recognized and developed, live longer healthier lives. Conversely, if the spiritual domain is unrecognized and underdeveloped by the individual, its power for positively impacting the body or mind may be vague and ineffective (Neuman, 2002).

Concerns Related to Spiritual Domain of Neuman’s Model.

It should be noted that some of these theoretical propositions present concerns regarding limitations of the theory. Proposing that individuals who deny their spiritual domain may experience negative health implications would seem to indicate that atheists in general cannot live healthy lives. Neuman has postulated that in varying degrees, spiritual development can empower an individual toward well-being by positively directing energy that can be used by both

the mind and the body. Neuman's description of the spiritual domain is rooted in a relationship with "the God Source" and of the human spirit combining with the "Holy Spirit as a gift from God," (Neuman, 2001, p. 16). However, it should be noted that from an existential perspective, Burkhardt and Nagai-Jacobson (1985) defined spirituality as that which gives meaning to life, pointing out that spirituality may or may not be expressed in traditional religious language or practices. Murray and Zentner (1989) elaborated on this perspective by stating, "...spirituality is a quality that goes beyond religious affiliation that strives for inspiration, reverence, awe, meaning and purpose, even in those who do not believe in any God" (p.257). Other expressions of existentialism may be realized in nature, art, music, love of animals, pets, loved ones and/or self (Burkhart et al., 2011; Ross, 1994). Tanyi et al. (2009) pointed out that other non-religious ways of communicating spirituality may include use of exercise, yoga techniques, and helping others who are ill or disadvantaged. Additionally, conveying a compassionate, caring and non-judgmental attitude is regarded by some experts as validations of spiritual considerations (Chung et al., 2007; Milligan, 2004; Tanyi et al., 2009).

Major Assumptions of Neuman's Model Adapted to Spiritual Domain.

Fulton (1995) particularized the concepts related to the spiritual domain by analyzing and superimposing the terms "*spiritual dimension*", "*spiritual well-being*", "*spiritual care*" and "*spiritual distress*" onto the major assumptions of the Neuman System Model (see Appendix B). This adaptation of the Model is based on the notion that there is a spiritual component with spiritual needs that is common to every client system or individual. If these needs are met, the client will experience a sense of spiritual wellness or spiritual well-being; contrariwise if the spiritual needs are not met, stressors may result in spiritual distress which may penetrate the spiritual flexible line of defense, normal line of defense, and lines of resistance leading to

possible energy reduction and depletion within the spiritual domain. Fulton (1995) categorically noted that “spiritual care as primary prevention can strengthen the flexible line of defense to retain optimal wellness” (p.79). Furthermore, if the lines of defense and resistance were penetrated, provision of spiritual care at the secondary and tertiary levels of prevention might result in stabilization and reconstitution of these lines resulting in the client demonstrating behaviors of optimal spiritual well-being (Fulton, 1995).

Theoretical Overview of Spiritual Well-Being in Nursing

Although the wellness continuum described by Neuman (2002) is not specific to the spiritual domain of the Model but may be applied to each sub-system individually or collectively, it provides further support for the assertion that one person’s measure of spiritual well-being may be more optimal than that of another person’s. This research study was guided by what Neuman theorized to be the spiritual domain, with the *client as system* being represented by the registered nurse.

Neuman’s explanation for the positive linkage between the degree of spiritual development and the ability to access spiritual energy as an inner resource has striking similarities to the relationship suggested in this study between spiritual well-being and the behavior exhibited by individuals who have acknowledged and developed their spiritual domain. The Model undergirds the stated notion that in general, some individuals will score higher than others on the Spiritual Well-being Scale (SWBS); in particular, nurses who have a strong sense of their own spiritual domain will score higher on the SWBS than nurses whose spiritual domain is still unrecognized or underdeveloped. The Model implies that nurses whose spiritual domain is well developed will be more apt to empathize with, and provide spiritual care to patients who are in spiritual distress.

This study's definition of spiritual well-being is in part grounded in an understanding of the description of Neuman's Spiritual Domain. There is congruence between Neuman's analysis of "the catalyzed human spirit with its physical and mental expressions" (Neuman, 2002, p.16), and this study's definition of SWB as the gentle exuberance that emanates from the life of one who is engaged in a wholesome relationship with God, self, community, and environment (Thorson & Cook, 1980, as cited in Chow, 2005). The relationship between God and the individual is categorically demonstrated in Neuman's Model as the person's spiritual domain which "combines with the Holy Spirit" (Neuman 2002. p. 16) whether in a joyful situation to celebrate wholeness (Thorson & Cook, 1980, as cited in Chow, 2005), or in a perilous event, to nurture, add meaning and derive peace, harmony, and contentment (Doenges & Moorhouse, 1998). The ability to celebrate wholeness and/or add meaning and derive peace despite the difficulties associated with the event is the hallmark of a person's spiritual well-being. This age old concept is expressed in the writings of the Apostle Paul who having endured severe hardship, was later inspired to write that "the Father of all comfort, comforts us in all our tribulations so that we can comfort others....with the same comfort that God has given us" (2 Corinthians 1:4, NIV).

Neuman compared the *seed* and the spiritual domain, noting that given optimal conditions, the seed will be transformed into a living form, and that with further nourishment and development it will eventually offer sustenance [to others] (Neuman, 2002). This analogy is tantamount to the "wholesome relationship with self, community, and environment" expressed in this study's definition of spiritual well-being. The parallel is apparent when an individual experiences delightful as well as perturbing life events and is nurtured and strengthened by the experiences of those events. Implicitly, despite the trials and crises, people who enjoy a

wholesome relationship with self (or high level of spiritual well-being) will find inner strength to “burst forth with transforming energy” (Neuman, 2002, p.16) and with renewed courage, will effectively cope with the difficult situation. Given the necessary support and encouragement, that individual will continue to develop inner resolve and will eventually be in a position to help others find hope, comfort, and meaning in the midst of their adverse situations. By the same token, individuals who enjoy “wholesome relationship with their community and environment” will be spiritually sustained by those entities during times of pain, distress and catastrophic life events. This positive exchange between the individual’s spiritual energy force and the community and/or environment will be enhancing to the individual’s spiritual well-being. The reverse may also be true, in that if there are upheavals in the community or environment, an individual with a high sense of spiritual well-being might be able to help that community find meaning, comfort and hope, even in the face of cataclysms. Contrariwise, individuals whose spiritual domain is undeveloped may lapse into severe spiritual distress in the face of personal trials, community distresses, or in the event of environmental disasters. Based on the open system interrelatedness and the energy exchange between the individual and the community, the spiritually well community (despite its distressful situation) will offer hope and comfort to the spiritually distraught individual (Neuman, 2002).

Similarly, nurses with interconnected relationships between their patients and other healthcare disciplines are engaged in a constant exchange with the entire healthcare system. In Neuman System Model, an individual may be regarded as an open system or *the client system* that is in dynamic, constant energy exchange with the environment. Comparable to other systems, the client system will experience repeated cycles of input, throughput (process), and output, which will serve as feedback for further input. This aspect of the Model is most fittingly

applied when considerations are given to the nurse-patient relationship as an open system. The nurse who has a steady, positive input into his/her spiritual domain and is being nurtured and developed via a relationship with God, self, community and/or environment (Thorson & Cook, 1980, as cited in Chow, 2005) will be more inclined towards an optimal measure of spiritual well-being. The process or throughput might be evident by the gentle exuberance that emanates from that nurse's life, and the output expressed in the provision of spiritual care. As Doenges and Moorhouse (1998) pointed out, individuals who exhibited a sense of spiritual well-being were able to add meaning, purpose, and value to life while they derived peace, harmony, and contentment despite the difficulties and challenges of life. Thorson and Cook (1980, as cited in Chow, 2005, p. 80) reiterated that such a state of spiritual well-being is defined by "the affirmation of life in a relationship with God, self, community and environment that nurtures and celebrates wholeness."

In explaining these four relationships (i.e.: with God, self, community, and environment), Fisher and Brumley (2008) pointed out that (a) the association with God or the transcendental domain involves the "relationship of self with something or some-One beyond the human level i.e.: ultimate concern, cosmic force, transcendent reality or God (p.50);" (b) the sphere of self or the personal domain, has to do with one's intra-relatedness with "oneself with regards to meaning, purpose and values in life" (p.50); (c) the realm of community or the "communal domain," is expressed in the quality and depth of interpersonal relationships between self and others relating to morality, culture, and religion. "These are expressed in love, forgiveness, trust, hope and faith in humanity" (p. 50); and (d) the "environmental domain is moving beyond care and nurture for the physical and biological to a sense of awe and wonder; for some people it is the notion of unity with the environment" (p. 50). Since one goal of the nurse in Neuman's

Model is to assist patients to attain and maintain system stability by promoting health and wellness, then nurses should be encouraged to develop their states of spiritual well-being thus placing themselves in a position to be nurturers who will celebrate wholeness in their own lives as well as in the lives of the patients they are called to care for.

Empirical Studies of Spiritual Well-Being

Several studies have investigated the concept of spiritual well-being in various populations of nurses as well as people from diverse backgrounds. This concept has been studied among college students (Hammermeister, Flint, El-Alayli, Ridnour, & Peterson, 2005), athletes (Ridnour & Hammermeister, 2008), women with breast cancer (Mickley, Soeken, & Belcher, 1992), social work students (Kamya, 1994), and business executives (Fernando & Chowdhury, 2010). Findings from these studies demonstrated that subjects who scored high on spiritual well-being also fared well in other enhancing qualities such as coping skills, life satisfaction, and ethical orientation. Studies among nurses have demonstrated similar findings. In the most recent systematic review of 80 nursing research studies on the topic of spiritual care published between 2006 and 2010, Cockell and McSherry (2012) noted that there is evidence to support the notion that nurses who are more developed in their spiritual domain will score higher on spiritual well-being, and are more apt to provide spiritual care than their counterparts who are less spiritually developed.

Instruments Used to Measure Spiritual Well-Being

A review of the related literature indicates that the Spiritual Well-being Scale (SWBS) by Paloutzian and Ellison (1982) was the most frequently used instrument to operationalize the concept of spiritual well-being. In addition to Paloutzian and Ellison's SWBS, the JAREL SWBS, and other instruments such as the Functional Assessment of Chronic Illness Therapy-

Spiritual Well-Being (FACIT-Sp), and the Spiritual Well-being Questionnaire (SWBQ) have been used to measure SWB in populations of college students and faculty, patients with chronic illnesses, the elderly, adolescents, and athletes.

Spiritual Well-being Scale (SWBS) by Paloutzian and Ellison (1982). The SWBS developed by Paloutzian and Ellison in the early 1980s was used to measure the concept of spiritual well-being in this study. This scale was drafted in response to a growing interest in quality of life and subjective well-being in the United States (Bufford, Paloutzian, & Ellison, 1991). The Spiritual Well-Being Scale (SWBS) is a 20-item self-report instrument with two subscales: the Religious Well-Being Scale (RWBS) and the Existential Well-being Scale (EWBS). The RWBS contains 10 items which refer to God and measure one's connectedness with God/Transcendent Being. The Existential Well-Being (EWBS) has 10 items which measure one's interrelations with others, the environment, community and self (i.e. one's sense of life purpose and life satisfaction). The RWBS, EWBS, and SWBS have good reliability. The test-retest reliability coefficients across four studies for the RWBS ranged from 0.88- 0.99, for the EWBS 0.73-0.98, and for the total SWBS the coefficients ranged from 0.82-0.99 (Bufford et al., 1991).

Researchers have reported a "ceiling effect" in the total scores of the SWBS, especially among Christian participants (Bufford et al., 1991; Genia, 2001). A "ceiling effect" occurs when a large concentration of the study participants scored the maximum or near maximum score limits (Hessling, Traxel & Schmidt, 2004). Bufford et al. (1991) noted that because of ceiling effects, the SWBS is not able to distinguish among people scoring above the median (50th percentile) especially in evangelical Protestant populations samples. Ellison and Smith (1991) pointed out that the SWBS has been used in over 300 research endeavors globally in various

populations from health care professionals to patients with chronic illnesses, and among people who rate themselves as Christians or non-Christians. Irrespective of the population, the scale has consistently demonstrated its validity and reliability in measuring the concept of spiritual health. Genia (2001) examined the psychometric qualities of the SWBS in a study of college students from diverse religious background, with specific focus on addressing the possible ceiling effects in the total SWBS and the factorial structure of the scale. Findings revealed that the differential patterns of correlation between the two subscales suggest that the RWBS and the EWBS are two distinct constructs, and that there were significant ceiling effects for the total SWBS, especially among Christian respondents.

In a study examining the relationships between gender and spiritual well-being, Hammermeister et al. (2005) used the SWBS to assess the spiritual well-being of 435 college students (males=172, females =263) in the Pacific Northwest region of the USA. Results revealed that females scored higher on the SWBS. For this study the Cronbach's alpha for the SWBS =0.89, with both subscales demonstrating strong reliability, (RWBS alpha =.95; EWBS alpha =.83). Ridnour and Hammermeister (2008) also reported very good reliability and internal consistency of the SWBS (alpha coefficient = .92) from a sample of university athletes ($n = 142$) who participated in a study to examine the relationship between spiritual well-being and coping skills in athletes. The study explored the hypotheses that spiritual well-being may have a positive influence on athletic coping skills. Results from this study showed that athletes who scored higher in spiritual well-being also demonstrated better athletic coping skills.

Fehring, Brennan, and Keller (1987) also used the SWBS to operationalize the concept of spiritual well-being in a study to investigate the correlations between spiritual well-being and psychological mood states among freshman nursing students ($n=95$), and college students

($n=75$). Mickley et al. (1992) used the instrument in a study aiming to clarify spiritual well-being, religiousness, and hope among women with breast cancer ($n =175$). Findings showed that patients who classified as intrinsically religious had significantly higher scores on SWB than did those who classified as extrinsically religious, hope was positively correlated with SWB, and that existential well-being was the primary contributor of hope. The SWBS was utilized by Kanya (1994) in an examination of the relationships between hardiness and spiritual well-being in graduate level social work students ($n =105$). Cronbach's alpha coefficient of .59 for the EWBS and .90 for the RWBS were reported for this study. In a Northeastern university, Anema, Johnson, Zeller, Fogg, and Zetterlund (2009) used the SWBS to measure spiritual well-being in individuals with fibromyalgia syndrome. The researchers noted that, "internal consistency of the SWBS is strong ($\alpha = 0.89$ for the SWBS, 0.78 for the EWBS, and 0.87 for the RWBS)" (p 14); however they did not present the reliability scores as it related to the study they conducted.

JAREL Spiritual Well-being Scale. The JAREL Spiritual Well-Being Scale was developed by Hungelmann, Kenkel-Rossi, Klassen, Stollenwerk (1996) as an assessment tool to provide guidelines for the formulation of a nursing diagnosis on spirituality in older adults. The scale has 21 questions, 11 of which focus on the self, four on others, five on the transcendent, and one which does not appear to fit into any spiritual domain. Moodley, Esterhuyse, and Beukes (2012) pointed out that although the model of spiritual well-being reflecting harmonious interconnectedness to Transcendent Being, self, others, community, and environment contains a reference to "Nature," the JAREL SWB Scale contains no reference to nature or the environment. Although this instrument was initially designed to measure SWB in geriatric patients, it has been used to assess SWB among different populations in various studies.

Fulton (1992 as cited in Baldacchino et al., 2010) tested the JAREL SWB scale on two groups of baccalaureate nursing students ($n=225$) and faculty members ($n=41$) between the ages of 19 and 64 years old and confirmed the reliability of the instrument, reporting a Cronbach's $\alpha = 0.81$. Using three different translations of the JAREL SWBS, Baldacchino et al. (2010) also tested the scale on three cohorts of nursing students ($n = 140$) between ages 22 and 24 years old. The reliability of the scale remained consistently strong despite versions of the instrument being administered in English, Maltese, and its original language of Dutch; with Cronbach's α of .82, .77 and .79 respectively. The JAREL SWB scale has also been used to measure the concept of spiritual well-being in other research populations with consistent reliability measures (Boland, 2000; Marsh, 1993; Yeh and Bull, 2009).

Other instruments for measuring spiritual well-being. Brady, Peterman, Fitchett, Mo, and Cella (1999) employed the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being (FACIT-Sp) to measure spirituality in a sample of ethnically diverse patients with cancer ($n = 1610$). The instrument, consisting of 12-items (Cronbach $\alpha = 0.87$), was designed to measure aspects of spirituality such as a sense of meaning in one's life, harmony, peacefulness, and a sense of strength and comfort derived from one's faith (Fitchett et al., 1996 as cited in Brady et al., 1999). Findings from Brady et al.'s (1999) study revealed that spirituality is associated with quality of life to the same degree as physical well-being. Spiritual well-being was found to be related to one's ability to enjoy life even in the midst of adverse symptoms. Krupski et al. (2006) also used the FACIT-Sp to investigate the spiritual well-being of men with prostate cancer ($n = 222$). Findings from the study revealed that low spirituality was associated with significantly worse physical and mental health, sexual function, and more urinary concerns. Reliability scores of the instrument for this study were not reported.

Fisher (1998 as cited in Fisher & Brumley, 2008) proposed yet another spiritual well-being model and developed the self-rating Spiritual Well-being Questionnaire (SWBQ). In a later study, Fisher and Brumley (2008) used the Spiritual Health and Life Orientation Measure (SHALOM) developed by Fisher to provide insights into the ideals for spiritual well-being among health care staff ($n = 225$). The aim of that study was to investigate participants' spiritual well-being and how it related to their workplace (Fisher & Brumley, 2008). It is not clear how, if at all, Fisher's SWBQ is related to the SHALOM instrument for measuring spiritual well-being. However, the relational domains (self, others, the environment and/or God) outlined in the description of the SHALOM instrument are almost identical in parts to the language used by Hungelmann et al. (1996) and Paloutzian and Ellison (1982) in describing pertinent aspects of the JAREL Spiritual Well-being Scale and the SWBS respectively. It is also noteworthy that with the exception of the FACIT-Sp, there is consistency in the language used by Fisher (1998 as cited in Fisher & Brumley, 2008), Hungelmann et al. (1996), and Paloutzian and Ellison (1982) to define the concept of spiritual well-being.

While the FACIT-Sp was designed specifically to measure facets of spirituality—such as a sense of meaning in life, harmony, peacefulness, and a sense of strength and comfort from one's faith despite adverse symptoms—all the other instruments for measuring spiritual well-being were designed to evaluate relationships with self, others, community and God/Transcendent Being. All the aforementioned instruments have been found to be reliable in various populations of patients as well as health care professionals, students, and others. The SWB Scale by Paloutzian and Ellison (1982) was used to measure the concept of spiritual well-being in this study. This instrument was ideal because it offered balanced consideration to both the religious and the existential aspects of spiritual well-being.

Description of Spiritual Well-Being in Nursing Students

In a longitudinal study, Baldacchino et al. (2010) assessed the relationships between spiritual well-being (SWB) and certain demographical factors among four cohorts of nursing/midwifery students in Malta. The JAREL SWBS was used to measure the spiritual well-being of 334 nursing students (females $n=289$, males $n=45$), ages 17-25 years enrolled in the undergraduate Diploma and BS Nursing/Midwifery Program at Malta University. Descriptive and inferential analysis showed no significant correlation between the SWB and the ages of Diploma students over the four year period of study, (T1: $r = -0.036$, $p = 0.732$); (T2: $r = -0.012$, $p = 0.919$); (T3: $r = -0.089$, $p = 0.532$); (T4: $r = -0.205$, $p = 0.139$). The same was true for the students enrolled in the BS Nursing Program across time—statistical correlation ranged from T1-T4: $r = -0.007$ to -0.204 , $p = 0.139$ to 0.964 .

By gender there were no significant differences in the SWB scores of the participants enrolled in the Diploma and BSc Programs, although the female participants in both groups scored slightly higher than their male counterparts. Results of the gender analysis for the Diploma students showed the SWB score of male students ranging from $x = 96.11$ to 103.92 (SD 10.357 to 14.741) and for the females students $x = 96.43$ to 104.38 (SD 10.984 to 16.269). T-test score ranged: $t = -0.119$ to 0.524 , $df = 73$ to 113 and $p = 0.615$ to 0.906 . Mean scores for male students enrolled in the BSc program ranged from $x = 35.71$ to 42.39 (SD 8.021 to 12.426) and for their female colleagues $x = 41.87$ to 44.69 (SD 6.762 to 16.515); t -test results for the BSc students showed a range of $t = -2.129$ to 0.242 , $df = 78$ to 111 and $p = 0.038$ to 0.809 . ANOVA supported by Bonferroni testing indicated no significant differences in the total SWB between the two cohorts in each program across time. Results showed a range of T1-T4: $F = 0.596$ to 2.284 , $p = 0.080$ to 0.484 . However, “results for mean differences between groups by one way

ANOVA were considered to be statistically significant at $p < 0.0125$ following a Bonferroni correction of $(0.05/4 = 0.0125)$ to decrease the likelihood of Type I error” (Baldacchino et al., 2010, p.271).

Unlike the post Bonferroni findings of Baldacchino et al. (2010), a descriptive study conducted by Abbasi et al. (2014) showed no significant differences between the SWB of first year students and that of fourth year students. Both groups scored in the moderate range on the SWBS developed by Paloutzian and Ellison. Of a highest possible total score of 120, the first year students scored an average of 65.58 and the fourth year students 67.17. In that study, 350 nursing students enrolled in three schools of nursing in Iran were studied. The study aimed to investigate and compare responses of the first year ($n = 105$) and fourth year students ($n = 178$) regarding spiritual well-being, spirituality, and spiritual care perspectives. While the researchers presented a descriptive analysis of the ages and gender of both groups of participants, they did not offer an inferential comparison between those demographical factors and the students’ level of SWB. Such information would have provided greater insight regarding the demographic factors that might have some bearing on the nurses’ SWB. It should be taken into consideration that (despite very similar populations) the variances in the findings between Baldacchino et al. (2010) and Abbasi et al. (2014) might be related to the fact that the teams of researchers used different instruments to measure the concept of spiritual well-being.

Description of Spiritual Well-Being in Practicing Registered Nurses

Musgrave and McFarlane (2004) used the SWBS developed by Paloutzian and Ellison (1982) to measure the concept of spiritual well-being. The researchers conducted a path analysis to investigate the effects of age, ethnicity, education, religiosity, and spiritual well-being on the attitudes of Israeli oncology nurses ($n = 155$) toward spiritual care. It was hypothesized that the

nurses' spiritual well-being would have a direct impact on their attitudes toward spiritual care, and that the demographical factors of age, ethnicity, and education would have an indirect influence on the nurses' attitude towards spiritual care. Comparable to the current study's definition of spiritual well-being the researchers theoretically defined spiritual well-being as "the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness" (p. 323).

Data from Musgrave and McFarlane (2004) showed subjects were female (99%), with a mean age of 43.39 years (range = 26–68 years), RNs without BSN (36%), RNs with BSN, (43%), and RNs with Master's degree or higher (21%). The nurses had a mean of 18.29 years of professional experience (range= 1 to 47 years), and worked in the specialty area of oncology for an average of 9.19 years (range= 1 to 33 years). Sixty-nine percent (69%) of the nurses worked in a hospital setting with 71% in full-time positions. Ninety-six percent (96%) were Jewish, 2% Christians, 1% Muslims and 1% others; 58% categorized themselves as secular, 21% as traditional, and 21% as religious. Multiple regression analyses demonstrated that the predictor variables of age ($\beta= 0.02, p=0.69$), and education ($\beta= -0.01, p=0.82$) did not have a strong influence on the respondents' spiritual well-being. The hypotheses that age, ethnicity and education would have an impact on the nurses' attitude toward spiritual care were not supported by the findings; analysis of data revealed a small total effect of age (-0.03), ethnicity (-0.05), and education (0.16). Similarities exist between the findings of Musgrave and McFarlane's (2004) study and that of the Baldacchino et al's. (2010) study in that there were no significant associations between the participants' age, level of education and their SWB score.

Using the self-formulated instrument, the Spiritual Health and Life Orientation Measure (SHALOM) to measure the concept of spiritual well-being, Fisher and Brumley (2008)

concluded that the beliefs and worldview of nurses and pastoral care givers had a greater influence on their SWB than did their age, gender, or work setting. A total of 225 Australian nurses and pastoral care-givers from three different health care settings (hospice $n = 23$, public hospital $n = 154$ and private hospital $n = 40$) participated in the study. Analysis of data revealed an average age of 44.25 years, most subjects were female ($n = 196$), and those working in hospice were older ($x = 49.4$ years). Nurses employed in hospice were more religious than those in the other settings, and overall, female participants scored higher than their male colleagues. The findings from this study bear some similarity to that of Baldacchino et al.'s (2010) study where female participants scored slightly higher on SWB Scale; and the Musgrave and McFarlane (2004) study which showed minimal association between the nurses SWB and their ages, ethnicity and educational preparations. As Fisher and Brumley (2008) so aptly concluded, "the beliefs and worldview of health care staff influence their ideals for spiritual well-being to a greater extent than age, gender, or workplace setting" (p. 49).

Spiritual well-being and spiritual care perspectives. Over the past decade, the theme of spiritual well-being among nurses has been the focus of an increasing number of empirical studies both in the academic and the practice settings (Abbasi et al., 2014; Baldacchino et al., 2010; Fisher & Brumley, 2008; Musgrave & McFarlane, 2004). Findings from these studies consistently indicate that the nurse's SWB is an important determinant in the nurse's attitude towards providing spiritual care.

Musgrave and McFarlane (2004) utilized the SWBS developed by Paloutzian and Ellison (1982) to measure the concept of SWB in a path analysis to investigate the relationships of select demographical data, religiosity, and spiritual well-being on the attitudes of Israeli oncology nurses toward providing spiritual care. The Spiritual Care Perspective (SCP) Survey (a subscale

of the Nursing Spiritual Care Perspective Scale (NSCPS) by Taylor et al., 1994), was used to measure the nurses' attitude towards the provision of spiritual care. Spiritual well-being was theoretically defined as "the affirmation of life in a relationship with God, self, community, and environment that nurtures and celebrates wholeness" (p. 323). In this quantitative study, research packages were mailed out to the 520 members of the Israeli Oncology Nursing Society; a response rate of 30% ($n = 155$) was obtained. Regression analysis showed the nurses' attitudes toward spiritual care were significantly impacted by their SWB ($\beta = 0.39, p = .0010$) and extrinsic religiosity ($\beta = -0.26, p = 0.003$). The nurses' intrinsic religiosity ($\beta = 0.61, p = .0005$) and extrinsic religiosity ($\beta = 0.28, p = .0005$) were also shown to have significant influences on their spiritual well-being. The research hypothesis that the nurses' spiritual well-being would have a direct impact on their attitudes towards spiritual care was therefore sustained. The researchers further pointed out that, "spiritual well-being was not only a significant, positive predictor of attitudes toward spiritual care ($p = 0.001$), but it also was the most significant contributor to attitudes towards spiritual care" (p. 325). For the data analyzed, Musgrave and McFarlane (2004) reported a Cronbach alpha of 0.88 for the SWBS and 0.75 for the SCP Survey subscale.

In a descriptive comparative study conducted by Abbasi et al. (2014), the researchers compared the responses of first year and fourth year baccalaureate nursing students regarding their SWB, spirituality, and spiritual care perspectives (SCP). The SWB Scale and the NSCPS were used to measure the students' spiritual well-being and spiritual care perspectives respectively. Cronbach alpha scores of 0.87 for the SWB Scale and 0.75 for the NSCPS were reported for the data analyzed. The study findings indicated no significant differences in the SWB, spirituality or SCP of the first year students' and that of the fourth year students. Over ninety-eight percent (98.8%) of the first year and 100% of the fourth year students obtained

moderate level scores on the SWB scale ($x = 65.58$, $SD = 7.73$) and ($x = 67.17$, $SD = 6.55$) respectively. The mean scores and SDs of spiritual care perspective for the first year students were 4.45 (0.65) and for the fourth year students 4.33 (0.76). There were no statistical differences between the two groups ($P = 0.19$).

Although Abbasi et al. (2014) offered no inferential or correlational analysis of the data collected (because that was not the intent of the study), their study is of interest because the researchers investigated, compared, and reported their findings on two variables that constitute the independent variables (viz. SWB and SCP) for this current study. Furthermore, the instruments used by Abbasi et al. (2014) to operationalize the concepts of SWB and SCP are identical to those used by Musgrave and McFarlane (2004) to measure the concepts of SWB and attitudes towards spiritual care. These instruments were also used in the current study to measure the concepts of spiritual well-being and spiritual care perspectives. In this study the Spiritual Well-being (SWB) Scale developed by Paloutzian and Ellison (1982) was used to measure spiritual well-being, and the revised version of the Nursing Spiritual Care Perspective Scale (NSCPS) by Taylor (2004) provided measurement for spiritual care perspectives.

Spiritual well-being and provision of spiritual care. Provision of spiritual care is not the only predicted benefit that patients will receive from nurses who report a high sense of their own spiritual well-being. Other related studies have demonstrated that: (a) nurses who were spiritually well were more assured that their patients were being helped by the services they provide (Fisher & Brumley, 2008), (b) there was a positive correlation between spiritual wellness and life satisfaction among nurses (Habib, Riaz, & Akram, 2012), (c) spiritual well-being had a direct negative effect on burnout among nurses, and a direct positive effect on hardiness in the same population (Marsh, 1997), and (d) spiritual well-being among nurses was a strong predictor

of caring behavior (Roberts, 2002). Vance (2001) found a positive relationship ($r = 0.19, p < 0.05$) between nurses' spiritual well-being and frequency of assessing and intervening in the spiritual care of patients. An earlier study conducted with student nurses also verified that those who scored higher on the spiritual well-being scale were more apt to provide spiritual care (Soeken & Carson, 1986). These findings were also reiterated among patients and family care-givers (Lowry, 2012; Mickley et al., 1992; Yeh and Bull, 2009); those who scored high on spiritual well-being also tended to have positive outcome. Findings from a study conducted by Yeh and Bull (2009) among family care-givers revealed that as spiritual well-being increased, negative mental health symptoms decreased ($r = -0.55, p = 0.000$). In addition, an emerging theme from Lowry's (2012) qualitative descriptive study, which aimed to describe the relationship between spirituality and health among aging adults in various states of health, indicated that a positive state of spirituality will contribute to a person's overall health and wholeness.

Summary and critique of research on spiritual well-being. Across studies the definitions of the concept invariably noted that spiritual well-being is impacted by the extent to which people live in harmonious relationships with God/Transcendent Being, self, community, and the environment. Based on the aforementioned empirical studies conducted in various countries, among nurses from different specialties, levels of education, and using different instruments, the findings have been consistent that the spiritual well-being of the nurse does have an impact on the nurse's perspective or attitude towards providing spiritual care as well as on the actual provision of spiritual care. There were mixed results and in some studies, insignificant findings regarding the relationships between spiritual well-being and certain demographical factors such as age, gender, years in nursing practice, and area of specialty. For example,

findings indicated that the gender of subjects had minimal influences on their total SWB, with females scoring slightly higher on the SWB Scales in all the studies. It is therefore evident that the nurse's SWB is not significantly incumbent on his/her age, gender, or clinical expertise. One primary commonality among the studies discussed above lies in the conceptual definition of spiritual well-being. The cohesiveness in the definition of the concept might be an essential factor in the consistency of outcomes of the studies.

These findings were important to the present study because the conceptual definition for spiritual well-being used by the researchers above was used to explicate the concept of spiritual well-being. Furthermore, the SWB Scale by Paloutzian and Ellison (1982) was used to measure the concept of SWB in this study.

Theoretical Overview of Spiritual Care Perspective (SCP)

Neuman (1995) posited that an individual's spiritual perspective may negatively or positively influence and even control the physiological, psychological, sociocultural, and developmental domains of the individual, explaining that "the spirit controls the mind and the mind controls the body" (Neuman, 2002, p. 16). The Model further points out that the beginning of a person's spiritual awareness and development can occur at any stage of the life cycle (Neuman, 2002).

Based on Neuman's assumptions, it can be postulated that nurses whose spiritual lines of defense and resistance are intact as evidenced by love, faith/trust, hope, meaning and purpose in life, and meaningful relationships with God/higher being and others will convey a healthy and positive attitude toward their own life situations as well as to that of their patients (Fulton, 1995). Conversely, nurses whose spiritual lines of defense and resistance are weakened or penetrated as evidenced by overwhelming fear, guilt, loneliness, hopelessness, and detachment from

God/transcendent being and others will be unable to define their spiritual perspective and may even entertain negative spiritual attitudes (Fulton, 1995). Such negativisms might be expressed when addressing personal circumstances as well as patient related situations. Turan and Yavuz Karamanoğlu (2013) noted that in order for nurses to understand the spiritual needs of their patients, they must first develop an understanding of their own spirituality by becoming aware of their own beliefs (i.e.: attitudes, perspectives) and values. The researchers further noted that factors which might lead to effective spiritual care included the nurse's perception of spiritual needs and spiritual care, the nurse's personal belief system, life experiences, and sensitivity to the spiritual domain.

Another illustration of the nurse's spiritual care perspective based on the assumptions of the Model's spiritual domain is indicated in the nurse's attitudes and beliefs regarding the provision of spiritual care as primary, secondary, and tertiary interventions based on the patient's spiritual needs. Several studies have demonstrated that nurses who score high on the SCP Scale were more inclined to perform a purposeful assessment of their patients' spiritual needs followed by compassionate intervention of spiritual care in response to the spiritual assessment findings (Chism & Magnan, 2009; Chung et al., 2007; O'Shea et al., 2011; Tiew et al., 2013). It has also been demonstrated in the body of nursing literature that there is a positive relationship between the spiritual care perspectives and spiritual care practices among nurses who were in varying stages of their academic endeavors (Baldacchino, 2010; Chism & Magnan, 2009; Giske & Cone, 2012; Stranahan, 2001) as well as clinicians in the various practice settings (Burnhardt, & Nagai-Jacobson, 1985; Deal & Grassley, 2012; Lind et al., 2011; Mueller, 2010; Tanyi et al., 2009).

Additionally, the Neuman System Model references three personal factors, namely, inter-, intra-, and extra- personal strengths (or stressors), that may be associated with the

physiological, psychological, sociocultural, developmental, and spiritual domains. With respect to the spiritual domain, an individual's inter- and intra-personal strengths are demonstrated by acceptance, forgiveness, hope, finding meaning and purpose in life (Fulton, 1995). These attributes are in turn related to the individual's harmonious relationship with others, God, Deity, or higher being. On the other hand, the spiritual manifestations of inter- or intra-personal stressors would be displayed in symptoms of spiritual distress, such as hopelessness, loss of purpose or meaning in life and a sense of powerlessness. It has been hypothesized, and there is evidence to support the notion, that nurses who are in such a state will lack perspective in providing spiritual care to their patients and will also score low on the Spiritual Care Perspective Scale (SCPS) (Cavendish et al., 2004; Fawcett & Nobel, 2004; Milligan, 2004).

Empirical Studies of Spiritual Care Perspective

A review of the literature indicates that nursing is not the only professional discipline that is interested in how its members perceive the role of spirituality in their practice. Lavinder, Patel, Campo, and Lichtman, (2012) investigated the perceived role of spirituality in physical therapy education by surveying Directors of Clinical Education and Academic Coordinators of Clinical Education ($n=111$) of 182 accredited Physical Therapy education programs across the United States. Analysis of data revealed that 69% of respondents agreed that Physical Therapy students need to be educated on the role of spirituality in healthcare. Forty-one percent indicated that the role of spirituality has not been explored in physical therapy; 47% of respondents agreed that incorporating the spiritual domain in the curriculum would reinforce the core values and code of ethics of the American Physical Therapy Association (APTA). The researchers concluded that although the majority of Directors and Coordinators perceived that spirituality is important and should be included in the education of physical therapists (PTs), only 40% of

programs included such contents in their curriculum. It was also noted that including spiritual educational contents in the PT curricula is important because the *APTA's Vision 2020* encompasses spirituality in its values for compassion, integrity, and excellence.

In a similar study, Dobmeier and Reiner (2012) examined topics on spirituality that were addressed in the education curriculum of students enrolled in counseling programs, and explored students' perceptions of preparedness to address spirituality in their counseling practice. Interns ($n=335$) from thirty-six accredited counseling programs were surveyed about their perspectives of the preparation they received regarding integration of aspects of spiritual, ethical, and religious competencies into their counseling practice. Results showed that most students felt prepared to integrate topics of spiritual wellness, meaning, hope, and faith into practice and that exposure to spiritual contents via course work, classroom discussions, and experiential activities were useful in learning about spirituality.

Researcher-developed instruments were used to measure the research variables and concepts in both studies mentioned in this subsection. Neither teams of researchers reported a Cronbach alpha reliability score for either of these newly developed instruments.

Instruments used to measure Spiritual Care Perspective

Several statistically reliable instruments have been designed, tested and consistently used to measure the concept of spiritual care perspective in nursing. The Nurse Spiritual Perspective Care Scale (NSPCS) developed by Taylor et al. in 1994 is frequently used for operationalizing the concept of spiritual care perspective. The original NSPCS has two parts: Part I was designed to measure the nurse's spiritual care practices and Part II for measuring the nurse's spiritual care perspectives. The NSPCS was revised in 2004 to become two separate scales. Part I of the original scale was revised, and is now known as the Nurse Spiritual Care Questionnaire (NSCQ).

The purpose of the NSCQ is to measure the frequency of nursing activities intended to support the patient's spiritual domain (E. J. Taylor, personal communication and unpublished document obtained via e-mail on October 16, 2014). There will be no further discussion of the original (NSPCS-Part I) or the revised instrument (NSCQ) in this section of the chapter because those instruments were not used to operationalize any variable in the current study. However, the revised NSCPS- Part II now referred to as Spiritual Perspective Scale-Revised (SPCS-Rv) was used for measuring nurses' spiritual care perspectives in this study. The SCPS-Rv is a 10-item questionnaire with a reported Cronbach's alpha of .82 (E. J. Taylor, personal communication and unpublished document obtained via e-mail on October 16, 2014). Responses were based on a 5-point Likert scale ranging from 1 (*strongly agree*) to 5 (*strongly disagree*).

Stranahan (2001) modified and used Part II of the original NSCPS by Taylor et al (1994) to measure the attitudes and beliefs of 102 nurse practitioners (NPs) in a study aimed to examine the relationship between spiritual perception, attitudes about spiritual care and spiritual care practices. Findings indicated a positive correlation between the NPs' perception of their own spirituality and the amount of spiritual care provided. Stranahan did not provide reliability data of the modified NSCPS-Part II.

To compare the pre- and post-test results of a spiritual education session, O'Shea et al. (2011) used the SCPS-Rv to measure spiritual perceptions and attitudes about spiritual care in 41 pediatric and neonatal nurses employed in a large university-affiliated children's hospital. The researchers reported that the reliability of the SCPS-Rv for the pretest demonstrated a Cronbach's alpha of 0.81; and for the posttest 0.82. Findings from the study revealed that the educational session had a significant effect on nurses' spiritual perceptions and attitudes about providing spiritual care ($t = 6.19, p = .00$). Results also showed that the more spiritual nurses perceived

themselves, the more positive their perspectives were toward providing spiritual care to patients and their families. These findings corroborated Stranahan's earlier study among NPs.

Conclusions from Chism and Magnan's (2009) study examining the relationship between spiritual care perspectives and expression of spiritual empathy also yielded similar findings. In that study, the researchers used Taylor's SCPS-Rv to capture data regarding the spiritual care perspectives (attitudes, beliefs, and values towards spiritual care) of student nurses enrolled in various levels of nursing academia (from BSN to Doctoral Degree Program). A Cronbach alpha of 0.80 was reported for the SCPS-Rv.

The Spiritual Perspective Scale (SPS), authored by Reed in 1987, also demonstrated strong internal reliability; Cronbach's alpha estimation of reliability is consistently above .90 (Stranahan, 2001). However, unlike Taylor's SCPS-Rv, which measures attitudes towards spiritual care, Reed's SPS is frequently used for measuring an individual's views regarding the extent to which spirituality impacts his/her life and spiritually related activities. Although Reed's SPS is not specifically geared to measure attitudes regarding spiritual care, it is reasonable to postulate that an individual's views regarding spirituality and spiritual related activities might have a direct or indirect influence on one's attitude, beliefs, and values towards spiritual care. Construct validity of the SPS has been established, in that the scale consistently demonstrates interrelatedness between research participants' religious background and their scores on the SPS. This instrument consists of 10 Likert-type items, ranging from 1 (*disagree*) to 6 (*strongly agree*) for each item, or frequency of occurrence from *often* to *rarely*. The SPS has a reported Cronbach alpha co-efficient of 0.92 (Reed, 1987). Ronaldson et al. (2012) used the SPS to measure spiritual perspectives in Australian nurses employed in acute care and palliative care settings. Stranahan (2001) used the same tool to measure "*spirituality*" (i.e. *one's awareness of the inner*

self, and a sense of connection to higher being, nature or others) among nurse practitioners (NPs) in the United States, and O'Shea et al. (2011) used the tool to measure pediatric and neonatal care nurses' perceptions of how they held certain spiritual views and engaged in spiritually related interactions.

The Spirituality and Spiritual Care Rating Scale (SSCRS) developed by McSherry in 1997 has also been used among various populations of nurses to measure factors related to existential spirituality, religiosity, spiritual care, and personal care, as well as attitude, beliefs, and perspectives about spiritual care. The SSCRS is a self-reported questionnaire consisting of 17 items rated on a 5-point Likert-type scale, and has been used in over 42 studies in 11 countries (McSherry & Jamieson, 2011). The instrument has demonstrated consistent levels of reliability and validity with Cronbach's alpha scores ranging from 0.64 to 0.84 (Ross et al., 2014). Ross et al. (2014) selected the SSCRS (paper format) to measure the perception and spiritual care of undergraduate nurses/midwives ($n = 531$). McSherry and Jamieson (2011) used an online version of the instrument to survey over 4,000 nurses across the United Kingdom to obtain their perceptions of spirituality and spiritual care. Ozbasaran, Ergul, Temel, Gurol Aslan, and Coban (2011) also used the SSCRS (paper format) to measure the same variables among 319 Turkish nurses. Alpha coefficient for the Turkish version of the SSCRS was reported to be 0.84.

The SCPS-Rv by Taylor was used to measure spiritual care perspective in this study. This instrument was selected over the others mentioned in this section because of its consistently reported strong alpha reliability ranging from 0.80 to 0.82. The scale has been used among nurses from a range of specialties (Musgrave & McFarlane, 2004; O'Shea et al., 2011; Chism and Magnan, 2009; Stranahan, 2001; Taylor et al., 1994). The items are directly related to seeking data about nurses' attitude, beliefs, and values associated with providing spiritual care.

This feature is unlike that of other instruments which delved into taking account of the beliefs, values, and dignity of others (McSherry, Draper, & Kendrick, 2002), or measures an individual's views regarding the extent to which spirituality impacts his/her life and spiritually related activities (Reed, 1987). In so much as these instruments allude to the concept of spiritual perspectives, each author's definition of the concept does make room for the consideration of one's attitude, beliefs, and values towards providing spiritual care.

Description of SCP in Nursing Students

Using a non-probability convenience sample of university level nursing students ($n = 223$), ranging from Baccalaureate to Doctoral program enrollees, Chism and Magnan (2009) aimed to explore the relationship of nursing students' spiritual care perspectives to their expressions of spiritual empathy. After controlling for relevant demographic and spiritual background variances, hierarchical regression analyses were conducted to determine the extent to which the demographical variables and spiritual care perspective of the nursing students accounted for their expression of spiritual empathy. Statistical procedures for correlation and hierarchical linear regression were used to analyze the data. Zero order Pearson product-moment correlations were used to examine the relationships among demographic variables, spiritual care perspectives, and expression of spiritual empathy. Results showed that "considering oneself spiritual" correlated most highly on the Spiritual Care Perspectives Scale (SCPS) ($r = 0.457, p < 0.001$). Other demographic factors that showed significant correlations on the SCPS were church attendance ($r = 0.24, p < .001$), gender –being female– ($r = 0.26, p < .001$) and having a religious affiliation ($r = -0.19, p < .001$). The demographic variables of age, spiritual training and level of education showed a weaker than expected correlation with SCPS scores. However, these findings are contrary to well documented findings of strong correlations between spiritual

training, levels of education, and one's attitudes towards spiritual care (Chung et al., 2007; O'Shea et al., 2011; Ozbasaran et al., 2011; Stranahan 2001). Empirical findings consistently indicate that nurses who report having spiritual training and more advanced professional education have a more positive perspective towards spiritual care.

Description of SCP in Practicing Registered Nurses

O'Shea et al. (2011) conducted a quasi-experimental study aimed at evaluating the effect of a spiritual education session on the spiritual care attitudes and perspectives of 41 pediatric and neonatal nurses in a large university affiliated children's hospital. Analysis of the demographic data showed participants' ages ranged from < 25 to 65 years old, with years in professional practice from 2 to 20 years. Participants were mostly white female (97.56%), most were married (57%), and Catholic (96.30%). There was significant positive correlation between the nurses' age and their personal spirituality (PS) ($r = .31, p = .05$). Similar correlation was found between years of professional practice and PS ($r = .33, p = .04$). One way ANOVA indicated that nurses who were actively religious scored significantly higher in personal spirituality than those who did not practice a religion ($F = 9.48, p = .00$). The researchers noted that no other demographic factors were significantly related to the nurses' PS or their perspective toward providing spiritual care.

Contrary to findings from O'Shea et al. (2011) study of neonatal and pediatric nurses, Musgrave and McFarlane's (2004) study of oncology nurses ($n = 155$) concluded that the nurses' age ($\beta = -0.04, p = 0.58$) and ethnicity ($\beta = 0.01, p = 0.88$) did not have significant impact on their attitude towards spiritual care. Tiew et al. (2013) in a study of student nurses' perspectives of spirituality and spiritual care noted that students participating in their study reported a high level of spiritual awareness, and that age was not a constraining factor. Baldacchino and James

(2010) in a study of 113 nurses employed in a local state residence for elderly people reported similar findings. The researchers pointed out that there were no significant differences in the nurses' perception of their roles in providing spiritual care and their gender and age ($t = 0.192, p = 0.848$) and ($t = 0.251, p = 0.803$) respectively.

The aforementioned findings of Baldacchino and James (2010), Musgrave and McFarlane (2004), and Tiew et al. (2013) are unlike other related studies which reported a positive correlation between the nurses' attitude towards spiritual care and their age and level of education (Stranahan, 2001). Ozbasaran et al.'s (2011) findings in a study of Turkish nurses ($n = 319$) suggested that the educational level, belief in the evil eye, and area of employment had a positive impact on the nurses' perception of spirituality. The relationships between the total mean perception scores and independent variables were analyzed by Mann–Whitney U and Kruskal–Wallis tests. Statistically significant differences were found between nurses' perceptions of spirituality and their age groups ($KW \chi^2 = 24.32, p < 0.01$), education level ($KW \chi^2 = 10.94, p < 0.05$), department of employment ($KW \chi^2 = 14.37, p < 0.01$), marital status ($U = 9.94, p < 0.01$), length of clinical experience ($U = 9.69, p < 0.01$), and nurses' belief in the evil eye ($U = 5.36, p < 0.01$). The findings indicated that younger nurses, those with a Master's degree, singles, those employed in pediatrics and psychiatry, and those with less than ten years of clinical experience scored higher on the Spirituality and Spiritual Rating Scale. It should be noted that the nurses who participated in this study were from convenience samples drawn from three different public hospitals in Turkey. Unlike the other studies discussed in this section, the nurses participating in Ozbasaran et al.'s (2011) study were employed in a wide range of nursing specialties, from psychiatry to pediatrics.

In comparing the spiritual perspective of nurses employed in palliative care and acute care nursing, Ronaldson et al. (2012) reported that RNs in palliative care were older (mean age 43 years compared to 33.5 years, $p < 0.05$), had more years of nursing experience (average 18.3 years compared to 9.6 years $p = 0.05$), had been in their area of specialty much longer (9.5 years compared to 6.6 years $p = 0.05$), and had longer years of employment at their current facility, (6.9 years compared to 4.7, $p = 0.05$) than RNs employed in acute care. In both groups there were more women than men, 85.7% in palliative care and 78% in acute care. Seventy-four percent (74%) of RNs in acute care had a BSN compared to 44% of RNs in palliative care; however 44% of the nurses in palliative care were certified in their area of specialty compared to 10% of RNs in acute care. The older, more experienced nurses in palliative care scored higher in spiritual perspective than their counterparts in acute care nursing. Descriptive analysis showed RNs employed in palliative care scored higher ($x = 4.1$, $SD = 1.0$, $p = 0.05$) in their spiritual perspective than their colleagues in the acute care settings ($x = 3.7$, $SD = 1.3$, $p = 0.05$).

While the findings of this study were dramatic, they are not surprising because it is documented that nurses employed in palliative care, oncology, and hospice care do have a tendency towards being spiritual, demonstrate significant spiritual perspectives, and have positive attitudes towards spiritual care (Cockell & McSherry, 2012; Musgrave and McFarlane, 2004; Taylor et al., 1994). However, the researchers offered no definitive clarification about whether or not the tendencies of palliative care nurses to have high spiritual perspectives were linked to their ages, years in practice, area of employment, gender and/or their employment longevity in the same facility.

Spiritual Care Perspective and Provision of Spiritual Care

Historically, nurses have been called upon to provide holistic care to their patients. While there is consensus in the literature regarding the nurse's perspectives (i.e.: attitudes, values, and beliefs) towards the provision of care in the physiological, psychological, sociocultural, and developmental domains, nurses continue to hold different viewpoints about care in the spiritual domain and their role in the provision of spiritual care (Baldacchino, 2010; Fulton, 1995; Gallison et al., 2013; Neuman, 2002; Ross, 2006). Conceptually, *spiritual care perspective* is defined as the attitudes and beliefs nurses have regarding the provision of spiritual care in nursing (Chism & Magnan, 2009; Taylor et al., 1994). Various studies have indicated that nurses' spiritual care perspectives range from views that the patient's spiritual care was not a nursing responsibility accompanied with feelings of incompetence related to providing spiritual care (Cavendish et al., 2004; Fawcett & Nobel, 2004; Gallison et al., 2013; Milligan, 2004), to the nurse perceiving that spiritual care was a professional responsibility accompanied by ensuring that such care was provided via meaningful interventions (Rieg, Mason, & Preston, 2006; Ross, 2006; Tanyi et al., 2009).

O'Shea et al.'s (2011) study of 41 pediatric nurses supported the existing evidence demonstrating that positive attitudes, perceptions, and values toward spiritual care will increase the likelihood of those nurses providing spiritual care to their patient. The study also demonstrated that one spiritual education session had a positive effect on the nurses' perspectives toward providing spiritual care. This was indicated by the participants' post educational session scores on the SCPS-Rv ($t = 6.19, p = .00$). The researchers also reported a strong linear correlation between the participants' comfort level in providing spiritual care with their personal spirituality ($r = .66, p = .00$); and noted that "the more spiritual the pediatric nurse viewed

themselves, the more positive their perspectives were toward providing spiritual care to patients and families” (O’Shea et al., 2011, p.39). Ronaldson et al.’s (2012) findings which indicated an association between palliative care nurses’ spiritual perception and providing spiritual care corroborate O’Shea et al.’s (2011) findings.

Ronaldson et al. (2012) compared the spiritual care practices of nurses employed in palliative care ($n = 42$) to that of acute care RNs ($n = 50$) to determine the correlation between the nurses’ spiritual perspective and their spiritual caring. The Spiritual Perspective Scale (SPS) (Reed, 1987) was used to measure the extent to which the nurses considered spirituality an influence in their lives. The concept of spiritual caring was operationalized by the Spiritual Care Practice Questionnaire (SCPQ) (Vance, 2001). Descriptive and analytical statistics (mean, SD, t -test, Pearson’s correlation and regression) were used to interpret the data collected in the Ronaldson et al. (2012) study. Pearson’s correlation showed a positive significant correlation between the spiritual perspective and the spiritual care practice among RNs working in palliative care ($n = 42$, $r = 0.37$, $p = 0.02$) that was not present in the acute care nurses ($n = 50$, $r = -0.03$, $p = 0.84$).

Using Reed’s SPS to operationalize the concept of spiritual perception, Stranahan (2001) reported a significant correlation between the scores of nurse practitioners’ (NPs) spiritual perspective (SP) and their response to questions related to their degree of religiousness ($r = .433$, $p < .001$). A statistically significant correlation was also found between the NPs’ spiritual perspective and the frequency with which they attend religious services ($r = .426$, $p < .001$). The correlation between how religious they perceive themselves to be and the frequency with which they attend religious services was also significant, ($r = .649$, $p < .001$). Although the study did not explicitly measure the correlation between the religiosity of nurses and provision of spiritual

care, the researcher suggested that participants in the study might have merged the definitions of spiritual and religious, resulting in the SPS measuring “religiosity as well as, or instead of, spirituality” (Stranahan, 2001, p. 100).

Ozbasaran et al. (2011) explored the perspective of spirituality and spiritual care in relation to demographical data among Turkish nurses. Using the socio-demographic data form and the Spirituality and Spiritual Care Rating Scale (SSCRS) the researchers identified differences in spirituality and spiritual care perspective as they related to demographic variances among study participants. The questionnaires were distributed to a convenience sample of 348 Turkish nurses in three local public hospitals in western Turkey. On the Kolmogorov–Simirnov test the SSCRS scores did not demonstrate a normal distribution ($p < 0.05$); therefore Mann–Whitney U and Kruskal–Wallis tests were used to assess associations between SSCRS and categorical variables. Multiple linear regressions were used to identify the impacts of variables on the nurses’ perception of spirituality and spiritual care. Results showed the effects of education level ($\beta = 0.17, t = 4.27, p < 0.01$), department of employment ($\beta = 0.15, t = 3.86, p < 0.01$), length of work experience ($\beta = -0.28, t = 3.98, p < 0.01$) and belief in the evil eye ($\beta = 0.22, t = 2.42, p < 0.01$) were factors influencing the nurses’ perception of spirituality and spiritual care ($R^2 = 0.156$).

The nurse’s perception of his/her professional role is yet another factor that may determine the nurse’s attitude and viewpoints concerning spiritual care. In a descriptive exploratory study conducted among 113 full time nurses working with institutionalized older persons, Baldacchino and James (2010) investigated nurses’ views regarding their role in the spiritual care of older people living in a local state residence. Participants in this study completed The Nurses’ Role in Spiritual Care Questionnaire. The findings revealed significant

differences between subgroups of nursing ranks ($t = 2.171, p = 0.032$) and years of clinical experience ($t = 2.354, p = 0.019$). The researchers noted that various factors such as life experience, clinical practice, knowledge, personal spirituality, and awareness about the importance of care in the spiritual dimension might influence the nurses' perception about their role in providing spiritual care. Nurses with over 16 years of clinical experience had a more positive perspective about their role in providing spiritual care ($t = 2.354, p = 0.019$) and were more inclined to provide such care ($n = 65, x \text{ score} = 96.22, SD 8.015$); compared to nurses with < 5 to 15 years of clinical experience ($n = 48, x \text{ score} = 93.15, SD 7.574$). These findings support the existing body of nursing knowledge regarding the positive impact of one's life experiences on one's awareness of personal spirituality and dimension in spiritual care (Baldacchino & James, 2010; Chism and Magnan, 2009; O'Shea et al., 2011; Ronaldson et al., 2012; Reed, et. al, 2014; Ross, 2006).

In a cross-sectional, multinational, descriptive survey study describing the perceptions of spiritual care among undergraduate nurses/midwives and their perceived competence in delivering spiritual care, Ross et al. (2014) used the SSCRS to measure perceptions of spirituality and spiritual care. Questionnaires were completed by a convenience sample of 531 predominantly Christian undergraduate nurses/midwives from six universities in four European countries. Results showed that "students held a broad view of spirituality and spiritual care" (Ross et al., 2014, p. 3), indicating that there were no significant differences between the participants' perspectives of the existential spirituality ($m = 3.81, SD = 0.47$) and the religiosity elements ($m = 3.94, SD = 0.60$). The participants considered spiritual care ($m = 4.29, SD = 0.45$) and personal care ($m = 4.01, SD = 0.51$) to be of equal importance. Although the researchers reported that these findings may be contradictory, the study provides further evidence to support

the hypothesis that nurses who score high on spiritual care perspectives (whether the existential or the religious elements) will also be more apt to consider spiritual care as an important intervention in their patient care plan.

Chism and Magnan (2009) conducted a descriptive correlational study to determine whether nurses' spiritual care perspective had an impact on their expression of spiritual empathy. Guided by the theoretical assumption that the nurse's expressions of spiritual empathy is a form of spiritual care, a non-probability convenience sample of university level nursing students ($n = 223$), ranging from Baccalaureate to Doctoral program enrollees completed three paper and pencil tools: (a) the Spiritual Care Perspectives Scale (SCPS) (reported Cronbach's alpha = 0.80), (b) the Expression of Spiritual Empathy Scales (ESES 3) (Cronbach's alpha = 0.66), and (c) a demographic worksheet. Details from the descriptive analysis of the demographic data were discussed in the preceding section of this paper. Hierarchical regression analysis demonstrated that spiritual care perspective ($\beta = 0.337$, $t = 4.81$, $R^2 = 0.210$, $p < 0.001$) was the best predictor of expressions of spiritual empathy. Additionally, "considering oneself spiritual" ($p.601$) showed strong correlations with spiritual care perspectives ($r = 0.457$, $p < 0.001$). The findings corroborated those in the current empirical literature, showing that spiritual care perspective was the best predictor that spiritual care will be provided.

Summary and critique of research on spiritual care perspectives. Several factors will determine the nurse's perspective (i.e.: attitude, values, viewpoint) regarding spiritual care. Factors such as nurses' educational preparedness to assess and deliver spiritual care (O'Shea et al., 2011; Ozbasaran et al., 2011; Stranahan, 2001), nurses' perception of their role in providing spiritual care (Baldacchino & James, 2010), as well as nurses' perception of their own spirituality, and/or religiousness (Ozbasaran et al., 2011; Ross et al., 2014; Stranahan, 2001)

have an impact on how nurses perceive the provision of spiritual care to patients in various settings. Irrespective of the nurses' age, practice setting (Baldacchino & James, 2010; O'Shea et al., 2011; Ozbasaran et al., 2011; Ronaldson et al., 2012); or level of education (Ross et al., 2014; Stranahan 2001) a positive correlation has been found between nurses' spiritual care perspectives and their provision of spiritual care.

Of the studies mentioned in this section, three different instruments were used to operationalize spiritual care perspective. Although the aforementioned researchers used the term *spiritual perception or spiritual perspective* in the title of their study, and aimed to measure the concept of "spiritual perspectives", "perception towards spiritual care", "spirituality, and/or attitudes about spiritual care" among nurses, only Chism and Magnan (2009) offered a precise definition of "spiritual care perspective" as "the nurses' feelings, attitudes, beliefs and values about providing spiritual care" (Chism & Magnan, 2009, p. 598). However, since the other researchers reportedly used the instruments to measure spiritual perspectives, personal spirituality, self-awareness, and spiritual views, it might be postulated that there is a connection between the understanding of these terms and that of *spiritual care perspective*. It was also noted that the concepts of *spiritual care perspective* and *provision of spiritual care* seemed at times to be contextually interwoven. This insinuation may be related to the fact that some instruments such as the NSCP Scale (Taylor et al., 1994) and the SSCRS (McSherry et al., 2002) combined both concepts in the same instrument as Part I and Part II.

An appraisal of these terms was important because for the purpose of this study spiritual care perspectives was related to the nurse's attitudes, feelings, thoughts, values, beliefs and view about spiritual care (Chism and Magnan, 2009; Taylor et al., 1994) and not the nurse's self-awareness, personal spirituality, or the actual provision of spiritual care. Although each

researcher used a different phrase to communicate the concept of the nurse's spiritual care perspective, and given the combination of the measurement of spiritual care perspective and provision of spiritual care on the same instrument (as Part I and II), it would have been illuminating if there was cohesiveness in the definitions that each researcher offered for the term that was used to communicate spiritual care perspectives [viewpoint, attitude, perception].

Illumination is needed because spiritual care perspective among nurses continues to be a topic of interest in nursing research. This on-going interest might be related to the current resurgence of consensus among nurses and other healthcare professionals that spiritual care is an important component of basic holistic care, and secondly while nurses embrace their role in providing holistic care, most perceive themselves to be ill-prepared to provide spiritual care to their patients (Burnhardt & Nagai-Jacobson, 1985; Chism & Magnan, 2009; Chung et al., 2007; Deal & Grassley, 2012; Gallison, et. al., 2006; Hodge, 2006; Lantz, 2007; Mitchell et al., 2006, Ronaldson et al., 2012; Ross, 2006; Vance, 2001). In an effort to obtain clarity and additional insight of the nurse's spiritual care perspective, several studies have been conducted on different populations of nurses, in various settings, nationally and globally. However, as noted earlier in this paper, most of these studies were done among nurses employed in settings other than adult acute care environments. This study sought to address the gap of the scarcity of studies on spiritual care perspectives among nurses employed in the acute care setting.

Theoretical Overview of Provision of Spiritual Care (SC) in Nursing

The concept of spiritual care in nursing is not a new phenomenon (Barnum, 2006; Wong, et al., 2008). From the era of Florence Nightingale to the current awakening of interest in addressing the patient's spiritual needs, nurses have always understood the need to treat the patient as a physiological, psychological, sociocultural, developmental, and spiritual being (Lind

et al., 2011; Neuman, 1995). With specific reference to the provision of spiritual care, the Neuman System Model theorizes that, “through careful assessment of the client’s needs in the spiritual area, followed by purposeful intervention, such as fostering hope that affects the will to live, the relation between the spiritual variable [domain] and wellness may be...utilized as an energy source in achieving client change and optimal system stability” (Neuman, 2002, p. 16).

In a detailed explication of the spiritual domain of Neuman’s Model, Fulton (1995) noted that the patient can be moved towards spiritual wellness through an accurate assessment of stressors that may be impacting the individual’s life physiologically, psychologically, developmentally, or socioculturally. Although these stressors might not be directly spiritual in nature, the spiritual health of the patient becomes a factor in mitigating these stressors because as Neuman points out, “the spirit controls the mind and the mind controls the body” (Neuman, 2002, p.16). Additionally, the Model assumes that spiritual development in varying degrees will empower an individual towards physiological, psychological, developmental, or sociocultural well-being by “positively directing spiritual energy for use first by the mind and then by the body” (Neuman, 2002, p. 16). Fulton’s (1995) clarification of the spiritual domain of the Model further explained that after an accurate assessment of the client’s spiritual needs is completed, the nurse will be able to determine whether spiritual care should be implemented at the primary, secondary, or tertiary level.

Primary care as intervention would be implemented when the nurse’s assessment reveals that the flexible line of defense of a patient’s spiritual domain is intact and that spiritual wellness or well-being prevails. In such instances primary care will serve to minimize stressors and strengthen the patient’s flexible line of defense in the spiritual domain thus optimizing the

patient's wellness level. According to Fulton's explanation, primary spiritual care involves identifying the patient's coping strength and supporting healthful activities.

Spiritual care at the secondary level of prevention is indicated when there are stressors impacting on or threatening to penetrate the flexible line of defense. Secondary intervention would involve collaboration between the nurse and the patient to set goals aimed at alleviating symptoms or situational stressor, thus avoiding penetration of the flexible line of defense, normal line of defense or lines of resistance (Fulton, 1995).

Spiritual care at the tertiary level is indicated when there are symptoms of spiritual distress or maladies of the human spirit that have penetrated the flexible line of defense, the normal line of defense, and/or the lines of resistance. Care at the tertiary level is aimed at "protecting the basic structure and restoration of spiritual wellness" (Neuman, 1995, p. 85). Tertiary care interventions may include active listening, being empathetic, therapeutic touching, personal sharing, and the nurse's therapeutic use of self (Fulton, 1995). Other existential interventions may include the use of music, art, and reading as an adjunctive therapy. Religious interventions may include praying with the patient or offering prayers, reading religious literature, and assisting the patient with religious rituals (Fulton, 1995; Milligan, 2004; Savel & Munro, 2014).

Fulton (1995) further emphasized that "the nurse provides spiritual care in order to attain [safeguard] the normal line of defense and promote stabilization and reconstitution" (p. 85). Outcomes of spiritual care intervention were successful when the patient "expresses meaning and purpose in life, reestablishes relationships, and resumes practices of belief system" (p. 85). These indicators of a successful outcome are consistent with this study's definition of provision of spiritual care as outlined in Chapter One. Fulton (1995) further noted that if spiritual care

interventions were not employed, the integrity of the lines of resistance may be reduced leading to a critical depletion of spiritual energy and possible death.

Empirical Studies on Provision of Spiritual Care

There is agreement in the current body of nursing literature that the provision of spiritual care is a nursing responsibility (Baldacchino and James, 2010; Cockell and McSherry, 2012; Gallison et al., 2013; Milligan, 2004; Narayanasamy, 2006; Savel & Munro, 2014; Tanyi et al., 2009; Vance, 2001), that involves purposeful interventions geared towards providing care to the human spirit across the life span (Baldacchino, 2010; Caldeira & Hall, 2012; Mueller, 2010; Neuman, 2001; , O’Shea et al., 2011; Pesut, 2009; Savel & Munro, 2014), irrespective of the practice setting (Deal & Grassely, 2012; Gallison et al., 2013; Ronaldson et al., 2012), the individual’s cultural beliefs (Vance, 2001), nationality (Abbasi et al., 2014; Chung et al., 2007; Fisher & Brumley, 2008), religious practices or atheistic views (Deal & Grassley, 2012; Tanyi et al., 2009). As Neuman (1995, p.79) noted, the spiritual domain of an individual is “innate...whether or not it is ever acknowledged or developed” by the individual. There is no dispute in the literature that each individual is a composite of body, mind and spirit (Cavendish et al., 2004; Deal & Grassley, 2012; Neuman, 1995; Savel & Munro, 2014; Tanyi et al., 2009) and all agree that nurses have a professional obligation to provide holistic care for the patients entrusted to their care (Baldacchino, 2010; Cavendish et al., 2004; Deal & Grassely, 2012; Gallison et al., 2013; Neuman, 1995; Ronaldson et al., 2012; Savel & Munro, 2014; Tanyi et al., 2009). It is also well documented that spiritual care is embodied in the care for the whole person and that nursing care is not truly holistic if spiritual care is not included in the patient’s plan of care (Baldacchino, 2010; Neuman, 1995; Pesut, 2009, Savel & Munro, 2014; Tanyi et al., 2009).

There is empirical evidence to validate: (a) the numerous benefits of spiritual care (Chan, 2009; Deal & Grassley, 2012; Levin, 2001; Lind et al., 2011; Tanyi et al., 2009); (b) the factors and forces that create barriers to the provision of spiritual care (Chism & Magnan, 2009; Deal & Grassley, 2009; Gallison et al., 2013; Milligan, 2004; Ronaldson et al., 2012; Stranahan, 2001; Tanyi et al., 2009; Vance, 2001) and (c) the various types of existential as well as religious interventions that are regarded as spiritual care (Chism & Magnan, 2009; Deal & Grassley, 2009; Levin, 2001; Milligan, 2004; Tanyi et al., 2009). Research instruments with good reliability and validity measures are also available for measuring the concept of spiritual care practices.

Instruments Used To Measure Provision of Spiritual Care

The Spiritual Care Practice Questionnaire (SCPQ) developed by Vance (2001) has been most frequently used to measure the practice of spiritual care among acute care nurses. This instrument consists of two parts, plus one qualitative question soliciting additional comments on each section. Part I: Spiritual Assessment and Intervention consists of nine positive statements designed to measure how often nurses performed spiritual assessment and provided spiritual intervention to their patients. Responses to each item on Part I of the questionnaire were measured on a five-point Likert-type scale ranging from 1 (*very seldom*) to 5 (*very often*). A sum score of 32 has been established as an “ideal mean.” This ideal mean is an indication that the nurse is involved in spiritual care activities somewhere between *occasionally* and *often*. Part II: Spiritual Care Barriers Questionnaire consists of nine barrier-related statements and is designed to measure the perceived barriers that prevent nurses from providing spiritual care to their patients. The required response to each of these nine statements is either *agree* or *disagree*. Test-retest reliability for the instrument in its entirety was reported as $r = 0.80$. Internal consistency for Part I of the instrument, which addressed spiritual assessment and interventions,

had a Cronbach alpha = 0.87; while Part II, which measured the barriers to care, had a Cronbach alpha of 0.64 (Vance, 2001). Vance first used the SCPQ to examine the delivery of spiritual care among acute care nurses in a 963 bed community teaching hospital in a large Midwestern city. Gallison et al. (2013) used the same instrument to measure spiritual care practices of acute care nurses in a large hospital in New York City. Ronaldson et al. (2012) also used the instrument to measure the spiritual caring practices in nurses employed in palliative and acute care environments in Sydney, Australia.

These three studies reported similar findings, especially related to the barriers to provision of spiritual care. All three studies reported that although a high percentage of nurses perceived themselves to be spiritual, implementation of spiritual care overall was seriously lacking. This finding was a bit unusual because it is commonly reported in studies done among other populations of nurses that those who report a high level of spirituality also report a stronger tendency to provide spiritual care to their patients.

Part I of Taylor et al.'s (1994) Nurses Spiritual Care Perspective Scale (NSCPS) is another instrument that has been used to measure the frequency of nurses' activities that are intended to support the patient's spiritual domain. The instrument consists of 12 statements related to the nurse's spiritual care intervention. Participants are asked to respond to statements about recent provision of spiritual care based on a Likert-type scale ranging from 1 (*rarely*) to 4 (*very often*). Stranahan (2001) used the instrument to measure spiritual care practices in nurse practitioners. Stranahan noted that the "reliability and validity coefficients for the NSCPS were not available from the authors" (p. 94); neither were they calculated from the data collected for her study. Several researchers have reportedly used both Parts I and II of Taylor et al.'s (1994) NSCPS, but in reporting the findings, focused on Part II of the instrument which addressed the

nurses' attitude towards providing spiritual care and not on the actual care provided. Stranahan (2001) used Part I of the NSCPS to measure provision of spiritual care and a different instrument for measuring attitudes and beliefs about spiritual care. As mentioned earlier, the NSCPS Part I has since been revised and renamed Nurse Spiritual Care Questionnaire (NSCQ). The NSCQ contains 17 items with Likert-type response options ranging from 1 (*never provide spiritual care*) to 5 (*very often provide spiritual care*). Total score on the instrument may therefore range from 17-85. Content validity of the NSCQ is supported by a content validity index of 0.88 and an internal reliability by a Cronbach alpha of 0.93 (E.J Taylor, unpublished document provided via e-mail on October 16, 2014). Taylor noted that the validity of the newly revised instrument was further studied in one dissertation study, however the statistical validity of the instrument for that study was not provided.

Milligan (2004) used a questionnaire to measure nurses' spiritual care practices among 59 Scottish Registered Nurses enrolled in a post-registration palliative care program. The questionnaire consisted of eight spiritual care questions with responses based on a five point Likert-type scale, three qualitative-type questions where respondents answered by free text and seven multiple choice questions where answers were selected from a list of options. There was no information regarding who authored the questionnaire or how the tool was developed; neither were there any statistical measures regarding the validity or reliability of the instrument.

Summary of instruments used for provision of spiritual care. Irrespective of the instrument used for measuring practice of spiritual care, and the population of nurses responding to the survey, findings were consistent in regard to the barriers to providing spiritual care. Findings revealed that nurses lacked confidence, aptitude, and adequate educational preparation to perform spiritual care. On the other hand, there was disagreement regarding the impact of

certain demographical data and the provision of spiritual care among nurses. For example, Vance (2001) reported no significant inferences between spiritual care practices and the nurses' educational level (associate, diploma, baccalaureate, or master's degree), attendance at a religiously affiliated nursing school, or number of years in practice, while Stranahan (2001) reported opposing findings. Noting that nurses who were more educated tended to provide spiritual care on a regular basis, Ronaldson et al. (2012) also reported that nurses in palliative care perceived themselves to be more spiritual and reported providing spiritual care more often than their counterparts in the acute care settings.

The SCPQ Part I developed by Vance was used to measure provision of spiritual care in this study. This instrument was selected because of all the aforementioned instruments for measuring the concept of spiritual care practices, the SCPQ Part I has consistently demonstrated good statistical reliability and validity. Additionally, Vance's phrasing of the items on the instrument acknowledges both the religious and the existential aspects of spiritual care. Her definition of the concept of spiritual care and spirituality is also harmonious with related concepts and variables being examined in this study.

Provision of Spiritual Care Among Nursing Students

Using a convenience sample of 61 nursing students from a part-time Bachelor of Science degree program in Hong Kong, Chung et al. (2007) conducted a quantitative study examining the relationship of nurses' spirituality to their understanding and practice of spiritual care. The Nurses' Spirituality and Delivery of Spiritual Care (NSDSC), a 27 item researcher-developed instrument was used to measure the nurses' relationship with "the self-dimension" and "the beyond dimension" in connection to their understanding and practice of spiritual care. The *beyond dimension* referred to the participants' relationship with God or a Supreme Being, and

the *self-dimension* referred to the relationship with oneself. Overall test–retest reliability of the NSDSC was 0.89.

Analysis of the demographic data revealed participants were 21 to 40 plus years old; 90.2% female ($n=55$), 9.8% male ($n=6$); 59% married ($n=36$); 63% religious ($n=34$), with 40% Christians, 8.2% Buddhists, and 14.2% Taoist, 18% were areligious; work experiences ranged from 3 years to 6.3 years. There was no statistically significant relationship between demographic factors and the nurses' understanding and practice of spiritual care except the nurses' religion, which showed nurses who were non-religious scored higher ($mean = 3.9, 0.7, p = 0.001$) on the *beyond dimension* aspect of the NSDSC than nurses who reported religious affiliations ($mean = 3.1, 0.6, p = 0.001$).

Findings from the study further revealed that there was a statistically significant positive relationship between the self-dimension and the practice of spiritual care ($r = 0.26, p < 0.05$), with relative contribution of self-dimension to practice of spiritual care being ($\beta = 0.68, t = 3.62, p = 0.001$); this relationship was not found between the beyond dimension and the understanding or practice of spiritual care ($\beta = 0.19, t = 1.16, p = 0.258$). Unlike most published studies on this topic, Chung et al.'s (2007) study showed a negative relationship between religious affiliations and the dimension beyond self ($p < 0.001, r$ value was not reported). There were no other differences between the other demographical factors and the practice of spiritual care. The researchers pointed out that these findings were “different from those of other studies which show that nurses' spirituality is a significant factor in supporting the understanding and practice of spiritual care” (Chung et al., 2007, p. 165). Chung et al.'s findings are in disagreement with the well-established body of nursing evidence on the topic cited throughout this paper. In seeking to justify these findings the researchers emphasized that “the importance of the self to

spiritual care is shown through the need for continuous development within the self through seeking greater self-awareness, wholeness and a sense of satisfaction” (p. 166). They further noted that the contented self would reach out to understand others, thus enabling the nurse to focus on the concerns of others when delivering spiritual care. Despite the reasoned argument presented by the researchers, the inconsistency of this finding raises further questions regarding the association between one’s relationship with God/Superior Being and that person’s spiritual care practice. Additionally, it should be considered that the uniqueness of this finding might be related to the fact that the NSDSC is a newly developed instrument being used for the first time. It is also noteworthy that the demographical survey instrument created by Chung et al. (2007) did not include questions about the educational status or inclusion of spiritual care education of the participants. Several studies have presented evidence that the nurse’s level of education and spiritual care education might be contributing factors in whether or not spiritual care is provided (Giske & Cone, 2012; Milligan, 2004; O’Shea et al., 2011; Ronaldson et al., 2012).

In a somewhat similar study Ross et al. (2014) used a cross-sectional, multinational, descriptive survey design to describe how European student nurses/midwives ($n = 531$) perceived spirituality/spiritual care and how competent these nurses perceived themselves to be in delivering spiritual care. Demographic characteristics of the sample indicated the participants’ age range was < 20 to 40 years old (with 80% under 26 years), 62% were attending secular universities, the majority were religious (87%), predominantly Christians (80%, $n = 416$), 60% prayed regularly daily/weekly, and 51% attended religious meetings daily/weekly. Over one third (35%, $n = 185$) engaged in some form of existential practices ranging from doing voluntary work, practicing art, to resting in nature daily or weekly. The researchers did not provide

statistical data on how these demographic data influenced the students' perceived spiritual care competency.

Provision of Spiritual Care Among Practicing RNs

Gallison et al. (2013) used the SCPQ authored by Vance (2001) to assess spiritual care practices and perceived barriers to spiritual care among registered nurses ($n = 271$) employed in the acute care setting of a large New York City hospital. The SCPQ is a two-part Likert-type scale with one qualitative question for each sub-scale. Part I provides information on spiritual care practices of nurses in the acute care settings, and Part II measures the perceived barriers to spiritual care. Analysis of demographic data showed the sample was relatively young in age (75% <40 years old), primarily female (88%), and ethnically diverse. Thirty-one percent were employed in oncology, 28% in general medicine, and 25% in critical care, with years in practice ranging from < one year to 16 years. Participants were mostly Roman Catholic ($n = 59$, 49.2%) and Protestant Christian ($n = 22$, 18.3%). Seventy-nine percent ($n = 95$) indicated that they currently screened their patients for spiritual needs and 75% indicated they did not attend a religiously affiliated school. Over eighty percent (80.8%) were educated at the Baccalaureate level ($n = 97$), and 11.7% at Master's level ($n = 14$). Further findings from this study indicated that 61% of the participants scored less than the ideal mean on the SCPQ, and that although 96% believed that addressing the spiritual needs of the patient was within their scope of practice, 48% reported that they rarely provided spiritual care. Although nurses identified themselves as being spiritual, findings showed that spiritual assessment of patients was not frequently done. For the open-ended question related to provision of spiritual care, 44% of nurses indicated "making referrals," 34% prayed with patients and families, and 17% reported being present with patients.

Participants in Gallison et al.'s (2013) study acknowledged that their greatest perceived barriers to providing spiritual care were belief that the patient's spirituality was private and distinct from nursing care, lack of time to provide spiritual care, difficulty drawing the line between proselytizing and spiritual care, and challenges with addressing patient's spiritual needs when their spiritual beliefs were different from that of the patients. The findings from this study are important because it is one of the very few studies done in the clinical setting among nurses in the acute care environment. Similar studies were mostly done among nursing students in various academic locales, or among nurses who provide care in hospice, long term, or critical care settings. Although Gallison et al., (2013) did not discuss the correlations among the demographical findings and the spiritual care practices of the participants, the data does provide information regarding the settings and the characteristics of nurses who have participated in studies related to provision of spiritual care in nursing.

Vance (2001) provided some very essential inferences between aspects of the demographical data and provision of spiritual care in a study population of 174 RNs who provided direct patient care in the acute care setting of a large community teaching hospital in the Midwestern USA. The study aimed to "determine how the spirituality of acute care registered nurses (RN) influences spiritual care delivery, and to identify barriers which inhibit providing spiritual care" (Vance, 2001, p. 1). Inferential findings between the demographic data and the research variables indicated that there were no significant relationships between the nurses' delivery of spiritual care and their years of nursing practice, their attendance of a religiously affiliated nursing school or their level of education (which ranged from diploma to Master's Degree). Vance (2001) reported that using a linear modeling, the specialty of critical care and medical-surgical nursing were similar, but showed no statistical significance in their

delivery of spiritual care. Nurses employed in behavioral health scored higher on provision of spiritual care but the differences in score were not significant; and nurses in the clinical specialty of women's health scored significantly lower ($p = <.01$, $SD = .5$) than other nurses. The study also revealed that although the nurses perceived themselves to be spiritual only 25% of them provided adequate spiritual care to their patient.

Vance's findings are in opposition to those of Stranahan's (2001) which indicated that nurses with higher levels of education, and those who perceive themselves to be spiritual will score significantly higher on provision of spiritual care. Vance noted that subjects "perceived themselves to be highly spiritual, yet only slightly more than a quarter of the respondents provided adequate spiritual care to their patients." These differences might be related to the fact that the studies were done in different settings, among dissimilar populations of nurses and using different instruments to measure provision of spiritual care.

Bathey's (2012) exploratory study on nurse managers' perspective of spiritual care and the leadership role of CEOs, nursing administrators, chaplains, and other organizational leaders found that while the spiritual dimension of holistic care was considered essential to healing, the practice of such care was still lacking. The researcher further noted that despite the requirements and criteria from accreditation agencies and professional codes identifying spiritual care as an aspect of the nurse's role, there were no well-defined guidelines for implementing such care. Bathey (2012) drew the conclusion that if nurse managers implemented agency-wide programs for spiritual care then nurses (and other health care professionals) would have clear guidelines for providing such care and the organization would have evidence that accreditation standards were being met.

In a similar study on leadership and spiritual care in neonatology, Caldeira and Hall (2012) offered audacious implications for nursing management stating that, “managers have responsibility to ensure that spiritual care is carried out for babies and their families and to care for the team as spiritual leaders” (p. 1069). In a most unprecedented manner the researchers have boldly placed the responsibility for the spiritual care of the neonates, their families, and the staff on the shoulders of managers, declaring that nurse managers must assume the role of spiritual leader for the health team they are called to lead. Although this is not the first study to underscore the importance of healthcare administrators taking the lead to encourage the provision of spiritual care to the patient and spiritual well-being in their nursing staff, the study is the first to bravely declare that managers should provide spiritual leadership for the team.

However, despite this declaration from Caldeira and Hall (2012), there is agreement in literature that spiritual care of the patient is the responsibility of each individual who is a member of health care team (Pesut, 2008; Vance, 2001). With this understanding, it is essential for nurses to be equipped to provide spiritual care to their patients, irrespective of the nurse’s age, area of specialty, ethnicity, years of experience, and religious or spiritual background.

Tanyi et al. (2009), in their phenomenological study, scrutinized how family practice physicians, nurse practitioners, and physician assistants incorporate spiritual care in practice. In this study the researchers conducted semi-structured interviews with three physicians, five nurse practitioners, and two physician assistants. Participants were asked “to describe how they incorporated spirituality [spiritual care] into their practice when caring for patients.” An analysis of the participants’ response gave rise to five major themes: (1) discerning instances for overt spiritual assessment, (2) displaying a genuine and caring attitude, (3) encouraging the use of

existing spiritual practices, (4) documenting spiritual care for continuity of care, and (5) managing perceived barriers to spiritual care.

All the participants revealed that they had to master the art of discerning and assessing the spiritual needs of their patients noting that, “overt spiritual issues [and cues] were salient when working with patients suffering from chronic diseases” (Tanyi et al. 2009, p. 692). Questions such as ‘Why me?’, ‘Why is this happening?’, and ‘What have I done?’ were taken as cues to initiate spiritual assessment. Another cue that the participants recognized was that of waiting for the patient to bring up the topic of spiritual matters – this paved the way for the health care providers to address the patient’s spiritual concerns. There was consensus among the participants that observing the patient’s comfort level with spiritual care topics and developing a professional rapport with their patients enabled the provision of spiritual care. Participants emphasized that they provided care to the human spirit by displaying a genuinely caring, non-judgmental demeanor, treating patients honestly and fairly, following the Golden Rule (treating others the way you would like to be treated) as well as actively listening to their patients (Tanyi et al., 2009). One participant noted that creating a positive attitude can have successful outcomes even if the patient does not have a religious background. Another, noting that there is a spiritual aspect to everyone, indicated that if the patient is areligious, spiritual care was provided by encouraging the patient to think about what gives strength and hope.

Findings from Tanyi et al’s. (2009) study indicated that other non-religious ways of providing spiritual care included encouraging patients to use exercise, yoga techniques, and helping others who are ill. Provision of spiritual care for patients who were religious included encouragement to use their spiritual resources that were helpful in the past, employing only positive spiritual practices such as “talking to a minister,” “going to church” and “helping

others.” One participant emphasized the importance of discouraging bizarre rituals and encouraging patient to take their medication.

It was noticeable that the findings from this study did not include most of the usual ways reported in the literature for incorporating spiritual care into nursing practice. Interventions such as praying with or for the patient, reading of scripture or inspirational writings were never mentioned as a means of providing spiritual care. This study provided evidence that spiritual care can be provided to patients despite the array of barriers to providing such care. Over the year, one primary barrier to spiritual care provision was differentiating between spiritual care and religious intervention. However the findings of this study have clearly distinguished that there were effective ways for delivering spiritual care whether the patient is religious, nonreligious, or atheistic. Providers can meet the spiritual needs of nonreligious and atheistic patient’s by “being good listeners, honest, remaining non-judgmental, and treating patients fairly” (Tanyi et al., 2009, p. 692). In addition to these approaches, patients who are religious may have their spiritual needs met by providers “encouraging them to use existing spiritual practices” (p. 692) that has proven helpful to them.

The idea of waiting for the patient to broach the subject of spiritual care used by participants in the Tanyi et al. study sounds very noble and plausible, however, upon close scrutiny, and compared with approaches to care in the physiological, psychological, sociocultural, and developmental domains, the approach of waiting for the patient to bring up the topic is unacceptable. This is so because in the natural and spontaneous progression of providing holistic care, the nurse is unintimidated to initiate questions and discussions about the most sensitive matters in the aforementioned domains. The question then is why should it be any different for the spiritual domain? As findings in other related studies have indicated, hesitancy

in providing spiritual care is largely related to the lack of educational preparation in providing spiritual care (Giske & Cone, 2011; Milligan, 2004; O'Shea et al., 2011; Stranahan, 2001; Vance, 2001). If nurses were as educationally prepared to provide basic care in the spiritual domain as they are prepared to provide care in the other four domains, it is likely that well documented barriers to addressing the patient's spiritual needs such as lack of time, fear of proselytizing and fear of offending might become less pervasive.

One of Tanyi et al.'s (2009) thematic findings specified "providers who recognize the importance of spiritual care in their patients' health and healing will find time to incorporate it [into the patient's plan of care]" (p. 692). However, there is consensus in the nursing literature that nurses do recognize the importance of spiritual care to their patients (Gallison, et al., 2013; Milligan, 2004; Stranahan, 2001; Taylor et al., 1994). Chism and Magnan (2009) aptly pointed out that while nurses have a high regard for patients' spiritual care, they often feel restricted in providing such care because they lack the theoretical educational as well as the clinical role modeling in the provision of spiritual care. Apart from the well-established empirical finding in the nursing literature that suggests the provision of spiritual care in nursing practice depends, in part, on nurses clarifying their own spiritual care perspectives (Baldacchino, 2010; Chan, 2009; Chism & Magnan, 2009; Gallison et al., 2013; Stranahan, 2001; Tanyi et al., 2009); the lack of spiritual care education in nursing academia and during clinical rotations appears to present a major foundational deficit in preparing nurses to provide spiritual care (O'Shea et al., 2011; Pesut, 2009; Ross et al., 2014; van Leeuwen et al., 2008).

The phenomenological study conducted by Deal and Grassley (2012) to explore the lived experience of giving spiritual care among nephrology nurses working in acute and chronic hemodialysis settings provided contrasting illumination and clarity to the subject of spiritual care

provision in nursing. In this study ten nurses were interviewed with the central question being, “Tell me about a memorable time you had with a patient taking care of his or her spiritual or psychosocial needs” (p.473). Based on the analysis of the participants’ responses, five themes were identified: a) drawing close, b) drawing from the well of my spiritual resources, c) sensing the pain of spiritual distress, d) lacking resources to give spiritual care, and e) giving spiritual care is like diving down deep. From these themes the researchers reported that “patients and nurses draw close during the giving of spiritual care, that nurses have spiritual resources they use to prepare for and give spiritual care” (p. 471). In their discussion of the thematic findings the researchers pointed out that the nurses offered support by being personable, available and approachable in their interactions with the patients. The nurses also felt that they instinctively knew the patients who needed this attention (spiritual care), especially “the first timers who come in crying, scared out of their wits, heightened anxiety, some are angry” (p. 474). In these moments most nurses would sit with the patient and offer reassurance. One nurse emphasized that “sitting” versus “standing” was the preferred position for being with the patient, explaining that the position of standing may convey the feeling of dominance over the patient.

In keeping with the established evidence from preceding studies, the participants in Deal and Grassley’s (2012) study reported that “they relied on their own spiritual resources as they gave spiritual care” (p. 475), noting that their spiritual resource included exercises such as “drawing on God,” “drawing on prayer,” and “drawing on patients.” The authors further noted that “several participants mentioned how being a spiritual person and relying on the presence of God gave them strength and wisdom in how to care for their patients” (p. 475). There was agreement among the participants that although providing spiritual care was a very positive experience there were also many challenges. Challenges included lack of time to give effective

spiritual care, feeling frustrated about being unable to provide spiritual care because of the lack of resources (time, privacy, and feeling drained of spiritual energy). Nurses feeling “afraid to trespass” was another challenge (p. 476). One nurse reported that after a while, the nurses “know who to approach and who not to approach” (p. 476) about addressing spiritual needs. There was agreement that if the nurse was not comfortable with discussing complex spiritual issues with the patient, then the best option was to call the hospital chaplain to see the patient.

Although calling the chaplain is such an indirect way for nurses to provide spiritual care, it is still a viable option. However, such an option does not absolve nurses of their professional responsibility to provide direct care to patients in spiritual distress. This is especially true when considerations are given to the fact that in the acute care settings nurses are physically present with their patients 24 hours per day, seven days per week, even after hospital chaplains are gone for the day. If nurses are cognizant that spiritual care can be as simple as being therapeutically present, listening and holding the patient’s hand (Savel & Munro, 2014), then the trepidations of feeling afraid to trespass (Deal & Grassley, 2012), and not wanting to cross the line between providing spiritual care and proselytizing (Gallison et al., 2013; Ronaldson et al., 2012; Vance, 2001) would be eliminated, thus allowing the nurse the ease to address the needs of the patient’s spirit.

As Savel and Munro (2014) pointed out, many of the terms associated with spirituality (and provision of spiritual care) such as active listening, therapeutic touch, and humor may already be integrated into routine nursing care. While nurses might not identify these techniques as spiritual care intervention, with appropriate spiritual care education the value of these skills in providing spiritual care can be learned. Deal and Grassley (2012) elaborated on the other ways in which nurses may provide spiritual care to their patients, noting that purposeful spiritual

interventions also include praying with or offering prayers for patients, facilitating music that lifts the patient's spirit, holding hands, and arranging or facilitating spiritual or religious rituals at the patient's request. Savel and Munro's (2014) view about the usage of terms associated with spiritual care already being integrated in usual nursing care agrees with Deal and Grassley's (2012) statement that spiritual care is also conveyed by being caring and respectful. As members of a caring profession, the expectations for nurses to be kind, empathetic, nurturing, compassionate and respectful are constantly being emphasized from the seat of nursing education to the clinical arena. These expectations are often regarded as fundamental elements to the core personality of nursing as a profession. Such attributes demonstrated by nurses "will help the patient to regain meaning and purpose in life, faith or trust, hope, love, and forgiveness" (Deal & Grassley, p. 472). There is a need for nurses to be consciously aware and intentional in their implementation of the basic elements of nursing care which at times, depending on one's perspectives may amount to provision of spiritual care. It might be as simple as taking a deep breath to clear the mind in order to be truly present before entering a patient's room (Savel & Munro, 2014), or actively listening to and holding a patient's hand (Deal & Grassley, 2012).

Giske and Cone (2012) conducted a grounded theory study to determine undergraduate nursing students' perspectives on spiritual care and how they learn to assess and provide spiritual care to patients. Data for the study were collected via semi-structured interviews with 42 undergraduate nursing students from three universities in Norway. Findings from this study indicated that participants' main concerns were about creating a professional relationship with their patients while maintaining a rapport when spiritual needs were identified. This concern was resolved by the participants becoming receptive to learning spiritual care, which included students being open to knowing themselves on a deeper level.

These findings substantiated the conclusion from previous studies that a trusting, respectful, and non-judgmental style of communication between the provider of care and the patient are essential for the provision of spiritual care (Milligan, 2004; Tanyi et al., 2009). Giske and Cone (2012) also expressed the need for spiritual care education focused on spiritual and existential themes throughout the nursing program. This recommendation provides validation for the approaches reported by participants in Tanyi et al.'s (2009) study, and supports the findings of Creel's (2007) phenomenological study on the meaning of spiritual nursing care for ill individuals with no religious affiliation. Milligan (2004) also confirms that spiritual care giving among nurses have included religious activities as well as non-religious activities such as establishing and maintaining relationships, supporting, and valuing. Giske and Cone (2012) concluded that a wide range of competencies were needed to fulfill the nursing focus on holistic patient care. It was also felt that nursing education should prepare students to recognize and act on spiritual cues.

Provision of spiritual care is not only beneficial to the patient, but studies have shown that nurses have also reported rewarding effects when they provide spiritual care to their patients (Baldacchino & Formosa, 2010; Deal & Grassley, 2012). In reporting on the findings of a small qualitative study ($n = 8$) on the impact of spiritual care on nurses, Baldacchino and Formosa (2010) noted that providing spiritual care had immediate as well as long term effects on the nurse's life. The immediate impact was described as "experiencing trust" and "feeling of happiness" (p.84). The long term impact of providing spiritual care on the nurse's life included: "searching for meaning and purpose," and "appreciating health and valuing human life" (p.84).

In other studies, nurses have reported various benefits to themselves when they provided spiritual care. These benefits include increased work satisfaction and fulfillment (Baldacchino,

2008; Deal & Grassley, 2012), feeling of overall well-being (Burkhart & Schmidt, 2012), increased spiritual intelligence and sensitivity (Burkhart & Schmidt, 2012; Yang & Mao, 2007), and increased empathy towards patients in spiritual distress (Chism & Mangan, 2009). The emotional distress and draining experiences related to the provision of spiritual care that some nurses in Deal and Grassley's (2012) study experienced was an unusual finding; however as the authors of that study explained, such adverse feelings may be similar to compassion fatigue.

Summary and critique of provision of spiritual care. Despite the challenges and feelings of inadequacy that most nurses experience in providing spiritual care to their patients, it is reasoned that education can make a difference in breaking down barriers, removing challenges, and overcoming obstacles. As professionals who spend a great deal of time educating themselves and their patients, nurses have witnessed firsthand the fruits of such educational endeavors. Hence, nurses should be encouraged that since competency has been achieved through education in the provision of effective nursing care in the physiological, psychological, sociocultural and developmental domains, there is no reason why proficiency cannot be attained for care in the spiritual domain. Gallison et al.'s (2013) study further demonstrated that although nurses do acknowledge their role as spiritual care providers, the hurdle of gaining confidence and competency in addressing the spiritual needs of their patients in the acute care setting cannot be ignored. Turan and Yavuz Karamanoğlu (2013) noted that the spiritual dimension is often disregarded although it is recognized as being of equal importance as care in the physical and psychological domains. Milligan (2004) shared similar views, commenting that spiritual care in nursing is neglected although a structured problem-solving approach could be adopted to ensure that spiritual care is given.

Despite the array of knowledge on the topic of spiritual care, there remains a dearth of research studies related to provision of care among registered nurses who are employed in the acute care setting, and how the spiritual well-being and spiritual care perspective of these nurses may influence their ability to provide spiritual care.

Summary of the Literature

From a review of the literature it is apparent that given the documented challenges and benefits of nurses providing spiritual care, the need for competency and increased confidence to provide such care is urgent. In general, nurses' state of spiritual well-being along with their attitude, beliefs, and values about spiritual care were recurring factors that seem to influence the provision of spiritual care. From academia to the practice setting there is also harmony and consistency in the aforementioned empirical studies and discussion of theoretical literature regarding considerations for making spiritual care an established reality of every-day nursing practice. Such considerations include: (a) the need to enhance or at the least encourage a greater sense of spiritual well-being among nurses; (b) enhancing the spiritual care perspective among nurses thus fostering a positive attitude towards providing spiritual care; and (c) promoting a culture of spiritual caring where nurses (as well as all health care personnel) can be nurtured and educated to provide care in the spiritual domain with similar ease to which care in the physiological, psychological, sociocultural and developmental domains is offered.

The gap in the literature is also clear concerning the need for further exploration into the spiritual well-being, spiritual care perspectives, and the actual provision of spiritual care among nurses employed in the acute care settings, especially because most related studies have been conducted among student nurses or practicing nurses employed in oncology, palliative care, hospice and long term care settings.

Chapter III

Methods and Procedure

Study Design

Using a descriptive correlational design, this study aimed to explore and determine the relationships between and among nurses' spiritual well-being, spiritual care perspectives, and provision of spiritual care to adult patients in acute care settings. This chapter presents an overview of the study sample, research setting, and sample size. A description of the instruments for measuring the aforementioned variables (*spiritual well-being, spiritual care perspectives, and provision of spiritual care*), the data collection and data analysis procedures used, processes for protecting human subjects via Internal Review Board (IRB), and ethical considerations are presented in this chapter.

Research Question

What are the relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in acute care settings?

Participants, Inclusion Criteria and Settings

Participants for the study included English speaking Registered Nurses (RNs) who were currently employed on a full time or part-time basis, as per-diem staff, and via employment agencies in healthcare organizations to deliver direct care to adult patients in acute care settings. RNs employed to deliver direct care to adults in acute care settings were recruited for this study regardless of their age, years of professional employment, religious or non-religious persuasions, level of nursing education, gender, race, ethnicity, area of specialty and work schedule. Participants were recruited through the Academy of Medical Surgical Nurses (AMS_N). Members of the AMS_N were the most suitable participants for this study because they were

dedicatedly employed to provide nursing care to patients in the acute care setting. The data collection for this study was done electronically via Survey Monkey[®], which is a secure survey website.

Selection Process

Participants for the study were from a convenience sample of acute care RNs drawn from the membership of the AMSN who met the designated study criteria and volunteered to participate in the study.

Exclusion criteria

This study excluded nurses who were non-English speaking as well as RNs employed in acute care settings who do not customarily provide direct patient care. RNs employed exclusively in hospice, palliative care and long term care facilities were not included in this study. This exclusion is based on the literature which demonstrates that these populations of nurses have a greater propensity to provide spiritual care to their patients (Milligan, 2004; Musgrave & McFarlane, 2004; Ronaldson et al., 2012; Taylor et al., 1994). Furthermore there is a gap in the literature regarding empirical studies of provision of spiritual care among nurses employed in the acute care setting that does not exist in hospice, palliative or long term care nursing practice.

Nurse Managers, Patient Care Directors, Administrators, Directors of Nursing, and Nurse Educators were also excluded because the study aimed to survey only nurses who were currently providing direct patient care. Although most acute care settings are comprised of units of service for the pediatric, neonatal and maternity populations, RNs employed in those areas were not invited to participate in the study. This exclusion criterion was important in order to maintain homogeneity among the study participants. Excluding RNs who were employed in pediatric and

neonatal services therefore limited the participants to nurses who were employed in adult care services. While RNs employed in maternity care are providing direct care to adult patients, the general consensus is that the majority of patients admitted to maternity units are not usually ill as in the case of those who are admitted to other units within the same health care organization. Moreover, RNs employed in pediatric and neonatal specialty units are seldom, if ever, required to provide direct care to the adult patient.

Sample Size and Power Analysis

The sample size for the study was based on the results of a power analysis. In order to strengthen the significance of the findings of this descriptive correlational study and in order to accurately conclude whether or not significant relationships exist between and among the independent and dependent variables, a power of at least 0.80 (80%) was acceptable. The level of significance was set at 0.05. Cohen (1988) power table for correlation coefficient indicated that a sample size of eighty ($n = 80$) participants would provide a power of 0.96 (96%) with a significance level of 0.05 ($p = 0.05$) for a medium effect ($r = 0.4$) for a 2 tailed test. A significance level of 0.05 would indicate a statistically significant one-on-one relationship between the variables being examined, with only a 5% probability that the relationship was found by chance. It was determined that a medium effect size of $r = 0.4$ is sufficient to indicate the magnitude of the relationship between the research variables; a two tailed test was designated because the results of the study may reveal either a positive or a negative relationship between the independent variables and the dependent variables (Bannon, 2013). Power analysis (done via G*Power) for planned linear multiple regression indicated a minimum sample size of one hundred and seven ($n = 107$), with a significance level of 0.05 ($p = 0.05$), power set at 0.95 (95%),

for a medium effect ($f^2 = 0.15$) with a total of seven predictors (<http://www.psych.uni-duesseldorf.de/abteilungen/aap/gpower3/>).

Recruitment Procedure for Research Participants

Participants for the proposed study were recruited from the Academy of Medical-Surgical Nurses (AMSN). Information for researchers desiring the participation of AMSN members as study participants was obtained from the Academy's website, contained in Policy 5.2., titled *Distribution of Membership List*. In accordance with the conditions of this policy, a request for use of the membership list with copy of proposal abstract, a cover letter, and research instruments along with evidence of Institutional Review Board (IRB) approval from Seton Hall University were submitted to the AMSN. The request was reviewed and approved by the AMSN Research Coordinator. A letter of approval (Appendix M) was sent electronically to the researcher within 10 business days. Additionally, the Academy promoted the surveys free of cost and ensured that they were distributed electronically to the over 11,500 members of AMSN. There is an expectation that the researcher will share the findings of the study in an AMSN educational venue.

The survey instruments were distributed to members of AMSN via a secure survey website—Survey Monkey[®]. An introductory letter (Appendix C) was delivered electronically from AMSN media to prospective RN participants ($N = 11,500$). The message included a link to the secure website, Survey Monkey[®]. Upon opening the link to Survey Monkey[®] website, self-selected participants were asked to read a letter of solicitation from the researcher (Appendix D). Participants were directed to follow the prompt to access and complete a work-related demographic survey, the SWBS, the SCPS-Rv, and the SCPQ Part I. Completed surveys

indicated the participants' consent and voluntary participation in the study as noted in the letter of invitation.

Research Variables and Questions

The independent variables for this descriptive correlational study are spiritual well-being and spiritual care perspectives. The dependent variable is provision of spiritual care. Potential covariate variables of select demographic factors included participants' age, commitment to personal spiritual practices, level of education, practice specialty and years of nursing practice. The study therefore sought to determine, explore and analyze the relationships between and among nurses' spiritual well-being, spiritual care perspectives, select demographic factors and their provision of spiritual care to adult patients in the acute care setting.

Research Questions

Q₁: Is there a relationship between acute care nurses' spiritual well-being and their provision of spiritual care to patients in acute care settings?

Q₂: Is there a relationship between acute care nurses' spiritual care perspectives and their provision of spiritual care to patients in acute care settings?

Q₃: Are there relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, select demographic factors and their provision of spiritual care to patients in acute care settings? (See Figure 1-1, p. 26).

Q₄: Are there relationships among acute care nurses' spiritual well-being, spiritual care perspectives and select demographic factors? (See Figure 1-2, p.26).

Questions one and two were answered with Pearson product-moment correlation (Bannon, 2013). Questions three and four were answered with Spearman Rho tests and regression statistics because there were statistically significant relationships ($p < .05$) between

and among the primary research variables as well as among three categorical demographic factors.

Measurement of Spiritual Well-being

The concept of *spiritual well-being* was operationalized by the score on The Spiritual Well-Being Scale (SWBS). This 20-item instrument was developed by Paloutzian and Ellison in 1982 to evaluate subjective reports of religious and existential well-being. The instrument is composed of two subscales, namely the Religious Well-Being Scale (RWBS) and the Existential Well-Being Scale (EWBS), each consisting of 10 items. All items in RWBS contain the word “God.” An example of a question from the RWBS is: “My relation with God contributes to my sense of well-being” (Paloutzian & Ellison (2009, p. 1). Conversely, all items contained in the EWBS are concerned with life satisfaction and direction; an example of such a question is “I feel a sense of well-being about the direction my life is headed in” (Paloutzian & Ellison (2009, p. 1). The SWBS provides an overall measure of the perception of spiritual quality of life as well as a score for each subscale—RWBS and EWBS (Paloutzian & Ellison, 2009).

Fifty percent of the items are worded in the negative direction to control for possible response bias. Three primary scores can be obtained from the SWBS; these are scores for the respondent’s religious well-being (RWB), existential well-being (EWB), and the overall spiritual well-being (SWB). Each item on the SWBS is scored on a 6 point Likert-type scale, with statements ranging from *strongly disagree* (1 point) to *strongly agree* (6 points). Negatively worded items are reverse scored. For the positively worded items, an answer of *strongly agree* is given a score of 6, *moderately agree* is scored 5, *agree* is scored 4, *disagree* is scored 3, *moderately disagree* is scored 2, and *strongly disagree* is scored 1. For the negatively worded items, an answer of *strongly agree* is given a score of 1, *moderately agree* is scored 2, *agree* is

scored 3, *disagree* is scored 4, *moderately disagree* is scored 5, and *strongly disagree* is scored 6. Totaling the scores for all items will give an overall SWB score ranging from 20 to 120. A score of 20-40 is indicative of low SWB, 41-99 indicates moderate SWB, and 100-120 reflects a sense of high SWB (Paloutzian & Ellison, 2009).

The developers of the instrument explained that the score for RWB is obtained by summing the odd numbered items on the SWBS which are worded to measure one's relationship and sense of satisfaction with God. RWB scores may range from 10 to 60, with a score of 10-20 reflecting a sense of unsatisfactory relationship with God, 21-49 indicating a moderate sense of RWB, and 50-60 indicative of a positive view of one's relationship with God. Paloutzian and Ellison (1991) further explained that the EWB score which measures the respondent's level of life satisfaction and life purpose is obtained by totaling the even numbered items on the SWBS. EWB scores may range from 10 to 60. A score of 10 to 20 suggests a low level of satisfaction with life and a lack of clarity about one's purpose in life. A score of 21 to 49 implies a moderate level of satisfaction and purpose in life and 50 to 60 reflects a high level of life satisfaction with a clear sense of purpose in life. The range of scores for each of the subscale was determined by Paloutzian and Ellison.

The SWBS by Paloutzian and Ellison (1982) was developed in response to the growing interest in quality of life and subjective well-being issues that came to the national forefront during the 1960s to 1970s. Since the quality of life literature of that day did not include the importance of the spiritual dimension as a determinant to quality of life concerns, and because Paloutzian and Ellison reasoned that, conceptually, quality of life involved material, psychological and spiritual well-being, the SWBS was designed by them to measure the spiritual dimension of well-being. In the initial research studies for the development of the SWBS,

various populations of “men, women, housewives, college students, young adults, and senior citizens, high school students, married and single persons, religious and non-religious people, people from large cities, small cities and rural areas” (Ellison 1983, p. 333), were surveyed to test the reliability and validity of the instrument. Paloutzian and Ellison (1982) reported that “the initial construction of the SWBS insured that it has good face validity” (p. 57); and that SWBS and its subscales were positively correlated with several standard indicators of well-being. Bufford et al. (1991) noted that early research studies using the SWBS showed test-retest reliability above 0.85 in three samples after one, four, and ten weeks and above 0.73 in a fourth sample after six weeks. Coefficient alpha was reported above 0.84 in seven samples.

Use of SWBS in Nursing Research. An exhaustive bibliography of research studies which used the SWBS was obtained from the authors of the instrument. The listing showed that the SWBS has been used in diverse population of participants ranging from sports, healthcare, social work, and psychology, to business, theology and education. It was noted that 21 of these studies were done among nurses of which 15 were unpublished and three were listed as dissertation abstracts.

Of the published studies, Musgrave and McFarlane (2004) utilized the Spiritual Well-being Scale (SWBS) to measure the concept of spiritual-wellbeing in a path analysis to investigate the effects of spiritual well-being on attitudes toward providing spiritual care in Israeli oncology nurses ($n = 155$). Results of regression analyses ($R^2 = 0.12$, $\beta = 0.39$, $p = 0.001$) supported the researchers’ hypothesis that spiritual well-being would have a direct influence on the nurses’ attitudes regarding spiritual care. For their study, Musgrave and McFarlane (2004) reported Cronbach’s alpha coefficient of 0.88 for the entire SWBS. In a more recent use of the SWBS by Yong, Kim, Park, Seo, and Swinton (2011) to operationalize spiritual well-being in

Korean nurse managers, the scale also demonstrated good internal consistency reliability with Cronbach's alpha ranging from 0.79 to 0.97. The researchers did not provide specific information on the alpha scores for the SWB Scale, but offered a range of scores for the four instruments used in the study. The *experimental* study, which examined the effect of a spirituality training program on the spiritual well-being and other variables of nurses in middle management positions, reported that participants in the experimental group showed higher scores in spiritual well-being ($F = 6.03, p = .018$) than their counterparts in the control group who received no spirituality training. Vance (2001) also reported good internal consistency with Cronbach alpha .90 and test-retest reliability ($r = .93$) for the total SWBS used in an exploratory survey of acute care nurses to measure the spiritual attitudes of the nurses. Vance reported significant correlations between the nurses' SWB scores and their spiritual care practices ($r = .19, p = <.05$).

In another study to evaluate the spiritual well-being of nurses and to appraise their views regarding the importance of offering spiritual assistance to patients, de Brito Pedrao and Beresin (2010) used the SWBS to measure the spiritual well-being in 30 nurses working in a Step-down Unit and an Oncology Unit in a hospital in Brazil. Although the researchers did not report on the reliability of the scale in the sample they studied, their findings that nurses who scored well on the SWBS also considered it important to offer spiritual assistance to their patients, were consistent with the findings of other related studies (Baldacchino et al., 2010; Musgrave &McFarlane, 2004). Notwithstanding the findings of the aforementioned studies, Duggleby, Cooper, and Penz (2009) reported contrary findings in their study of sixty-four Continuing Care Assistants (CCAs) who provided direct care to older people in home and nursing home environments in Canada. The aim of their study was to examine the relationships between hope

and spiritual well-being, job satisfaction, and self-efficacy. The researchers reported a statistically significant negative correlation between hope and spiritual well-being ($r = -0.42, p < 0.017$), indicating that as hope increased spiritual well-being decreased. The Cronbach's alpha for the SWBS in the study was 0.87.

Several studies conducted among patients as well as with other health care professionals discussed earlier using the SWBS do not substantiate Duggleby et al.'s (2009) findings. Dunn, Handley, and Shelton (2007) studied relationships between spiritual well-being, anxiety and depression in antepartum women ($n = 180$) on bed rest, and reported significant inverse relationships among the women's spiritual well-being, anxiety and depression. This indicated that as spiritual well-being increased, anxiety and depression decreased. The reliability consistency of the instrument for the study sample was not reported.

Despite the SWBS being one of the most widely used instruments for measuring the concept of spiritual well-being, and its demonstrated good internal consistency and construct validity, several researchers and critiques of the instrument have expressed concern about the "ceiling effect" especially among Protestant Christian participants (Bufford et al., 1991). "A ceiling effect occurs when a measure possesses a distinct upper limit for potential responses and a large concentration of participants score at or near this limit" (Hessling et al., 2004, para.1). Additionally the usefulness of the scale for measuring the SWB of people who are of the "Catholic, Jewish and other faiths outside the Judeo-Christian tradition" (Bufford et al., 1991, p.26) has been questioned; the instrument's tendency to be negatively skewed when used with religious populations has been problematic (Genia, 2001).

In responding to the recommendations for additional research studies and to address the need for investigating the non-parametric issues associated with the scale, Genia (2001)

conducted a study purposed “to build on previous research by examining the psychometric qualities and construct validity of the SWB scales in a spiritually heterogeneous sample” (Genia, 2001, p. 26). Two hundred and eleven college students participated in the study, of whom 34% were Catholic, 29% identified as various Protestant denominations, 13% were Jewish, and 24% were either religiously unaffiliated or identified as belonging to religions outside the Judeo-Christian tradition. Findings from Genia’s (2001) study indicated that factorial validity of the SWBS was supported, and that both subscales of the SWBS have good internal consistency across four religious affiliations. Cronbach’s alpha reliability coefficients for RWBS, EWBS, and SWBS respectively, based on religious affiliation, showed Catholic, .94, .91, .93; Protestant, .93, .78, .91; Jewish, .91, .84, .76; and nontraditionally religious, .93, .87, .88. Additionally, the data also supported the construct validity of the RWB subscale and the EWB subscale, replicating previous findings. Concerns regarding the “ceiling effect” among Protestant Christian participants was somewhat abated, with findings from the study suggesting that “ceiling effects” for the SWBS is associated with religious affiliation in general and not specific to a particular religion. Findings showed that the SWB scores were negatively skewed among Catholics and Protestants but showed a more symmetrical distribution among Jewish participants. The researcher concluded that the validity of combining the scales to form an overall SWB score might be questionable, especially since the RWB subscale and EWB subscale seem to measure distinct constructs. It was recommended that instead of presenting a total score for the overall SWBS, researchers should report scores for both RWB and EWB subscales as separate entities, because each subscale measured different aspects of spiritual health.

The SWBS by Paloutzian and Ellison (1982) (Appendix E) was used to measure spiritual well-being in this study because despite earlier concerns about ceiling effects and negatively

skewed results from respondents who are very religious, the instrument has consistently demonstrated a good reliability and construct validity across various studies involving diverse populations. The only exception was noted in Kamya's (1994) study of spiritual well-being among social work students, where the Cronbach alpha coefficient for the EWBS was reported .59; however the RWBS in that same study reported a reliability score of .90. It is also noteworthy that in all the studies reviewed, the reliability coefficient for the EWBS tended to be slightly lower than that of the RWBS and the overall SWBS. Findings from Genia's (2001) study were very helpful in resolving some of the concerns associated with the SWBS.

In this study the entire SWBS was used to measure the concept of spiritual well-being in acute care nurses. The total score for the SWBS incorporated data on the subjects' existential and religious aspects of spiritual well-being; this is important because the study's definition of spiritual well-being acknowledged that there is an existential as well as a religious component to the concept of spiritual well-being.

Measurement of Spiritual Care Perspectives

The concept of spiritual care perspectives was operationalized by the revised version of the Spiritual Care Perspective Scale (SCPS-Rv) (Appendix F). The original instrument, Nurse Spiritual Care Perspective Scale (NSCPS) Parts I & II was developed by Taylor et al. in 1994. NSCPS-Part I was geared to measure interventional aspects of spiritual care, while Part II measured nurses' attitude, values and perspectives about providing spiritual care. The original instrument (NSCPS) was later revised by Taylor in 2004 and presented as two separate entities: one for measuring the concept of *spiritual care practices* (SC-Pr.) and the other for measuring *spiritual care perspectives* (SCPS-Rv).

According to Taylor (E. J. Taylor, personal communication, October 16, 2014, and in unpublished document provided via e-mail), the items contained in the SCPS-Rv were drawn from the original NSCPS which was an extensive survey designed to inquire about nurses' spiritual care practices and perspectives. In its preliminary phase, the NSCPS was administered via mail during the mid-1990s to members of the Oncology Nurse Society ($n = 181$) and Hospice Nurses Association ($n = 638$). Data from these original respondents were used to psychometrically test the SCPS-Rv. Face validity for the SCPS-Rv was established by a panel of four oncology nurse researchers who are experts in spiritual care. Construct validity is supported by findings that show significant positive correlations between the SCPS-Rv and self-reported spirituality and religiousness. Evidence of construct validity was also provided by results of an exploratory factor analysis. Taylor (E. J. Taylor, personal communication, October 16, 2014) explained that during its revision, the 7-item SCPS-Rv produced an alpha reliability coefficient of 0.75, while the 10-item SCPS-Rv improved the alpha to 0.82. The first seven items of the SCPS-Rv are intended to measure the nurses' attitude regarding the importance of including spiritual care in routine nursing roles. Each item is followed by a five-point Likert scale response ranging from 1 (*strongly agree*), to 5 (*strongly disagree*). The last three items which address unidimensional aspects of the concept, also measure the nurse's perspective about providing spiritual care (E. J. Taylor, unpublished document provided via e-mail, October 16, 2014).

The five-point Likert-like scale that follows each of these three items elicits a response reflecting frequency, strength or comfort-level regarding the perceived ability or feeling of the nurse about spiritual care. For example item eight in prompting a response about frequency of spiritual care states, "I provide spiritual care every day at work: *rarely or never* (1) to *every day at work* (5)." In its totality reverse scoring is required for four of the ten items on the SCPS-Rv, thus

allowing for scores ranging from 10 to 50. A low score is an indication of a negative attitude towards spiritual care and a high score is indicative of a positive perspective towards spiritual care. The stability of the SCPS-Rv was measured during a test-retest reliability study of 45 undergraduate and graduate nurses at a sectarian school of nursing. The nurses completed the SCPS-Rv twice, with a two week interval between administrations. Results showed strong correlations between time I and time II suggesting stability of the newly revised instrument (Spearman's $\rho = .60$; Pearson $r = .65$; $p < .01$). Paired samples t-test demonstrated no significant difference between times ($t = 1.1$, $p = .27$, $df = 36$) (E. J. Taylor, personal communication, October 16, 2014).

Use of SCPS-Rv in Nursing Research. Based on a review of the literature and information obtained electronically from Dr. Taylor (author of the SCPS-Rv and co-author of the earlier NSCPS) it is indicated that the NSCPS and the SCPS-Rv have been used in four research studies to measure the concept of nurses' spiritual care perspectives and attitudes towards providing spiritual care among various populations of nurses who are engaged in different practice specialties. The findings for these studies have been described in details in Chapter II of this dissertation. The following discussion presents a brief overview of the four studies and the reported measure of internal consistency and scale reliability reported by the authors of those studies.

Musgrave and McFarlane (2004) used the original NSCPS Part II to measure attitudes toward spiritual care in oncology nurses ($n = 155$). The researchers reported a Cronbach alpha coefficient of 0.75 based on the data collected. Stranahan (2001) used the same scale to operationalize spiritual care practices and attitude toward providing spiritual care in nurse practitioners ($n = 102$). There was no report of the measures of internal consistency or scale reliability for Stranahan's study. In another study designed to evaluate the effectiveness of a spiritual education session, O'Shea et al. (2011) used the SCPS-Rv to measure the spiritual care

attitude of pediatric nurses and neonatal nurses ($n = 41$) before and immediately after an educational session on spiritual care. The reliability of the instrument for the pretest scores demonstrated a Cronbach's alpha of .81; and a posttest alpha coefficient of .82. In a study of 223 nursing students, Chism and Magnan (2009) used the Spiritual Care Perspective Scale to operationalize the nurses' perspectives of spiritual care as well as the attitudes and beliefs nurses have regarding spiritual care in nursing. The internal consistency and reliability score with a Cronbach's alpha of 0.80 reported by the researchers was similar to the score of .82 reported by Taylor (E. J. Taylor, unpublished document provided via e-mail on October 16, 2014).

Based on the aforementioned reported internal consistency and reliability, both the SCPS-Rv and the NSCPS are reliable instruments for measuring the nurse's perspectives, attitudes and values towards spiritual care. The reported range of Cronbach's alpha scores from 0.75 to 0.82 for the studies discussed in this section suggest that the items comprising both scales have relatively high internal consistency. This is considered acceptable in most research situations (Bannon, 2013). The SCPS-Rv was used to measure the concept of spiritual care perspective (attitude, beliefs and values) in this study because the instrument has demonstrated high internal consistency and reliability in earlier studies. Furthermore, the SCPS-Rv is preferred because the instrument focuses on the measurement of a single concept (i.e. *spiritual care perspectives*) unlike the original instrument (NSCPS) which embodies the measurement of two concepts, namely *spiritual care practice* and *spiritual care perspectives*.

Measurement for Provision of Spiritual Care

In this study the concept of provision of spiritual care was measured by the Spiritual Care Practice Questionnaire (SCPQ) authored by Vance (2001) (Appendix G). The SCPQ consists of two parts. Part I measures the frequency of assessment and interventions as it relates to provision of

spiritual care. Part II measures the barriers to providing spiritual care, and is used to determine the perceived barriers that inhibit provision of spiritual care by nurses. Vance (2001) explained that in its infantile stage the questionnaire was reviewed for content validity by a panel of experts consisting of a hospital chaplain of Baptist faith, a Unitarian Universalist lay minister, a medical librarian, a psychiatric clinical nurse specialist of Jewish faith, and a doctoral prepared nurse researcher specializing in spirituality. A panel of ten staff nurses from various areas of nursing practice reviewed the questionnaire for content validity and question clarity. Test-retest reliability was reported as $r=0.80$. Internal consistency for Parts I & II of the questionnaire showed Cronbach's alpha of 0.87 for Part I (assessment and interventions); and 0.64 for Part II (barriers to spiritual care) (Vance, 2001). During its developmental stage, the questionnaire was used to survey RNs in various acute care settings ($n = 173$) regarding their spiritual care practices among patients with medical/surgical, women's health and behavioral health concerns (Vance, 2001). There was an expected significant, but negative correlation ($r = -0.41, p = <.05$) between the barriers section and the assessment and interventions section of the questionnaire (Vance, 2001).

Part I (assessment and intervention section) of the SCPQ consists of nine positive statements, each describing various spiritual activities or practices. Responses to the SCPQ are scored based on a five point Likert Scale to indicate the frequency of these activities, from *very seldom* (1) to *very often* (5). An example of such items is: *I observe and/or inquire about past and present use of spiritual and/or religious practices and adaptive techniques (Examples: prayer, meditation, worship, receiving of sacraments, contact with clergy or chaplain, scriptural reading, music, guided imagery, contact with nature)*; responses range from *very seldom* (1) to *very often* (5). Possible scores on this practice section of the questionnaire range from 9 to 45.

Vance (2001) estimated a score of 32 as being realistically attainable for an ideal mean to represent nurses who practice spiritual caring somewhere between *occasionally* and *often*.

Part II (barrier section) of the SCPQ consists of nine barrier related statements; each requiring either *agree* or *disagree* responses, depending on whether each statement is perceived as being a barrier or not to the nurse's spiritual caring. An example of a barrier statement is: *I do not give much thought or attention to my own spiritual self and therefore do not consider my patients' spirituality a priority in their provision of care*. Response is either *agree* or *disagree*. The percentages of each perceived barrier is reported according to frequency of occurrence. The questionnaire also included one qualitative item for each sub-scale to allow for additional comments from the participants. For example the qualitative item for Part I states: *Please list any other nursing interventions you provide for the spiritual care of your patients*. Part II elicits response to the statement: *Please list any other barriers to providing spiritual care that you have encountered*.

Use of the SCPQ in Nursing Research

A search of the related literature revealed that apart from Vance (2001), only two teams of researchers (Gallison et al., 2013 and Ronaldson et al., 2012) have used the SCPQ to measure the concept of spiritual care practices. A brief overview of these studies is presented in this subsection; detailed accounts of the findings for both studies have been described in Chapter II.

Ronaldson et al. (2012) used the instrument in a cross sectional study designed to compare the spiritual care practices of RNs in acute care settings ($n = 50$) with their counterparts in palliative care ($n = 42$). Based on the data collected for that study, the researchers reported a Cronbach alpha of 0.89 for Part I (assessment and interventions) subscale. However, no alpha score was reported for Part II (barriers) subscale. Gallison et al. (2013) used the SCPQ in an

exploratory, descriptive study to examine spiritual care practices of acute care nurses ($n = 271$). The aim of the study was to describe the extent to which nurses were aware of and prepared to meet the spiritual needs of hospitalized patients. Although the researchers cited the internal consistency and reliability of the instrument obtained in Vance's (2001) study (alpha = 0.87 and test retest: $r = 0.80$), Gallison et al. (2013) made no mention of these scores based on the sample who participated for their study.

In the current study the SCPQ Part I designed to measure the frequency of assessment and intervention for spiritual care practices was used to operationalize the dependent variable, *provision of spiritual care*. This instrument was preferred because the items on the questionnaire were carefully worded to include spiritual care practices that are conveyed through traditional religious expressions, existential interventions, and adaptive techniques. This feature of the instrument was important to the study because various expressions of spiritual care (from traditional religious interventions to existential interjections) have been fully acknowledged as valid forms of spiritual care provision. Additionally, the SCPQ Part I has demonstrated high internal consistency reliability in studies that have used the instrument and reported such measure.

Permissions to use the SWBS, the SCP-Rv and the SCPQ Part I were granted by the respective authors of these instruments (see Appendices H, I, and J).

Demographic and Work-Related Questionnaire

Based on current literature for survey designs (Andres, 2012; Blasius & Thiessen, 2012), a questionnaire aimed to collect the demographic and work-related data of the study participants was created by the researcher. This questionnaire collected information related to participants' age, gender, race/ethnicity, educational level, number of years in practice as an RN, number of

years employed as an RN in current place of employment, number of hours worked per week, shift scheduled to work, average number of patients assigned per shift, commitment to personal spiritual practices, and inclusion of spiritual care nursing education (see Appendix K).

Data Collection Procedures

The three research instruments (the SWBS, SCPS-Rv, and the SCPQ Part I) along with the demographic and work-related questionnaire were administered via Survey Monkey®, a secure online survey website. These data collection instruments were made accessible to RNs employed in acute care settings of multiple health care organizations nationally via the Academy of Medical Surgical Nurses (AMSN).

An introductory message (Appendix C) was delivered electronically from the AMSN communication media to the total membership of the Academy ($N=11,500$). This message included a link to a secure website within Survey Monkey®. Upon opening the link to Survey Monkey®, self-selected participants were directed to read a letter of solicitation from the researcher (Appendix D), and afterward respond to three preliminary closed-ended questions (Appendix L). These questions were designed to determine whether or not the potential participants met the criteria for the study. Nurses volunteering to participate in the study who met the inclusion criteria were directed to follow the prompt to access and complete the demographic work-related survey, the SWBS, SCPS, and the SCPQ Part I. Nurses who did not meet these criteria based on their responses to the three closed-ended preliminary questions received a “thank you for your interest” message and were prompted to close the link. They were blocked from completing the survey instruments by a set feature in the Survey Monkey® website.

Participants who were allowed access to the survey were assured that their responses were confidential and anonymous. They were also informed that completing the surveys would take approximately 25-30 minutes, and that if they were unable to complete the surveys in one sitting they would be allowed to re-enter the survey site to complete the unfinished surveys. Completing and submitting the research instruments was an indication of the nurses' voluntary consent to participate in the study. Research instruments were accessible to the AMSN membership via Survey Monkey® for six weeks. To maximize the number of respondents, the Academy sent out one reminder to their members four weeks after the initial posting. The details regarding accessibility of research instruments to the membership of AMSN and the number of reminders that were sent out to the members were based on the usual practices of the Academy. Duplication of responses was prevented by enabling a particular feature within Survey Monkey that prevented respondents from submitting more than once.

Storage of Data. Upon completion of data collection, the data was downloaded from the Survey Monkey® website to two USB flash drives; one was kept in safe-keeping as a back-up. Confidentiality was maintained at all times by ensuring that USB flash drives containing survey data were kept in a locked drawer in the researcher's office when not in use. Only the researcher has access to the data. Anonymity of participants was assured through a set function of Survey Monkey. Additionally, there was no request for identifying personal information on the demographic survey or on any of the three research instruments. Research data will be retained in a secure drawer for a minimum of three years after the study is completed.

Statistical Procedures. Upon completion of data collection via Survey Monkey®, the data were analyzed using the Statistical Package for the Social Sciences (SPSS), Version 23.0 software (IBM SPSS Statistics, 2015). Descriptive statistics were used to analyze the

demographic data. Frequency counts, percentages and measures of central tendency were used to describe and summarize the characteristics of the study participants. Descriptive and reliability statistics were done for the instruments used in the study. Pearson r correlations were utilized to determine relationships between and among the research variables in which the data met the assumptions for use of parametric statistics. Spearman Rho nonparametric tests were employed to analyze associations between ordinal level data, and regression analyses were applied to determine the effects of significant predictor variables on the dependent variable.

Treatment of Missing Data. Although 37 surveys (22%) with significant amounts of missing data were removed from the data set by using the listwise deletion method (Bannon, 2013), an exception was made for eleven surveys in which participants reported invalid figures such as \$1.00 or \$0.00 for their annual income. Instead of discarding these surveys, (which were otherwise appropriately completed), the fictitious incomes were omitted from the analyses of data. The remaining 130 completed surveys (78%) offered a robust sample size, well above the ($n = 107$) required for the study.

Ethical Considerations

Consent Procedure and Protection of Human Subjects

Prior to any data collection, approval to conduct this research study was obtained from the Institutional Review Board (IRB) at Seton Hall University (SHU) (Appendix P). Members of the AMSN were informed of the study via an e-mail from the AMSN Research Coordinators after they approved the study for distribution to their members. The AMSN Research Coordinators reviewed the abstract, research instruments, evidence of IRB approval from SHU, and cover letter from the researcher before informing and distributing the research link to their members. The purpose of such scrutiny by AMSN was to ensure that the study was professional

and served the best interests of their members, protecting AMSN members from excessive and/or inappropriate requests. Member participation was voluntary and completion of the surveys indicated the nurses' consent to participate in the study.

Upon choosing to learn more about the study, prospective participants were directed to a letter of solicitation from the researcher (Appendix D). This letter informed participants of the purpose of the study, that their participation was totally voluntary, that all responses would be kept confidential, and that anonymity was assured by a set function in the Survey Monkey® website. It was further pointed out that there were no anticipated risks involved in completion and submission of the survey instruments; however, nurses had the right to refuse to participate or withdraw at any time after starting the research surveys.

Summary

This study used a descriptive correlational design to examine the relationships between and among nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to adult patients in the acute care settings. A convenience sample of nurses employed to provide direct patient care in the acute care setting was invited to complete the Spiritual Well-being Scale by Paloutzian and Ellison (1982), the Spiritual Care Perspective Scale-Revised (E. J. Taylor, unpublished document provided via e-mail on October 16, 2014), and the Spiritual Care Practice Questionnaire Part I (Vance, 2001). Additionally, study participants completed a demographic questionnaire designed by the researcher. Data were analyzed by using the SPSS version 23 software. Statistical procedures included descriptive and inferential statistics, Pearson's *r* correlations, Spearman Rho nonparametric tests and multiple linear regressions.

Chapter IV

Findings

The purpose of this study was to explore the relationships between and among registered nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in the acute care setting. This chapter presents the descriptive statistics, and the results of the inferential statistical analyses using the data obtained through the three survey instruments used in this study, namely: the Spiritual Well-being Scale (SWBS by Paloutzian and Ellison, 1982; Appendix E), the Spiritual Care Perspective Scale-Revised (SCPS-Rv by Taylor, 2004; Appendix F), the Spiritual Care Practice Questionnaire Part I (SCPQ Part I by Vance, (2001); Appendix G). Additionally, a demographic/work-related survey (Appendix K) was used to collect descriptive data from the study participants. Data collection for this study was done via the Survey Monkey® website over a six weeks period from November 10, 2015 to December 21, 2015. During this period, out of the total membership ($N = 11,500$) of the Academy of Medical Surgical Nurses (AMSN), a total of 331 nurses (2.93%) responded to the survey; of this number 164 nurses (49.6%) did not meet the inclusion criteria for the study. Of the remaining 167 nurses (50.4%) who met the study criteria, 37 surveys (22%) had a significant amount of missing data and 128 (77.0%) completed all four survey instruments. Two surveys (1%) had missing data related to a question on the exclusion criteria. However, the decision was made to include these two surveys in the final analysis of data because all other questions in all four surveys were completed. The data analysis and findings for this study were therefore based on the information obtained from 130 participants; (or 1.13% of the total membership of the AMSN). Of these 130 nurses, 78 (60%) responded to the open ended question about provision of spiritual care.

Procedures for Data Analyses

Data analysis was done using the Statistical Package for the Social Sciences (SPSS) Version 23 software (IBM SPSS Statistics, 2015). The sample size of $n = 130$ was sufficient to establish relationships between the dependent and independent variables because a priori, Cohen (1988) power table for correlation coefficient indicated that a sample size of eighty ($n = 80$) participants would provide a power of 0.96 (96%) with a significance level of 0.05 ($p = 0.05$) for a medium effect ($r = 0.4$) for a 2 tailed test. Power analysis (done via G*Power) for planned multiple regression with a significance level of 0.05 ($p = 0.05$), power set at 0.95 (95%), for a medium effect ($f^2 = 0.15$) with a total of seven predictors, indicated a minimum sample size of $n = 107$. A post hoc analysis for correlation coefficient (done via G*Power) for a sample size of $n = 130$, level of significance of 0.05 ($p = 0.05$), for a medium effect of $r = 0.4$ showed power of 0.99 (99%) for revealing relationships between variables.

Description of Study Sample

The study sample consisted of 130 registered nurses (RNs) who were employed to provide direct patient care in the acute care setting. Participants were predominantly married ($n = 84$, 64%), female (90.8%), who identified as White/Caucasian ($n = 95$, 73.1%), between the ages of 45-54 years ($n = 44$, 33.8%), with the average age being 46.05 years. Table 1 provides a detailed breakdown of demographic data related to the participants' race/ethnicity, marital status, gender, and age.

Table 1

Race, Marital Status, Gender, and Age of Participants

Demographic Factors	Grouping	Frequency	Percent
Race/Ethnicity	White / Caucasian	95	73.1%
	Black or African American	9	6.9%
	Hispanic	9	6.9%
	Asian / Pacific Islander	9	6.9%
	American Indian or Alaskan Native	1	0.8%
	Choose not to answer	5	3.8%
	Multiple ethnicity	2	1.5%
Marital Status	Married	84	64.6%
	Never Married	25	19.2%
	Divorced	17	13.1%
	Separated	3	2.3%
	Widowed	1	0.8%
Gender	Female	118	90.8%
	Male	12	9.2%
Age	18-24	1	0.8%
	25-34	34	26.2%
	35-44	13	10.0%
	45-54	44	33.8%
	55-64	37	28.5%
	65-74	1	0.8%

Note. Percent = percentage of $n = 130$ participants who completed all surveys

Nurses who participated in this study were representatives of a wide array of religious affiliations. The largest of these religious affiliations were Christians ($n = 44, 33.80\%$), followed by Catholic ($n = 41, 31.5\%$). Of the 130 respondents, 116 (89.2%) reported a very strong, strong, or moderately strong sense of commitment to their personal spiritual practices. Detailed descriptions of these data are outlined in Table 2.

Table 2

Religious Affiliation and Commitment to Personal Spiritual Practices

Demographic Factors	Grouping	Frequency	Percent
Religious Affiliations	Christianity	44	33.8%
	Catholicism	41	31.5%
	Protestantism	15	11.5%
	Buddhism	1	0.8%
	Islam	1	0.8%
	Hinduism	1	0.8%
	Inter/Non-denominational	6	4.6%
	No Religion	11	8.5%
Others	10	7.7%	
Commitment to Personal Spiritual Practices	Very Strong	41	31.5%
	Strong	41	31.5%
	Moderately Strong	34	26.2%
	Weak	7	5.4%
	Unimportant in life	7	5.4%

Note. Percent = percentage of $n = 130$ participants who completed all surveys

The educational qualification of the RNs who participated in this study ranged from Diploma to Masters of Science or Arts Degrees. The nurses reported obtaining their professional RN license 1 to 47 years ago ($\bar{X} = 15.08$, $SD = 11.84$), and have been providing direct patient care between 1 and 45 years ($\bar{X} = 14.00$, $SD = 11.12$). Respondents were employed in their current places of employment for an average of 10.83 years, $SD = 10.41$, (ranging from 1 to 47 years), and employed on their current nursing units for an average of 6.41 years, $SD = 7.02$, (ranging 1 to 40 years). Eighty-three nurses (63.8%) worked on the general medical-surgical unit; the others worked on different units within the acute care setting. Most participants ($n = 87$, 66.9%)

reported a nurse-to-patient ratio of 1 RN to 5-7 patients. Almost fifty-nine percent of the respondents were currently employed to work during the day shift, while the others worked the evening, night, or on rotation shifts. Although the number of hours of direct care provided per week by the nurses ranged from 10 to 72 hours, 90 respondents (69.2%) provided 36-40 hours of direct patient care per week. For the 119 records where salary data were reported, the mean annual income was \$66,150.22 ($SD = \$16,689.00$). The geographical locations of most participants (86.2%) were urban and suburban. Further breakdowns of the aforementioned data are displayed in Tables 3 and 4.

Table 3

Educational Qualifications, Nursing Unit Employed, Shift, RN-Patient Ratio, and Geographical Location

Demographic Factors	Grouping	Frequency	Percent
Edu Qualifications	Masters of Arts/Sci.	20	15.4%
	Bachelors of Arts/Sci.	80	61.5%
	Associate Degree	25	19.2%
	Diploma	5	3.8%
Nursing Unit Employed	General Med-Surg	83	63.8%
	Telemetry	14	10.8%
	Critical Care	4	3.1%
	Respiratory	3	2.3%
	Intermediate Care	3	2.3%
	Emergency Care	1	0.8%
	Other	22	16.9%
Primary Shift	Days	76	58.5%
	Nights	41	31.5%
	Evenings	7	5.4%
	Rotation	6	4.6%
Nurse-to-Patient Ratio	1 RN to < 2 patients	3	2.3%
	1 RN to 2-4 patients	36	27.7
	1 RN to 5-7 patients	87	66.9%
	1 RN to 8-10 patients	3	2.3%
	1 RN to >10 patients	1	0.8%
Geographical Location	Urban	65	50.0%
	Suburban	47	36.2%
	Rural	18	13.8%

Note. Percent = percentage of $n = 130$ participants who completed all surveys.

Table 4

Descriptive Information for Numerical Demographic/ Work Variables

Item	<i>n</i>	<i>M</i>	<i>SD</i>	<i>Minimum</i>	<i>Maximum</i>
# of years since RN Licensure	130	15.08	11.84	1	47
#of years providing direct pt. care	130	14.00	11.12	1	45
# of hours of direct care provided per week	130	34.64	9.90	10	72
# of years employed in current agency	130	10.83	10.42	1	47
# of years employed in current Nursing Unit	130	6.41	7.02	<1	40
Annual income	119	\$66,150.22	\$16,689.00	\$8,600	\$115,000

Only ten nurses (7.7%) indicated that their nursing education fully prepared them to provide spiritual care to their patients, while 53.8% felt somewhat prepared, and 38.5% felt they were not at all prepared to provide spiritual care (See Figure 4-1). Notwithstanding, 51 nurses (39.2%) felt confident about providing spiritual care to their acutely ill patients, 57 (43.8%) felt confidence in that role *sometimes*, and 22 (16.9%) were not at all confident in providing spiritual care in the acute care setting (see Figure 4-2). Similarly 115 nurses (85.5%) indicated that they felt either comfortable or somewhat comfortable with providing spiritual care, while 15 (11.5%) were not comfortable (see Figure 4-3).

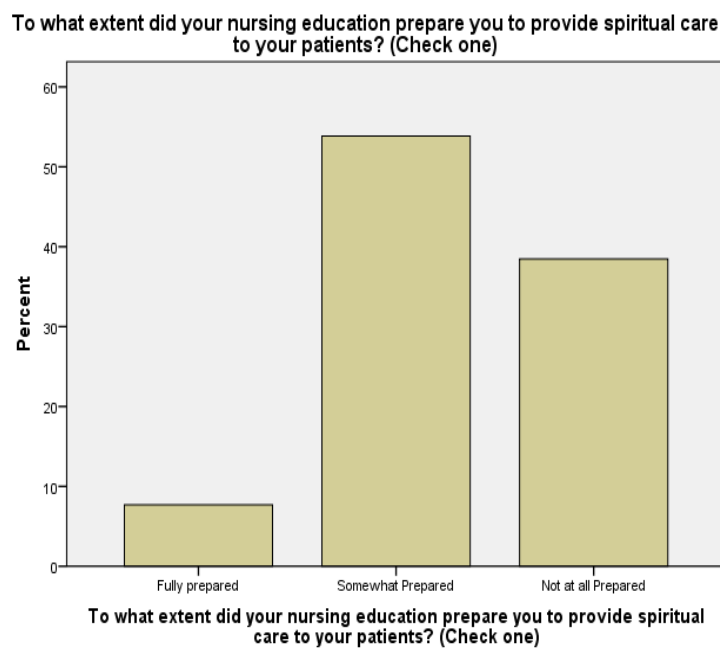


Figure 4-1. Bar graph indicating that very few nurses felt fully prepared by their nursing education to provide spiritual care.

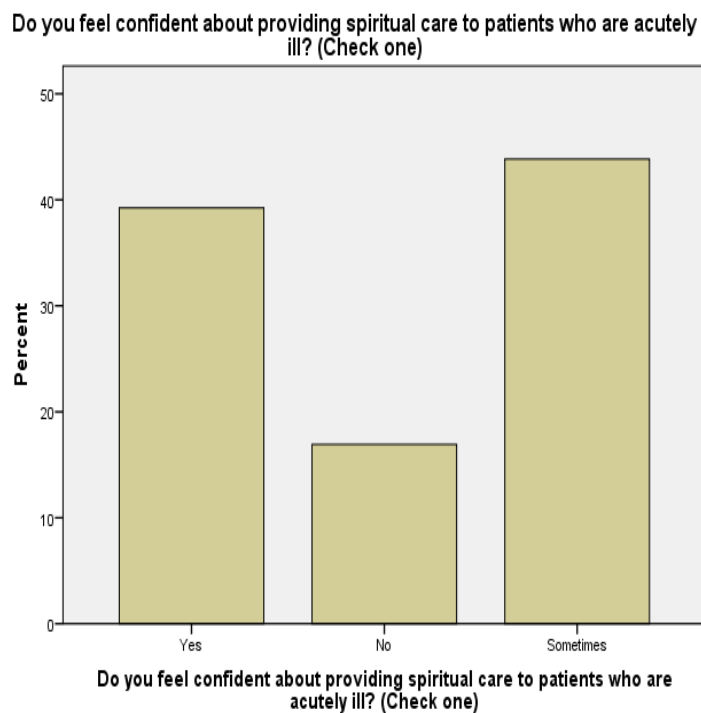


Figure 4-2. Bar graph illustrating that most participants felt some degree of confidence in providing spiritual care to patients who are acutely ill.

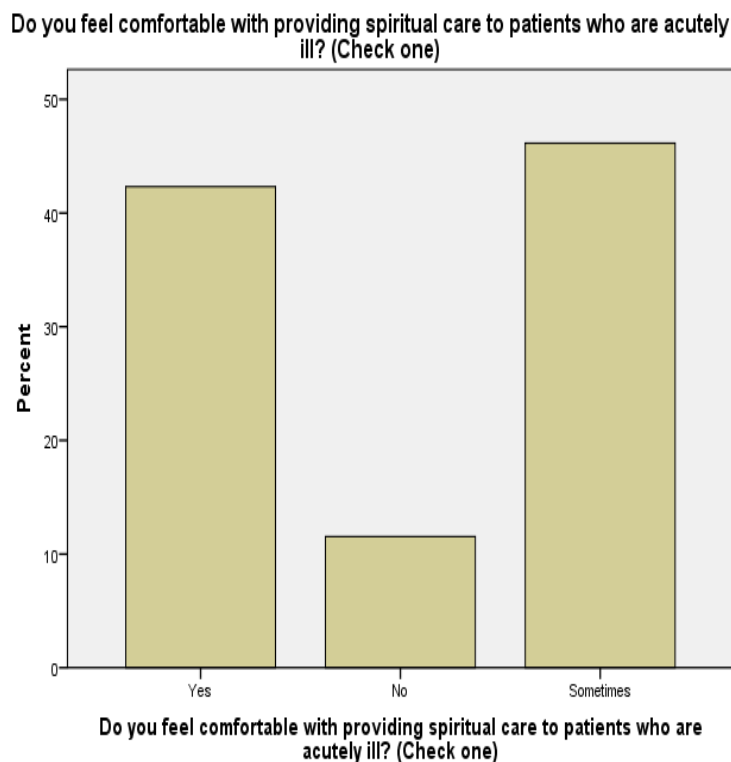


Figure 4-3. Bar graph demonstrating that the majority of participants were comfortable, at least sometimes in providing spiritual care to patients in the acute care setting.

Instrument Reliability

Instrument reliability based on the data collected for this study indicated Cronbach alpha scores of .92 for the SWBS, .82 for the SCPS-Rv, and .84 for the SCPQ Part I. These results are highly consistent with the scores reported by the authors and other researchers who have used these instruments. In their use of the SWBS, Musgrave and McFarlane (2004) reported an alpha score of .88, Hammermeister et al. (2005) reported a reliability score of .89, Ridnour and Hammermeister (2008) documented alpha coefficient = .92, and authors of the scale reported test-retest reliability coefficients .93, .99, .99, and .82 across four studies, with 1-10 weeks between testings. Similarly, researchers such as Chism and Magnan (2009), O'Shea et al. (2011)

and the author of the SCPS-Rv reported Cronbach alpha scores of .80 and .82 respectively for the SCPS-Rv. Randolson et al. (2012) and Vance (2001) have reported alpha scores of .89 and .87 respectively for the SCPQ Part I.

Description of the Independent and Dependent Variables

The descriptive information for the independent variables (nurses' spiritual well-being and spiritual care perspectives) along with the dependent variable nurses' provision of spiritual care, are presented in Table 5. The composite score for each scale was obtained by summing the scores on the individual Likert-type items. Before summing the scores on these items, the scores on some items had to be reversed due to the wording of these particular questions. It should be noted that according to the authors for the three scales used in this study, participant's scores may be interpreted as follow: (a) for the SWBS, a score in the range of 20 – 40 reflects a sense of low overall spiritual well-being, 41 – 99 reflects a sense of moderate spiritual well-being, and 100 – 120 reflects a sense of high spiritual well-being (Paloutzian and Ellison 1982); (b) for the SCPS-Rv, the scores can range from 10 to 50, where a low score indicates negative attitude toward spiritual care, and a high score indicates a positive perspective (E. J. Taylor, unpublished document); (c) for the SCPQ Part I, possible scores range from 9 to 45. Vance (2001) estimated 32 as the '*ideal mean*' to represent nurses who practice spiritual caring somewhere between '*occasionally*' and '*often*.'

Table 5

<i>Descriptive Information for Independent and Dependent Variables</i>					
Item	<i>n</i>	<i>M</i>	<i>SD</i>	<i>Minimum</i>	<i>Maximum</i>
SWBS Composite Score	130	98.50	16.79	43	120
SCPS-Rv Composite Score	130	36.95	5.56	24	49
SCPQ Part I Composite Score	130	29.38	6.19	15	44

As indicated in Table 6, based on the Shapiro-Wilk test of normality, scores for the SCPS-Rv and SCPQ Part I variables showed no significant deviation from a normal distribution since their *p*-values of .295 and .162, respectively, both exceeded .05. Conversely, the composite SWBS scores were significantly different from a normal distribution, evidenced by its *p*-value of .0001 being less than .05. This non-normal distribution of the SWBS scores was not considered to be a concern because the normality requirement for a Pearson correlation analysis could be waived when the sample size is greater than 30 (Field, 2013). The Shapiro-Wilk normality test was used instead of the Kolmogorov-Smirnov test, because Shapiro-Wilk normality test is more appropriate for smaller sample sizes ranging from 50 to 2000 participants (Bannon, 2013). Given the sample size of $n = 130$ for this study, the selected test for normality is suitable.

Table 6

<i>Tests of Normality of Distribution</i>						
	Kolmogorov-Smirnova			Shapiro-Wilk		
	Statistic	df	Sig.	Statistic	df	Sig.
SCPQ Part I	.07	130	.081	.98	130	.162
CompSWBS	.10	130	.001	.93	130	.000
CompSCPS-Rv	.08	130	.047	.99	130	.295

Figures 4-4 thru 4-6 display histograms showing the distributions of scores for the SWBS, SCPS-Rv and SCPQ Part I variables. While the scores for the SCPS-Rv and SCPQ Part I variables both had relatively symmetrical shapes, the composite SWBS scores had a significant negatively skewed distribution (Bannon, 2013). This was not regarded as a major concern because researchers who have used the SWBS have consistently reported a “ceiling effect” especially among Christian participants (Bufford et al., 1991; Genia, 2001). A “ceiling effect” occurs when a large concentration of the study participants scored the maximum or near maximum score limits (Hessling, Traxel & Schmidt, 2004). As shown in Figure 4-5, the “ceiling effect” was likewise noted in the sample of nurses who participated in this study, the majority of whom identified as Christians and Catholic.

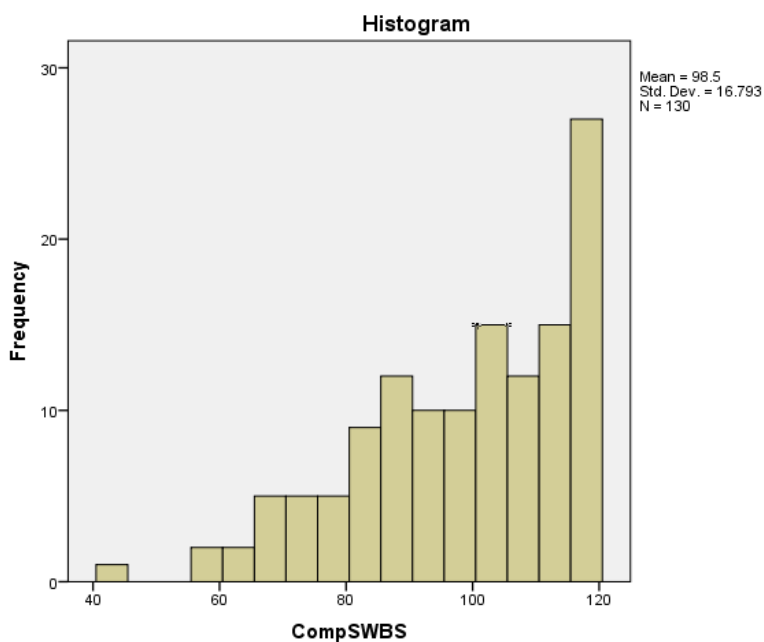


Figure 4-4. Bar graph showing distribution of negatively skewed scores for SWBS illustrating that most participants had a sense of high spiritual well-being.

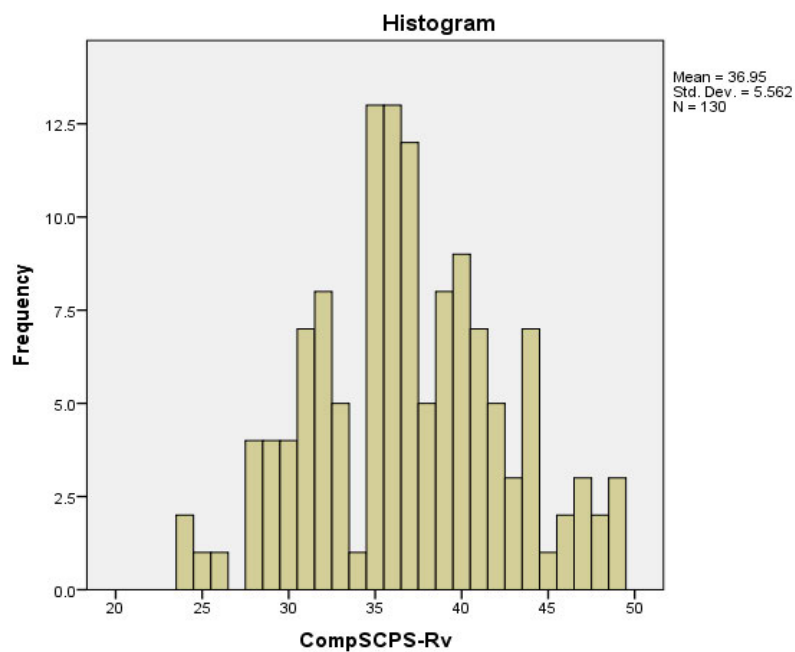


Figure 4-5. Bar graph showing composite scores for SCPS-Rv shows that most nurses who participated in this study had a positive perspective (attitude) towards providing spiritual care.

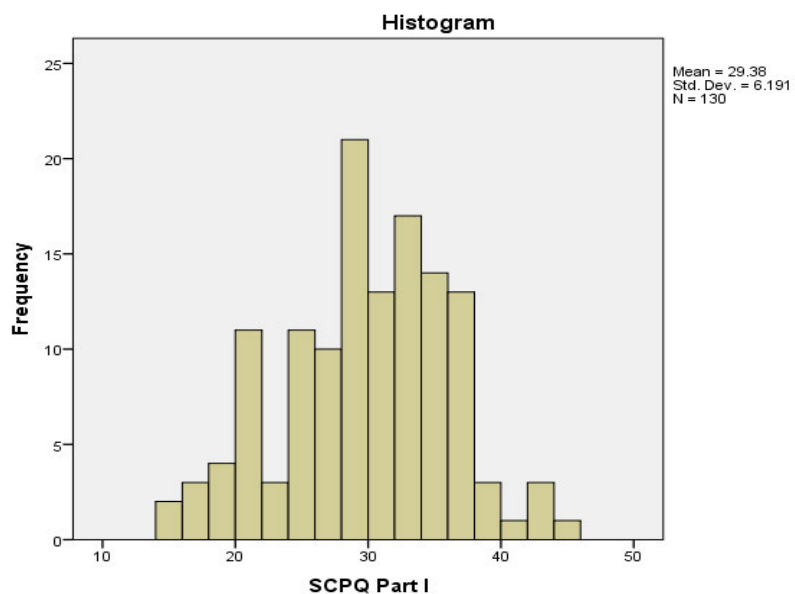


Figure 4- 6. Bar graph showing distribution of scores for SCPQ Part I illustrates that most nurses fell short of the *ideal mean* scores of 32, indicating that the majority of nurses participating in this study provided spiritual care less than often and occasionally.

Presentation of Statistical Analysis

Analysis of Data and Findings Related to Research Questions

In seeking to find answers regarding relationships between and among registered nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in the acute care setting, five pertinent research questions were posed. These questions were answered by examining the relationships between the composite scores on the SWBS, SCPS-Rv and the SCPQ Part I. It should be noted that although each of these composite scores was a combination of ordinal level Likert-type items, the composite score for each scale was treated as an interval/ratio level variable for purposes of performing the statistical analyses. This type of treatment is consistent with how such data are usually handled (Bannon, 2013). Since all three scales provided interval level data for the sample of RNs who completed the surveys, a Pearson correlation analysis was conducted.

Question 1: Is there a relationship between acute care nurses' spiritual well-being and their provision of spiritual care to patients in acute care settings?

As shown in Table 7, there was a statistically significant positive correlation between the respondents' spiritual well-being and their provision of spiritual care ($r = .27, p = .002$). This indicates that nurses whose spiritual well-being score reflected a moderate to high sense of spiritual well-being were significantly more likely to provide spiritual care to their acutely ill patients.

Question 2: Is there a relationship between acute care nurses' spiritual care perspectives and their provision of spiritual care to patients in acute care settings?

Results of Pearson's correlation displayed in Table 7 illustrate that there is a statically significant strong positive correlation between this sample of nurses' spiritual care perspectives

and their provision of spiritual care ($r = .63, p < .0001$). This finding provides evidence that nurses who scored above average on the SCPS-Rv were significantly more likely to provide spiritual care to their acutely ill patients.

Question 3: Are there relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, select demographic factors and their provision of spiritual care to patients in acute care settings?

As shown in Table 7 there is a moderate to strong positive correlation ($r = .45, p = .0001$) between spiritual well-being and spiritual care perspectives among the acute care nurses who participated in this study. This finding indicates that nurses in this study who had a sense of moderate to high spiritual well-being also had an optimistic perspective about providing spiritual care.

Of the five demographic factors initially designated to be examined in the present study, namely the nurses' age, commitment to personal spiritual practices, level of education, practice specialty, and their years of nursing practice (See Figure 1-1), four factors were found to be statistically non-significant. Spearman Rho correlational analyses revealed no significant relationships between and among provision of spiritual care and the nurses' age, level of education, practice specialty, or their years of nursing practice. However, there was a significant positive relationship between the nurses' commitment to personal spiritual practices and their provision of spiritual care ($r_s = .31, p = .0001$). This finding signifies that the nurses in this study who had a strong commitment to their personal spiritual practices also provided frequent spiritual care to their patients in the acute care setting.

Additionally, the demographic/work related factors of confidence in providing spiritual care, and comfort level in providing spiritual care, were serendipitously found to be significantly

related to provision of spiritual care. Table 8 displays Spearman Rho correlations showing a moderate to strong positive relationship between confidence in providing spiritual care and the actual provision of spiritual care ($r_s = .45, p = .0001$). A moderate relationship was found between the nurses' comfort in providing care and their actual provision of spiritual care ($r_s = .40, p = .0001$). These findings indicate that nurses who were confident and comfortable in providing spiritual care were providing frequent spiritual care to their patients in the acute care setting, and that the more confident and comfortable the nurses felt in their role of administering spiritual care to their patients the more likely they were to provide frequent spiritual care.

Question 4: Are there relationships among acute care nurses' spiritual well-being, spiritual care perspectives and select demographic factors?

Findings from Spearman Rho correlations showed a strong relationship between the participants' commitment to personal spiritual practices and their sense of spiritual well-being ($r_s = .70, p = .0001$). A statistically strong positive correlation was also found between the nurses' commitment to personal spiritual practices and their spiritual care perspectives ($r_s = .47, p = .0001$). These findings denote that nurses who reported a sense of moderate to high spiritual well-being, and demonstrated positive spiritual care perspectives (attitudes, values, and beliefs), were also strongly committed to their personal spiritual practices.

The demographic/work related factors of confidence in providing spiritual care and comfort in providing spiritual care also showed significant positive correlations with the nurses' commitment to personal spiritual practices, as well as with independent variables, spiritual well-being and spiritual care perspective. Table 8 shows significantly moderate positive correlations between the nurses' commitment to personal spiritual practices and their confidence ($r_s = .28, p = .002$), as well as their comfort ($r_s = .32, p = .0001$) in providing care. Weak but

significant correlations also existed between and among the nurses' spiritual well-being and their confidence and comfort in providing spiritual care ($r_s = .25, p = .0004$) for each pair of variables. On the other hand, there were statistically strong relationships between the nurses' spiritual care perspectives and their confidence in providing spiritual care ($r_s = .54, p = .0001$), along with their comfort in providing spiritual care ($r_s = .52, p = .0001$). These findings denote that as the nurses' sense of spiritual well-being and their optimistic attitude towards spiritual care increased, their confidence and comfort in providing spiritual care will also increase. Thus nurses who had a sense of high spiritual well-being and a positive attitude towards spiritual care were also likely to be confident and comfortable in providing spiritual care to their patients in the acute care setting.

Conversely, there were no significant relationships between and among the nurses' spiritual well-being and four select demographic factors: the nurses' age, level of education, practice specialty, and their years of nursing practice. Neither were there significant relationships between and among the participants' spiritual care perspectives and the aforementioned non-significant demographic factors.

Overarching Question: What are the relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in acute care settings?

Table 7 displays findings of Pearson's correlation demonstrating that there were statistically significant positive correlations between the nurses' spiritual well-being and their provision of spiritual care ($r = .27, p = .002$), and between their spiritual care perspectives and their provision of spiritual care ($r = .63, p < .0001$). This indicates that nurses whose SWBS scores reflected a sense of moderate to high spiritual well-being and those who scored above average on the SCPS-Rv were most likely to provide adequate spiritual care to their acutely ill

patients. Vance (2001) emphasized that nurses who score the *ideal mean* score of 32 on the SCPQ Part I were involved with providing spiritual care anywhere between *occasionally* and *often*. Thus adequate spiritual care is tantamount to the *ideal mean* score of 32. It is noteworthy that of the two predictor variables the nurses' perspective or attitude towards spiritual care showed a much stronger positive correlation with the dependent variable—provision of spiritual care—than did their sense of spiritual well-being.

Nevertheless, for the nurses in this study there was a moderate to strong positive correlation between spiritual well-being and spiritual care perspectives ($r_s = .45, p = .0001$); indicating that the higher the participant's sense of spiritual well-being, the more positive would be that person's attitude toward spiritual care.

Table 7
Correlations Between Interval/ Ratio Level Variables

		SCPQ Part I	CompSWBS	CompSCPSR	How many years since you have received your RN license?	How many years have you been providing direct patient care as an RN?	On an average how many hours of direct patient care do you provide per week?	Number of years employed in your current place of employment?	Number of years employed on your current nursing unit?	Indicate your annual income level in dollar amount: \$ _____
SCPQ Part I	Pearson Correlation	1	27**	63**	-.02	.00	-.02	-.10	-.04	-.10
	Sig (2-tailed)		.002	.000	.827	.970	.795	.245	.636	.260
	N	130	130	130	130	130	130	130	130	119
CompSWBS	Pearson Correlation	27**	1	45**	.06	.01	-.04	-.01	.08	-.07
	Sig (2-tailed)	.002		.000	.520	.931	.673	.877	.382	.441
	N	130	130	130	130	130	130	130	130	119
CompSCPSR	Pearson Correlation	63**	45**	1	.02	.03	.01	-.06	-.03	.04
	Sig (2-tailed)	.000	.000		.816	.714	.908	.507	.760	.694
	N	130	130	130	130	130	130	130	130	119
How many years since you have received your RN license?	Pearson Correlation	-.02	.06	.02	1	.94**	-.21*	.64**	.42**	.39**
	Sig (2-tailed)	.827	.520	.816		.000	.014	.000	.000	.000
	N	130	130	130	130	130	130	130	130	119
How many years have you been providing direct patient care as an RN?	Pearson Correlation	.00	.01	.03	.94**	1	-.15	.62**	.47**	.45**
	Sig (2-tailed)	.970	.931	.714	.000		.087	.000	.000	.000
	N	130	130	130	130	130	130	130	130	119
On an average how many hours of direct patient care do you provide per week?	Pearson Correlation	-.02	-.04	.01	-.21*	-.15	1	-.04	-.02	-.09
	Sig (2-tailed)	.795	.673	.908	.014	.087		.652	.818	.311
	N	130	130	130	130	130	130	130	130	119
Number of years employed in your current place of employment?	Pearson Correlation	-.10	-.01	-.06	.64**	.62**	-.04	1	.68**	.35**
	Sig (2-tailed)	.245	.877	.507	.000	.000	.652		.000	.000
	N	130	130	130	130	130	130	130	130	119
Number of years employed on your current nursing unit?	Pearson Correlation	-.04	.08	-.03	.42**	.47**	-.02	.68**	1	.24**
	Sig (2-tailed)	.636	.382	.760	.000	.000	.818	.000		.008
	N	130	130	130	130	130	130	130	130	119
Indicate your annual income level in dollar amount: \$ _____	Pearson Correlation	-.10	-.07	.04	.39**	.45**	-.09	.35**	.24**	1
	Sig (2-tailed)	.260	.441	.694	.000	.000	.311	.000	.008	
	N	119	119	119	119	119	119	119	119	119

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

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

Table 8

Correlations Between and Among the 5 Predictor Variable and the Dependent Variable

			Comp SCPQ Part I	Comp SWBS	Comp SCPSR	Personal spirit Ordinal	SpiritCare Confi Ordinal	SpiritCare Comfort Ordinal
Spearman's rho	Comp SCPQ Part I	Correlation Coefficient	1.000	.26**	.62**	.31**	.45**	.40**
		Sig. (2- tailed)		.003	.000	.000	.000	.000
		N	130	130	130	130	130	130
	CompSWBS	Correlation Coefficient	.26**	1.000	.42**	.70**	.25**	.25**
		Sig. (2- tailed)	.003		.000	.000	.004	.004
		N	130	130	130	130	130	130
	CompSCPSR	Correlation Coefficient	.62**	.42**	1.000	.47**	.54**	.52**
		Sig. (2- tailed)	.000	.000		.000	.000	.000
		N	130	130	130	130	130	130
	Personalspirit Ordinal	Correlation Coefficient	.31**	.70**	.47**	1.000	.28**	.32**
		Sig. (2- tailed)	.000	.000	.000		.002	.000
		N	130	130	130	130	130	130
	SpiritCare ConfiOrdinal	Correlation Coefficient	.45**	.25**	.54**	.28**	1.000	.76**
		Sig. (2- tailed)	.000	.004	.000	.002		.000
		N	130	130	130	130	130	130
	SpiritCare Comfort Ordinal	Correlation Coefficient	.40**	.25**	.52**	.32**	.76**	1.000
		Sig.(2- tailed)	.000	.004	.000	.000	.000	
		N	130	130	130	130	130	130

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

Multivariate Analysis of Significantly Related Variables

Given the aforementioned statistically significant correlations, multiple regression analyses were conducted to evaluate the strength of each predictor variable on provision of spiritual care interventions. Bannon (2013) explains that a multiple linear regression is most appropriate when examining an interval/ ratio level dependent variable such as provision of spiritual care.

The multiple regression models utilized the two independent variables—composite spiritual well-being and spiritual care perspectives scores—along with the three significant demographic variables mentioned above. It should be reiterated that the two independent variables were treated as interval/ ratio level variables, while the three demographic predictor variables were categorical variables with three or more response categories. In preparation for multiple regression analyses, the categorical variables were dummy-coded (Bannon, 2013). The commitment to spiritual practices variable was dummy coded into three variables with “very strong” being the reference category. Both the confidence in providing spiritual care variable and the comfort in providing spiritual care variable were each dummy coded into two variables. For both these variables, the “Yes” response served as the reference category. It should be noted that the number of dummy variables created for a given categorical variable is always one less than the number of categories in the original scale (Grimm & Yarnold, 2005).

For the first regression model, the three demographic predictor variables—commitment to personal spiritual practices, confidence in providing spiritual care, comfort level in providing spiritual care—were simultaneously entered into the model. The second regression model utilized the same three demographic predictor variables as the first model along with the composite spiritual care perspective score as a fourth predictor variable. Lastly, the third

regression model included three demographic control variables as well as both independent predictor variables (i.e.: the composite spiritual care perspective score and the composite spiritual well-being score). The rationale for the order in which the composite scores for the two independent predictor variables were entered into the regression was based on the fact that the composite spiritual perspective score had a stronger correlation with the dependent variable ($r = .63$), than did the composite spiritual well-being variable ($r = .27$) (Bannon, 2013). A post hoc G*Power analysis for linear multiple regression indicated that with a sample size of $n = 130$, using a level of significance of 0.05 ($p = 0.05$), for medium effect of .20 (Cohen, 1988) with five predictor variables, the study was powered at .99 (99%) (<http://www.psycho.uni-duesseldorf.de/abteilungen/aap/gpower3/>).

Table 9 shows an adjusted R^2 of .18 for the first model. This means that 18% of the variance in the dependent variable (provision of spiritual care) was explained by the three significant demographic variables. For the second model, the adjusted R^2 value was .39 which was an increase of .21 over the adjusted R^2 for the first model. In other words, the spiritual care perspective variable explained 21% of the variation in the dependent variable. The adjusted R^2 value for the third model was .38 which was slightly lower than that for the second model. This suggests that the inclusion of the spiritual well-being variable in the model did not improve the predictive capability of the model, even though the spiritual well-being variable had a significant correlation with the dependent variable.

The Durbin-Watson statistic value of 1.77 indicates that there was no significant autocorrelation among the regression residuals in the hierarchical regression model. The value of the Durbin-Watson statistic ranges from 0 to 4. As a general rule, the residuals are uncorrelated if the Durbin-Watson statistic falls in the 1.50 to 2.50 range. A value close to zero

indicates strong positive autocorrelation, while a value of 4 indicates strong negative autocorrelation.

(http://www.utexas.edu/courses/schwab/sw388r7/Tutorials/IllustrationofRegressionAnalysis_doc_html/046_Independence_of_ResidualsDurbinWatson_Statistic.html).

Table 9

Regression Model Summary^d with 5 Predictors

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Change Statistics					Durbin-Watson
					R Square Change	F Change	df1	df2	Sig. F Change	
1	.467 ^a	.218	.180	5.606	.218	5.725	6	123	.000	
2	.649 ^b	.421	.388	4.845	.202	42.635	1	122	.000	
3	.649 ^c	.421	.383	4.864	.000	.074	1	121	.786	1.767

a. Predictors: (Constant), ComfortDummy2, ConfDummy1, PSCDummy2, PSCDummy1, ComfortDummy1, ConfDummy2

b. Predictors: (Constant), ComfortDummy2, ConfDummy1, PSCDummy2, PSCDummy1, ComfortDummy1, ConfDummy2, CompSCPSR

c. Predictors: (Constant), ComfortDummy2, ConfDummy1, PSCDummy2, PSCDummy1, ComfortDummy1, ConfDummy2, CompSCPSR, CompSWBS

d. Dependent Variable: SCPQ Part I

The irrational decrease in the adjusted R^2 value when the composite spiritual well-being score was added to the hierarchical regression model suggests that there might have been some multicollinearity present among the five predictor variables included in this model.

Investigating Concern with Multicollinearity

To further examine the multiple collinearity concern, three different areas were scrutinized. The first area investigated was whether or not there were significant relationships among the three demographic variables that were included in the model. The Pearson Chi Square test was used to examine these relationships. The results of these tests were as follows: (a) commitment to personal spiritual practices and confidence in providing spiritual care had a significant relationship $\chi^2(6, n=130) = 16.52, p = .011 < .05$, Cramer's $V = .25$ which is a medium

effect. This indicates that the nurses' commitment to their personal spiritual practices was a good predictor of whether or not they were confident in providing spiritual care.

(b) Personal spiritual commitment and comfort in providing spiritual care also had a significant relationship $\chi^2(6, n = 130) = 17.22, p = .009 < .05$, Cramer's $V = .26$ which is a medium effect. This demonstrates that nurses who were committed to their personal spiritual practices were also comfortable in providing spiritual care.

(c) Confidence with providing spiritual care and comfort in providing spiritual care had a significant relationship $\chi^2(4, n = 130) = 124.33, p = .0001 < .05$, Cramer's $V = .69$ which is a strong effect. This denotes that those who were confident in providing spiritual care were also comfortable in providing spiritual care, and that confidence in providing spiritual care was a strong predictor of comfort in providing such care.

The second area utilized a Pearson correlation analysis to examine the relationship between the numeric (interval/ratio) independent variables spiritual well-being and spiritual care perspectives. Findings from this analysis illustrated that there was a statistically significant, strong positive relationship between the respondents' spiritual well-being and their spiritual care perspectives ($r = .45, p = .0001 < .05$). Thus, as the participants' spiritual well-being increased their spiritual care perspective will also increase (Burns & Groves, 2009).

The third area involved checking whether significant differences exist in the values of each of the two independent variables among the various categories of each of the three demographic variables. Since each demographic variable was categorical in nature while each independent variable was interval/ ratio level, one way ANOVA analyses were run to determine whether such differences exist. For the spiritual care perspective variable, the ANOVAs revealed statistically significant differences with each of the demographic variables. The results

are as follows: (a) Spiritual care perspective and commitment to personal spiritual practices: $F(2, 127) = 5.33, p = .006 < .05$; (b) Spiritual care perspective and confidence in providing spiritual care: $F(2, 127) = 26.05, p = .0001 < .05$; (c) Spiritual care perspective and comfort in providing spiritual care: $F(2, 127) = 23.14, p = .0001 < .05$. Likewise, for the spiritual well-being variable, the ANOVAs revealed statistically significant differences with each of the demographic variables. The results were: (a) Spiritual well-being and commitment to spiritual practices: $F(3, 126) = 41.98, p = .0001 < .05$; (b) Spiritual well-being and confidence in providing spiritual care: $F(2, 127) = 5.33, p = .006 < .05$; (c) Spiritual well-being and comfort in providing spiritual care: $F(2, 127) = 6.04, p = .003 < .05$.

As a further step in addressing this multicollinearity issue, the three categorical demographic variables were recoded as ordinal level variables using the Transform Compute Variable command in SPSS. The variables were recoded so that the weakest or least desirable category for each variable had the lowest values. For example, the recoded “commitment to spiritual practice” showed: 1 = weak/not important, 2 = moderately strong, 3 = strong, and 4 = very strong; and for confidence and comfort in providing spiritual care, the re-ordered values showed: 1 = no, 2 = sometimes, and 3 = yes. The rationale for changing these categorical variables to ordinal level variables was to create a natural order of the categories and to allow for the use of a Spearman Rho relationship test (Burns & Grove, 2009). Table 8 shows Spearman Rho correlation findings between and among the dependent variable, the two independent variables (spiritual well-being and spiritual care perspectives), and the three recoded ordinal level demographic variables.

For the spiritual care perspective variable, the Spearman Rho test revealed statistically significant relationships with each of the demographic variables. The results were: (a) Spiritual

care perspective and commitment to personal spiritual practices showed a medium to strong correlation of $r_s = .47, p = .0001 < .05$; (b) Spiritual care perspective and confidence in providing spiritual care showed a strong relationship of $r_s = .54, p = .0001 < .05$; and (c) Spiritual care perspective and comfort in providing spiritual care $r_s = .52, p = .0001 < .05$. Likewise, for the spiritual well-being variable, the Spearman Rho correlation test revealed statistically significant relationships with each of the demographic variables. The results were: (a) Spiritual well-being and commitment to personal spiritual practices: $r_s = .70, p = .0001 < .05$; (b) Spiritual well-being and confidence in providing spiritual care: $r_s = .25, p = .004 < .05$; and (c) Spiritual well-being and comfort in providing spiritual care: $r_s = .25, p = .004 < .05$. Moreover, the Spearman Rho correlations also revealed statistically significant positive relationships between and among each pairing of the demographic variables. Statistically significant positive relationships were also demonstrated between the demographic variables and each of the independent variables as well as with the dependent variable.

This investigation of multicollinearity revealed that significant relationships exist between and among all possible pairings of the five predictor variables that were included in the hierarchical regression model. According to Bannon (2013), the stakes are high for multicollinearity issues when there are moderate to strong correlations between and among predictor variables.

Resolving Concern with Multicollinearity

In seeking to resolve the multicollinearity issue, and given the medium to strong correlations between and among the dependent variable and the five predictor variables, the decision was made to combine the two predictor variables that were most strongly correlated (Fields, 2013) namely, confidence in providing spiritual care, and comfort in providing spiritual

care, which showed a strong correlation of $r_s = .760$. The newly formed variable was labeled “*spirit confi comfort combo*.” Table 10 displays a re-run of the hierarchical multiple regression using this newly formed variable, and the recoded ordinal commitment to personal spiritual practice variable in place of three original categorical demographic control variables. Model 1 shows an adjusted R^2 of .20, meaning that 20% of variance in the nurses’ provision of spiritual care was due to the two demographic variables—commitment to personal spiritual practices and the confidence-comfort combo variables. In the second regression model the adjusted R^2 of .39 indicates that the spiritual care perspective variable explained an additional 19% of the variances in provision of spiritual care. The adjusted R^2 in the third regression model was slightly lower than that of the second, signifying that adding the spiritual well-being variable to the model contributed very little explanatory power to the model. These results might be due to the ongoing multicollinearity issues, which were evidently unresolved despite combining the two most strongly correlated predictor variables.

Table 10

Model Summary with 4 Predictors and DV

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	R Square Change	Change Statistics			Sig. F Change	Durbin-Watson
						F Change	df1	df2		
1	.463 ^a	.215	.202	5.530	.215	17.351	2	127	.000	
2	.639 ^b	.408	.394	4.820	.193	41.140	1	126	.000	
3	.640 ^c	.409	.390	4.835	.001	.222	1	125	.638	1.805

a. Predictors: (Constant), SpiritConfiComfortCombo, PersonalspiritOrdinal

b. Predictors: (Constant), SpiritConfiComfortCombo, PersonalspiritOrdinal, CompSCPSR

c. Predictors: (Constant), SpiritConfiComfortCombo, PersonalspiritOrdinal, CompSCPSR, CompSWBS

d. Dependent Variable: SCPQ Part I

To investigate this problematic reoccurrence of multicollinearity, the variance inflation factor (VIF) values shown in the coefficient table (see Table 11) for this hierarchical regression were

examined. For the purposes of this study a VIF greater than 2.00 is equivalent to R^2 greater than .50 (which is indicative of a strong predictor) when the given predictor variable is regressed against the other predictors in the model. The VIF procedure was followed, in that the variable with the largest VIF greater than 2.00 was removed from the model first (Bannon, 2013). In this case, the variable *Personal Spiritual Commitment* with a VIF of 2.11 was removed.

Table 11

Hierarchical Regression: Personal Spiritual Commitment, Confidence/ Comfort in Providing Spiritual Care, Spiritual Care Perspective, Spiritual Well Being Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics	
	B	Std. Error	Beta	t	Sig.	Tolerance	VIF
1	(Constant)	17.91	2.01		8.92	.000	
	Personalspirit Ordinal	1.35	.51	.22	2.65	.009	.92
	SpiritConfiComfortCombo	1.68	0.39	.35	4.29	.000	.92
2	(Constant)	3.43	2.86		1.20	.232	
	Personalspirit Ordinal	.08	.49	.01	.17	.868	.77
	SpiritConfiComfortCombo	.44	.39	.09	1.13	.262	.70
	CompSCPSR	.64	.10	.58	6.41	.000	.58
3	(Constant)	4.31	3.42		1.26	.210	
	Personalspirit Ordinal	.26	.62	.04	.42	.674	.47
	SpiritConfiComfortCombo	.44	.39	.09	1.11	.269	.70
	CompSCPSR	.65	.10	.58	6.38	.000	.56
	CompSWBS	-.02	.04	-.05	-.47	.638	.49

a. Dependent Variable: SCPQ Part I

The hierarchical regression was re-run without this variable. As shown in the coefficients table displayed in Table 12, this regression produced results in which all the VIFs associated with the predictor variables were less than 2.0. However all the p -values associated with both the spiritual confidence-comfort combo and the spiritual well-being variable were not significant — i.e. the p - values were greater than .05.

Table 12

Hierarchical Regression: Confidence/ Comfort in Providing Spiritual Care Spiritual Care Perspective, Spiritual Well Being Coefficients

Model	Unstandardized Coefficients		Standardized Coefficients			Collinearity Statistics		
	B	Std. Error	Beta	t	Sig.	Tolerance	VIF	
1	(Constant)	20.42	1.81		11.27	.000		
	SpiritConfiComfortCombo	1.98	.39	.41	5.14	.000	1.00	1.00
2	(Constant)	3.40	2.84		1.20	.233		
	SpiritConfiComfortCombo	.44	.39	.09	1.14	.258	.70	1.44
	CompSCPSR	.65	.09	.58	7.12	.000	.70	1.44
3	(Constant)	3.77	3.16		1.19	.235		
	SpiritConfiComfortCombo	.44	.39	.09	1.13	.261	.70	1.44
	CompSCPSR	.66	.10	.59	6.63	.000	.59	1.70
	CompSWBS	-0.01	.03	-.02	-.27	.788	.80	1.26

a. Dependent Variable: SCPQ Part I

The next logical step involved identifying the variable with the largest non-significant p -value and removing that variable from the model (Bannon, 2013). In this case the spiritual well-being variable with a p -value of .788 was eliminated. The hierarchical regression was then re-run without this variable, leaving a model with two predictor variables i.e. the confidence-

comfort combo, and the spiritual care perspective variables. Table 13 shows the Coefficients Table for this regression. In this revised model the combo variable had a non-significant p -value of .258. This necessitated the elimination of the combo variable from the model.

Table 13

Hierarchical Regression: Confidence/ Comfort in Providing Spiritual Care and Spiritual Care Coefficients^a

Model	Unstandardized Coefficients		Standardized Coefficients		Collinearity Statistics			
	B	Std. Error	Beta	t	Sig.	Tolerance	VIF	
1	(Constant)	20.42	1.81		11.27	.000		
	SpiritConfiComfortCombo	1.98	.39	.41	5.14	.000	1.00	1.00
2	(Constant)	3.40	2.84		1.20	.233		
	SpiritConfiComfortCombo	.44	.39	.09	1.14	.258	.70	1.44
	CompSCPSR	.65	.09	.58	7.12	.000	.70	1.44

a. Dependent Variable: SCPQ Part I

Finally, a linear regression model was run, using the only remaining predictor variable, spiritual care perspective. In this final simple regression model, the spiritual care perspective variable was statistically significant ($p = .0001 < .05$) predictor of spiritual care provision. The spiritual perspective variable explained 40% of the variance of the dependent variable as indicated by the adjusted $R^2 = .402$. Tables 14 and 15 illustrate these findings.

Table 14

Simple Regression: Spiritual Care Perspective Model Summary^b

Model	R	R Square	Adjusted R Square	Std. Error of the Estimate	Durbin-Watson
1	.634 ^a	.402	.397	4.807	1.800

a. Predictors: (Constant), CompSCPSR

b. Dependent Variable: SCPQ Part I

Table 15

Simple Regression: Spiritual Care Perspective Coefficients^a

Model		Unstandardized Coefficients	Std. Error	Standardized Coefficients	t	Sig.
1	(Constant)	3.31	2.84		1.16	0.247
	CompSCPSR	0.71	0.08	0.63	9.27	0.000

a. Dependent Variable: SCPQ Part I

Spiritual Care Perspectives: A Mediator between Predictor Variables and Provision of Spiritual Care

As noted in the earlier sections of this chapter there were significant correlations between and among four predictor variables—namely, spiritual well-being, spiritual care perspectives, commitment to personal spiritual practices, the combined confident-comfort variables—and the dependent variable, provision of spiritual care. After eliminating all the other predictors in the final regression model, the only remaining variable was spiritual care perspective which explained 40% of the variance in the dependent variable. It then became apparent that the

spiritual care perspective variable might be mediating the effect of: (a) spiritual well-being on provision of spiritual care, (b) the nurses' commitment to personal spiritual practices on their provision of spiritual care, and (c) the effects of confidence/comfort on provision of spiritual care. In other words, there was a possibility that the effects of the respondents' sense of spiritual well-being, their commitment to personal spiritual practices, and their combined confident-comfort level in relation to provision of spiritual care were being influenced by their spiritual care perspectives (attitude, values, and beliefs).

Baron and Kenny (1986) explain that a given variable may function as a mediator to the extent that it accounts for relationships between the predictor variable(s) and the dependent variable. The mediating variable intervenes between the predictor variable(s) and the dependent variable, and helps to explain how and why the relationships exist (Polit & Beck, 2008). A mediator variable exists if the following hallmark conditions hold: (a) when there are variations in the levels of the predictor variables significantly accounting for variations in the assumed mediator; (b) when there are variations in the mediator significantly accounting for variations in the dependent variable; and (c) when a previously significant relationship between the predictor variable and the dependent variable is no longer significant when the predictor and mediator are regressed together on the dependent variable (Baron & Kenny, 1986). From a theoretical perspective, a substantial reduction in the once significant relationship will provide validation that a given mediator is indeed potent.

Hence, a series of regression analyses were performed to test whether or not the spiritual care perspective variable was indeed exerting a mediating effect on the predictor variables of spiritual well-being, commitment to personal spiritual practices, and the combined confident-

comfort. In each of these regressions, the standardized beta (β) was utilized as the measurement of the degree of strength between the applicable pair of variables in each model.

The three regression equations testing the mediating effects of spiritual care perspective on the predictor variable of spiritual well-being produced the following results:

- The first equation of regressing spiritual care perspectives on spiritual well-being showed a significant relationship between these two variables: $\beta = .45, p = .0001 < .05$.
- The second equation of regressing the provision of spiritual care on spiritual well-being revealed a significant relationship between this pair of variables: $\beta = .27, p = .002 < .05$.
- The third equation of regressing provision of spiritual care on both spiritual well-being and spiritual care perspectives showed a non-significant relationship between provision of spiritual care and spiritual well-being ($\beta = -.02, p = .785 > .05$) but a statistically strong significant relationship between provision of spiritual care and spiritual care perspective ($\beta = .64, p = .0001 < .05$).

The results of these three regression equations indicate that spiritual care perspective was indeed a significant mediator between the nurses' spiritual well-being and their provision of spiritual care.

The three regression equations testing the mediating effects of spiritual care perspective on the commitment to personal spiritual practices predictor were as follows:

- The first equation of regressing spiritual care perspectives on commitment to personal spiritual practices showed a significant relationship between these two variables:
 $\beta = .48, p = .0001 < .05$.

- The second equation of regressing the provision of spiritual care on commitment to personal spiritual practices revealed a significant relationship between this pair of variables: $\beta = .32, p = .0001 < .05$.
- The third equation of regressing provision of spiritual care on both commitment to personal spiritual practices and spiritual care perspectives showed a non-significant relationship between provision of spiritual care and commitment to personal spiritual practices ($\beta = .02, p = .846 > .05$) but a statistically significant relationship between provision of spiritual care and spiritual care perspective ($\beta = .63, p = .0001 < .05$).

These findings again demonstrate that the spiritual care perspective (attitude, values, and beliefs) of the nurses participating in this study was a strong mediator between the nurses' commitment to their personal spiritual practices and their provision of spiritual care.

Finally, the results of the three regression equations testing the mediating effects of spiritual care perspective on the combined confident-comfort predictor variable yielded the following results:

- The first equation of regressing spiritual care perspectives on the combined confident-comfort predictor showed a significant relationship between these two variables:
 $\beta = .55, p = .0001 < .05$.
- The second equation of regressing the provision of spiritual care on the combined confident-comfort predictor revealed a significant relationship between this pair of variables: $\beta = .41, p = .0001 < .05$.
- The third equation of regressing provision of spiritual care on both the combined confident-comfort predictor and spiritual care perspectives showed a non-significant relationship between provision of spiritual care and the combined confident-comfort

predictor ($\beta = .09, p = .258 > .05$) but a statistically significant relationship between provision of spiritual care and spiritual care perspective ($\beta = .58, p = .0001 < .05$).

These findings demonstrate that the spiritual care perspective of the nurses participating in this study was a strong mediator between their confidence and comfort in providing spiritual care and their actual provision of spiritual care.

Additional Statistical Analyses

Analysis of Variance (ANOVA), or independent samples *t*-tests were performed for each of the fourteen categorical demographic/work variables in association with the dependent variable (provision of spiritual care) to determine whether or not there were statistically significant differences among the group means. Findings from these analyses indicated that there were significant differences in the dependent variable scores among the categories for three demographical/work related variables: namely (a) participants' commitment to their personal spiritual practices, (b) confidence in providing spiritual care and (c) comfort level in providing spiritual care. The ANOVA results for the participants' commitment to their personal spiritual practices and their provision of spiritual care was significant $F(3, 126) = 5.00, p = .003 < .05$. A Bonferroni post hoc analysis indicated that nurses who had a very strong, strong, or moderately strong commitment to their personal spiritual practices provided spiritual care to their patients more frequently when compared to those who regarded such practices as either weak, or not important. Tables 16 and 17 present the descriptive and comparative analyses of these findings.

Table 16

Descriptive Statistics for Commitment to Personal Spiritual Practices
SCPQ Part I

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Very Strong	41	32.02	5.74	0.90	30.21	33.84	18	44
Strong	41	29.32	6.23	0.97	27.35	31.28	15	40
Moderately Strong	34	27.35	5.83	1.00	25.32	29.39	17	37
Weak or Not Important	14	26.71	5.73	1.53	23.41	30.02	15	36
Total	130	29.38	6.19	0.54	28.30	30.45	15	44

Table 17

ANOVA for Commitment to Spiritual Practices
SCPQ Part 1

	Sum of Square	df	Mean Square	F	Sig.
Between Groups	526.06	3	175.35	5	.003
Within Groups	4418.5	126	35.07		
Total	4944.5	129			

Tables 18 and 19 display the descriptive and comparative analyses for statistically significant ANOVA test regarding confidence in providing spiritual care $F(3, 127) = 14.04$, $p = .0001 < .05$. A Bonferroni post hoc analysis of these findings revealed that there was a significant difference in the provision of spiritual care among nurses who considered themselves confident in providing spiritual care. From their responses to the question—*Do you feel confident about providing spiritual care to patients who are acutely ill?*—it was evident that nurses who

are confident, will provide spiritual care more frequently ($x = 32.59$, $SD = 5.28$) than those who are either not confident or only felt confident sometimes.

Table 18

Descriptive Statistics for Confidence in Providing Spiritual Care
SCPQ Part I

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Yes	51	32.59	5.28	0.74	31.10	34.07	18	44
No	22	26.32	5.99	1.28	23.66	28.97	17	42
Sometimes	57	27.68	5.83	0.77	26.14	29.23	15	38
Total	130	29.38	6.19	0.54	28.30	30.45	15	44

Table 19

ANOVA for Confidence in Providing Spiritual Care
SCPQ Part I

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	895.09	2.00	447.54	14.04	0.00
Within Groups	4049.44	127.00	31.89		
Total	4944.53	129.00			

ANOVA procedures for comfort in providing spiritual care were also statistically significant $F(2, 127) = 10.61$, $p = .0001 < .05$. A Bonferroni post hoc analysis showed that there was a significant difference in the provision of spiritual care between nurses who were comfortable with providing spiritual care and those who were either not at all comfortable or

sometimes comfortable. Based on their responses to the question—*Do you feel comfortable with providing spiritual care to patients who are acutely ill?*—it was shown that nurses who felt comfortable with this responsibility provided spiritual care more frequently than their counterparts who were not as comfortable. Tables 20 and 21 illustrate the details of those scores.

Table 20

*Descriptive Statistics for Comfort Level in Providing Spiritual Care
SCPQ Part I*

	N	Mean	Std. Deviation	Std. Error	95% Confidence Interval for Mean		Minimum	Maximum
					Lower Bound	Upper Bound		
Yes	55	32.02	5.74	0.77	30.47	33.57	15	44
No	15	25.93	5.08	1.31	23.12	28.75	19	37
Sometimes	60	27.82	5.96	0.77	26.28	29.36	15	42
Total	130	29.38	6.19	0.54	28.30	30.45	15	44

Table 21

*ANOVA for Comfort Level in Providing Spiritual Care
SCPQ Part I*

	Sum of Squares	df	Mean Square	F	Sig.
Between Groups	707.63	2	353.82	10.61	0.00
Within Groups	4236.90	127.00	33.36		
Total	4944.53	129.00			

Analysis of Responses to Single Open Ended Item

Seventy eight (78) of the 130 study participants responded to the single open ended item from the SCPQ Part I—*please list any other nursing interventions you provide for the spiritual*

care of your patients. These responses were read and re-read, then sorted into five main thematic categories. These were: (a) Referrals to chaplain/other resources (25.6%), (b) Touching and active listening (24.4%), (c) Offering prayers (17.9%), (d) Assessing spiritual need (9%), and (e) Providing Bible and singing (3.8%). Another 17.9% of nurses responded—“nothing”, “none” or “N/A”.

Analysis of the single open ended item regarding *any other nursing interventions provide*, indicated that most respondents listed various spiritual care interventions that were already stated in the questionnaire for provision of spiritual care. It is not certain whether or not this repetition of interventions should be regarded as an oversight or a reiteration of spiritual care most often provided by the nurses. On the other hand, it might be reasonable to postulate that the relatively high percentage (17.9%) of nurses who indicated “no” or “nothing” as “other nursing interventions” might just be signifying that they were providing no other forms of spiritual care other than those mentioned in the questionnaire.

Summary of Analyses

Data analyzed from four surveys completed by 130 registered nurses revealed statistically significant positive relationships between and among the nurses’ spiritual well-being, spiritual care perspectives and their provision of spiritual care to patients in the acute care setting. There were also significant positive relationships between and among three demographic/work related items and the primary research variables. Hence, there were five significant predictor variables, viz. spiritual well-being, spiritual care perspectives, commitment to personal spiritual practices, confidence in providing spiritual care and comfort in providing spiritual care for the dependent variable, provision of spiritual care.

Initial hierarchical multiple regressions revealed no significant predictor-strength was exerted on the dependent variable when all five predictors were entered into the model. The conundrum of multicollinearity among the predictor variable was explored; and procedures for variable inflation factor applied to resolve those concerns. In the final analysis of the regression model, it was demonstrated that the nurses' spiritual care perspective accounted for 40% of the variances in provision of spiritual care, and was thus the strongest predictor of their provision of spiritual care to patients in the acute setting. Suspicion that the spiritual care perspective variable was having a mediator effect on the predictor variables was validated by a series of regressions analyses. Hence, the nurses' spiritual care perspective was recognized as a strong mediator of the effect of their spiritual well-being, commitment to personal spiritual practices, confidence and comfort in providing spiritual care on their actual provision of spiritual care.

Analysis of the single open-ended question indicated that some nurses restated several actions from the questionnaire as "*other nursing interventions*" they provide for the spiritual care of their patients. Interventions provided by respondents that were not previously listed were mostly existential actions such as *listening, quiet presence, therapeutic touching, quiet singing, and comfort care.*

Chapter V

Discussion of Findings

This descriptive correlational study explored the relationships between and among registered nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to adult patients in the acute care setting. This chapter presents a discussion of the interpretation and an appraisal of those findings in light of the primary research questions, along with a comparative review of the study's results to the related literature.

The Sample

Of the 11,500 members of the Academy of Medical Surgical Nurses (AMSN), only a representative sample of 130 nurses (1.13%) completed all four research instruments. This low response rate might be attributed to well documented data that response rates for web-surveys are consistently lower when compared to other self-administered surveys, and that on-line survey responses are driven by the population's level of interest in the topic (Andres, 2012; Bosnjak, Tuten, & Wittmann, 2005). For this study, the low response rate might also be related to the fact that 50% of the nurses who entered the study were directed to close the survey-link, because based on their responses to the first three questions they did not meet the inclusion criteria for the study. It was somewhat surprising that such a high percentage of the prospective respondents did not meet the study criteria, especially because 87% of the AMSN membership consists of Registered Nurses who are actively employed in the inpatient acute care environment (<https://www.amsn.org/>). Furthermore, another 22% who met the criteria did not complete all four surveys. Another factor that might be responsible for the low response rate to this study is the fact that the surveys were opened to the AMSN membership during the busy holiday season between Thanksgiving and Christmas, from November 10 thru December 21.

Albeit, the study sample was sufficient to provide ample power needed for meaningful correlation and regression analyses appropriate to answering the research questions.

Additionally, a strength of this on-line research survey is a study sample that was recruited from a highly respected national organization of professional nurses, with respondents from ten different racial backgrounds, who are employed in an array of nursing specialty units, practicing in three different geographical regions, and who identify with 18 different religious affiliations. It is probably unlikely that the rich blend of diversity reflected in this sample would have been captured in such an efficient manner if participants were recruited in another way.

Relationship between Spiritual Well-Being and Provision of Spiritual Care

In response to the first research question—*is there a relationship between acute care nurses' spiritual well-being and their provision of spiritual care to patients in acute care settings?*—Pearson correlations indicated that in this sample, the nurses' spiritual well-being showed a moderate positive correlation to their provision of spiritual care ($r = .27, p = .0001$). It was therefore evident that nurses who experience a sense of high spiritual well-being were also more likely to provide frequent spiritual care to their patients in the acute setting. However, in view of the negatively skewed distribution of scores on the SWBS ($x = 98.5, SD = 16.79$), (indicating that most respondents scored close to maximum score of 120), it was interesting to note that there was a moderate rather than strong correlation between spiritual well-being and provision of spiritual care. Roberts' (2002) study concluded that spiritual well-being among nurses was a strong predictor of caring behavior. Akin to the acute care nurses in Vance's (2001) study, the sample of nurses in the present study reported a sense of high spiritual well-being, yet most scored below the *ideal mean* of 32 for provision of spiritual care. The mean score for this sample's provision of spiritual care was $x = 29.30, SD = 6.19$. Vance (2001) found

a positive, but weak relationship ($r = 0.19, p < 0.05$) between acute care nurses' spiritual well-being and their frequency of assessing and intervening in the spiritual care of patients. The researcher expressed disappointment to find that, in view of the nurses' sense of high spiritual well-being, so few of the respondents were providing adequate spiritual care to their patients. Vance's sentiments are reiterated for this present study, even though for this sample, there was a moderate correlation between spiritual well-being and provision of spiritual care ($r = .27, p = .002$). Gallison et al. (2014) also utilized the SCPQ Part I to measure provision of spiritual care among 271 acute care nurses in a large New York City academic medical center; and reported similar findings ($x = 29.94, SD = 6.74$), indicating less than adequate provision of spiritual care. Although the reason for this less than strong correlation between spiritual well-being and provision of spiritual care was not explored in this study, it is noteworthy that the findings from this study support the spiritual domain of the Neuman System Model which emphasizes the importance for a "careful assessment of the client needs in the spiritual area, followed by purposeful intervention" (p. 15) for achieving optimal stability in the patient's overall condition (Neuman, 2002).

Relationship between Spiritual Care Perspective and Provision of Spiritual Care

In response to the second research question—*Is there a relationship between acute care nurses' spiritual care perspectives and their provision of spiritual care to patients in acute care settings?*—it is evident that for this study's sample, there is a strong positive correlation between the nurses' spiritual care perspectives and their provision of spiritual care to patients in acute care settings ($r = .63, p = .0001$). Descriptive statistics illustrated that most nurses scored well above the mean (i.e. greater than 25) on the SCPS-Rv ($x = 39.95, SD = 5.56$). These findings signify that the nurses comprising this sample had a positive attitude towards spiritual care,

indicating that as the nurses' spiritual care perspectives increased their frequency of providing spiritual care will also increase. Using the unrevised version of the SCPS in a study of oncology nurses attitudes and beliefs regarding spiritual care, Taylor et al.'s (1994) study sample also demonstrated a positive correlation between those nurses' spiritual care attitudes and their provision of spiritual care. These findings were similar to that of this study which used the revised version of the SCPS to measure spiritual care perspectives.

Ronaldson et al. (2012) also conducted a study in Australia aimed at comparing 42 palliative care nurses' spiritual perspectives and spiritual care practices with that of 50 acute care nurses. Similar to the findings of this study the researchers reported a statistically significant positive correlation between the palliative care nurses' spiritual perspectives and their provision of spiritual care ($r = 0.37, p = 0.02$). However, it is remarkable to note that the acute care nurses in Ronaldson et al.'s (2012) study showed a negative correlation between their spiritual perspectives and their provision of spiritual care ($r = -0.03, p = 0.84$). Such a contradictory finding is intriguing especially when comparing the results of the palliative care nurses in Ronaldson et al.'s study, and the acute care nurses ($r = .63, p = .0001$) in the present study. It should be noted that while both studies used the same instrument (SCPQ Part I) to measure provision of spiritual care, different instruments were used to measure spiritual care perspectives. It could be argued that using different instruments might explain some of the dissimilar findings in the acute care nurses' spiritual care perspectives in the two studies. It is also possible that the discrepancies in findings might be rooted in how the constructs of spiritual perspectives and spiritual care perspectives were measured, even though similar term was used for the variable.

In light of such conflicting findings, further research is needed among various populations of acute care nurses using the same instrument to measure the concept of spiritual care perspectives.

Relationships between and Among Spiritual Well-Being, Spiritual Care Perspectives, Select Demographic Factors and Provision of Spiritual Care

In response to the third research question—*Are there relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, select demographic factors [i.e. nurses' age, commitment to personal spiritual practices, level of education, practice specialty, years of nursing practice- See Figure 1-1] and their provision of spiritual care to patients in acute care settings?*—results of Pearson correlations have provided evidence that there is a strong positive association between this sample of acute care nurses' spiritual well-being and their spiritual care perspectives. This finding provides additional validation for the conclusion of studies conducted by Musgrave and McFarlane (2004) and Vance (2001). Both researchers reported a positive relationship between the nurses' spiritual well-being and their spiritual care perspectives (attitudes, beliefs and values). Interestingly, the SWBS by Paloutzian and Ellison (1982) was used to measure the concept of spiritual well-being in this study as well as in the two aforementioned studies. For the three studies, different versions of Taylor's SCPS and the then recently published-Spiritual Involvement and Beliefs Scale (SIBS) were used to measure spiritual care perspectives in the oncology nurses and acute care nurses who participated in the studies. This is exciting because although the SCPS-Rv was used to measure spiritual care perspectives among acute care nurses in this study, and the SIBS was used by Vance (2001) to measure the spiritual attitudes among acute care nurses, the findings are consistent that a positive

relationship exists between spiritual well-being and spiritual care attitudes in acute care nurses even when different instruments are used to measure the concept of spiritual care perspectives.

Furthermore, Fisher and Brumley (2008) drew similar conclusions from their study of a mixed sample of nurses employed in private and public hospitals, as well as nurses and pastoral care givers employed in hospice care. Using their researcher developed instrument (The Spiritual Health and Life Orientation Measure [SHALOM]) to identify key aspects of spiritual well-being and how it is related to the participants' workplaces and lived experiences, the researchers concluded that the beliefs and worldview (perspective) of the participants had a greater influence on their spiritual well-being than did their age, gender or work environment. This evidence is reiterated in one aspect of this study's finding, which demonstrated that spiritual care perspective (attitude, beliefs, and values) has a strong mediating effect on spiritual well-being. Although there were some significant associations between certain demographic factors and spiritual well-being of the participants in Fisher and Brumley's (2008) study, none of these had an effect on the respondents' spiritual well-being that was so strong as their beliefs and worldview (perspectives).

In regards to the independent variables—spiritual well-being, and spiritual care perspectives—and the dependent variable, provision of spiritual care, this study along with researchers such as Vance (2001), Ronaldson et al. (2012), and Gallison et al. (2014), used the same instrument (SCPQ Part I) to measure provision of spiritual care in acute care nurses and reported similar findings of an overall inadequate provision of spiritual care. Such unswerving findings might be an indication that despite their sense of high spiritual well-being, and their positive spiritual care perspectives, nurses employed in acute care environments are encountering barriers to providing spiritual care to the hospitalized patient. The fact that Ronaldson et al.

(2012) used the same instrument to measure spiritual care practices in palliative care nurses and found significant positive results is not surprising, because it is documented that nurses employed in the specialties of hospice, oncology, and palliative care are inclined to provide spiritual care routinely (Cockell & McSherry, 2012; Taylor et al., 1994). Additionally, the nature of palliative care nursing might account for those nurses' positive attitudes towards spiritual care and their actual provision of spiritual care. Parallel to the palliative care nurses, but unlike the acute care nurses in Ronaldson et al. (2012), this study found a significant positive relationship between the acute care nurses' spiritual care perspective and their provision of spiritual care although different instruments were used to measure the concept of spiritual care perspective.

Results of data analyses for this study revealed no significant relationships (or differences in scores) between and among the originally selected demographic variables—the nurses' age, level of nursing education, practice specialty, or number of years in nursing practice—and the primary research variables. Such findings were contradictory to some earlier studies, and yet validating to other related studies conducted among nursing students, acute care nurses, pediatric nurses, and nurses employed in palliative care (Chism & Magnan, 2009; Musgrave & McFarlane, 2004; Ozbasaran et al., 2011; Ronaldson et al., 2012; Vance 2001).

The aforementioned studies highlight the concern that there are still inconsistencies in the literature about whether or not certain demographic factors such as the nurses' age, practice specialty, number of years in practice and level of nursing education are related to their spiritual well-being, spiritual care perspectives, or their provision of spiritual care.

In the present study, three demographic variables, namely: (a) commitment to personal spiritual practices, (b) confidence in providing spiritual care, and (c) comfort in providing spiritual care showed significant relationships with each other as well as with the primary

research variables— spiritual well-being, spiritual care perspectives and provision of spiritual care.

There was a strong positive correlation between the nurses' commitment to personal spiritual practices and their spiritual well-being ($r_s = .70, p = .00$), indicating that respondents who scored higher on the SWBS also had a stronger commitment to their personal spiritual practices. This finding bears similarity to that of Musgrave and McFarlane's (2004) study among Israeli oncology nurses, in which intrinsic and extrinsic religiosity explained a total variance of 54.6% of the sample's spiritual well-being. Genia (2001) showed that college students "who reported a satisfying relationship with God were likely to be intrinsically religious and attend worship services frequently" (p. 31). Mickley et al. (1992) revealed that patients who classified as intrinsically religious had significantly higher scores on the SWBS.

Although the above-mentioned researchers investigated relationships between intrinsic and/or extrinsic religiosity and spiritual well-being, and the present study explored relationships between commitment to personal spiritual practices and spiritual well-being, an individual's degree of religiosity is often expressed in his/her commitment to personal spiritual practices. The findings from this study provides evidence that acute care nurses who are committed to their personal spiritual practices will report a sense of high spiritual well-being. Given this study's definition of spiritual well-being, these nurses are fulfilled in their relationships with self, others, the environment, and God or a transcendent power greater than themselves.

Spearman Rho non-parametric test also revealed moderate to strong positive correlation between the acute care nurses' commitment to personal spiritual practices and spiritual care perspectives ($r_s = .47, p = .00$), and a moderate correlation to actual provision of spiritual care ($r_s = .31, p = .00$). These findings are comparable to that of Stranahan's (2001) study which

concluded that NPs who scored high on their perception of personal spirituality, also had high scores on spiritual care perspective, and that the higher the scores were on personal spirituality the more frequently the NPs practiced spiritual care interventions. Stranahan (2001) defined spirituality as “an awareness of one’s inner self and a sense of connection to a higher being, nature, others, or to a purpose greater than oneself” (p. 93). Such a definition infers the nurse’s commitment to stay connected to inner self, higher being, others, nature, or greater purpose. There is agreement in the literature that spiritual practices may include traditional religious activities or existential doings (Burkhardt & Nagai-Jacobson, 1985; Murray & Zentner, 1989; Savel & Munro, 2014; Tanyi et al., 2008).

Comparable to the findings of this study, O’Shea et al. (2011) reported a strong linear correlation between pediatric nurses’ comfort in providing spiritual care and their personal spirituality ($r = .66, p = .00$). Likewise, in the present study, there was a moderate correlation between commitment to personal spiritual practices, and a strong correlation between spiritual care perspective and confidence and comfort in providing spiritual care. Provision of spiritual care and confidence in providing spiritual care were also significantly correlated with comfort in providing care.

Spiritual Well-Being, Spiritual Care Perspectives and Select Demographic Factors

In response to the fourth research question—*Are there relationships among acute care nurses’ spiritual well-being, spiritual care perspectives and select demographic factors [i.e. nurses’ age, commitment to personal spiritual practices, level of education, practice specialty, years of nursing practice- See Figure 1-2]?*—as mentioned in the forgoing sub-section, the nurses’ commitment to their personal spiritual practices was the only select demographic

variable that was found to have significant relationships to their spiritual well-being, and spiritual care perspectives.

Spiritual Well-Being, Spiritual Care Perspectives and Provision of Spiritual Care

In response to the overarching research question—*What are the relationships between and among acute care nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in acute care settings?*—study results indicated that for the sample of nurses participating in this study, there were moderate to strong statistically significant positive relationships between and among the nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in the acute care settings. Pearson's correlation analysis showed a moderate positive relationship between spiritual well-being and provision of spiritual care ($r = .27, p = .0001$); a strong positive correlation between spiritual care perspectives and provision of spiritual care ($r = .63, p = .0001$); and a strong positive correlation between spiritual well-being and spiritual care perspectives ($r = .45, p = .002$). The fact that there was a much stronger relationship between the nurses' spiritual care perspective and their provision of spiritual care than there was between their spiritual well-being and provision of spiritual care suggests that the nurses' attitude towards spiritual care might be a good indicator of whether or not spiritual care will be provided. Nevertheless this study provides corroborative evidence that nurses who have a sense of high spiritual well-being will also have positive spiritual care perspectives; and that both of these variables should be regarded as contributing factors to the provision of spiritual care.

Musgrave and McFarlane's (2004) study among oncology nurses in Israel revealed similar findings, in which regression analysis showed the nurses' attitudes toward spiritual care were significantly impacted by their SWB ($\beta = 0.39, p = .0010$). In the most recent systematic

review of 80 nursing research studies on the topic of spiritual care published between 2006 and 2010, Cockell and McSherry (2012) noted evidence that nurses who are more developed in their spiritual domain will score higher on spiritual well-being and are more apt to provide spiritual care than their counterparts who score low on the SWBS. However, it is apparent from the findings of this study as well as Vance's (2001) study that despite acute care nurses' overall sense of high spiritual well-being and positive attitude towards spiritual care, there is a below average performance in the actual provision of spiritual care (Vance 2001). The overall marginal scores for the participants' provision of spiritual care despite their comparable hefty scores for spiritual well-being and spiritual care perspectives might be an indication that although the nurses possess certain intrinsic determinants for providing spiritual care, there are existing barriers that might be over-riding their core attitudes and sense of spiritual well-being pertaining to delivering spiritual care in the acute care setting. This disconnect might be related to many factors and is worth investigating and resolving, especially since nurses in all practice settings are called upon to deliver holistic care to their patients, which includes care in the spiritual domain (Neuman, 2002).

Discussion of Regression Analysis

Given the significant correlations between and among the three demographic covariates, the two independent variables and the dependent variable, hierarchical multiple regression analyses were done to identify the predictive power of the five significant predictors on the dependent variable. Concern regarding the issue of multicollinearity was raised when results of regression analyses showed none of the five predictors exerting significant predictive power on the provision of spiritual care.

Upon resolving the multicollinearity concerns through a series of statistical operations that required eliminating predictor variables and revising the regression model, a final simple regression model revealed that the spiritual care perspective variable was the only remaining statistically significant ($p = .0001 < 0.5$) predictor of spiritual care provision. The spiritual care perspective variable explained 40% of the variance in the dependent variable, provision of spiritual care ($R^2 = .402$). Additionally, Table 10 further illustrates that the R^2 of .402 and the *adjusted* R^2 of .397 are quite similar in values. According to Bannon (2013), as a basic rule, the closer the R^2 and the *adjusted* R^2 , the more generalizable and credible is the estimate of the R^2 . Therefore, the closeness of these two values in the present study provides increased assurance in regards to the generalizability of the evidence that the spiritual care perspectives (attitude, values, and beliefs) of acute care nurses is a strong predictor of the provision of spiritual care by those nurses.

Given this revelation from the final analysis, suspicions arose about whether or not spiritual care perspective variable was mediating the effect of spiritual well-being and the three demographic predictors on spiritual care practices. A series of statistical procedures were performed which confirmed that spiritual care perspective was in fact mediating (that is responsible for the relationships) between the other predictor variables and the dependent variable.

Chism and Magnan (2009) also concluded that spiritual care perspectives was the best predictor of *expression of spiritual empathy* among nursing students enrolled in undergraduate thru postgraduate degree programs. The researchers further explained that the nurses' *expression of spiritual empathy* is indeed a form of spiritual care. Ronaldson et al., (2013) also established that the spiritual perception of palliative nurses strongly correlated with those nurses' provision

of spiritual care ($r=.37, p = < .05$). Likewise Stranahan's (2001) findings that nurse practitioners who reported a favorable attitude toward providing spiritual care also scored modestly on inclusion of spiritual care in their practice.

Discussion of Responses to Open-Ended Question

In response to a single open-ended item from the SCPQ Part I—*please list any other nursing interventions you provide for the spiritual care of your patients*—seventy eight study participants (60%) provided comments that were sorted into five thematic categories. Although most responses fell into the categories labelled “*making referrals to chaplain/other resources*” (25.6%), “*touching and active listening*” (24.4%), and “*offering prayers*” (17.9%), it was noted that several of the interventions listed by the respondents were already included in the questionnaire and could not be strictly regarded as “*other nursing interventions*” that were provided for patients. However the most frequently occurring *other nursing interventions* indicated by participants were existential actions that involved active listening, music, art, singing, quiet presence, comfort care and touching, (such as *empathetic touch, healing touch, reiki* and *holding hand*). Although the use of therapeutic communication was mentioned in the questionnaire as a spiritual intervention for assisting patients with reflecting, finding purpose and exploring strengthening elements, and while active listening is regarded as a component of therapeutic communication, it was felt that given the broadness of the term “therapeutic communication,” and for the purposes of this study, “*active listening*” was considered as *other nursing interventions* in the context of the responses to the open-ended question.

The fact that as many as 28% of the respondents identified an existential spiritual care intervention as “*other nursing interventions*” provided for spiritual care should not be surprising. Findings from Tanyi et al., (2009) qualitative study titled—*How family practice physicians,*

nurse practitioners, and physician assistants incorporate spiritual care in practice—revealed that all the participants in that study provided spiritual care that was completely existential in nature. Furthermore responses to the open-ended question in this study were in perfect alignment with well documented evidence that spiritual care goes beyond religious affiliations and traditional religious expressions (Brown et al., 2006; Burkhart et al., 2011; Murray & Zentner, 1989; Paloutzian & Ellison, 1982; Ross, 1999); and may involve activities such as guided imagery, music, art, exercise, showing respect, caring and non-judgmental attitudes (Burkhart et al., 2011; Chung et al., 2007; Milligan, 2004; Tanyi et al., 2009). Findings from the open-ended item in this study further validate theoretical concepts from Neuman System Model which indicate that spiritual care should be routinely provided because the spiritual domain is an innate component of every human being, and exists even in individuals who deny their spiritual existence. Hence existential spiritual care may be provided for patients who are atheistic or areligious.

It is essential that acute care nurses have a strong working knowledge of such concepts and findings from empirical studies, since these may be resourceful tools in guiding their spiritual care practices.

Strengths of Study

One strength of this study is embodied in the racial, ethnic, and religious diversity of the sample of nurses from a variety of nursing specialties obtained through a large national organization. Although a large percentage of the study respondents were Caucasians, Christians, and females, this may be a proportional reflection of today's nursing profession across the USA. A strength of this study is the likelihood that the findings are generalizable to nurses employed to provide direct patient care to acutely ill hospitalized patients; this likelihood is hinged on the

similarities in the R^2 and *adjusted R²* values illustrated in the final regression output. However, considering that individuals are drawn to electronic research studies based on their interest in the topic, the findings for this study might not be a true reflection of the entire membership of the AMSN ($N=11,500$); therefore biases may exist in the sample. Such biases would reduce the possibilities for generalization of the study findings. Nevertheless the R^2 -values convey a compelling message regarding the credibility of this study.

An additional credible feature in the design of this study is the fact that the study is undergirded by facets of a well-established nursing philosophical framework, namely, The Neuman System Model.

Another strength of the study is the Cronbach's alpha reliability measure of the research instruments used for measuring the spiritual well-being ($\alpha = .82$), spiritual care perspectives ($\alpha = .84$), and provision of spiritual care ($\alpha = .93$) for the sample of acute care nurses who participated in this study. Burns and Grove (2009) have indicated that for an established research instrument the acceptable alpha is .80. This provides confirmation that the instruments used in the current study have reliably and consistently measured the constructs for which each was employed to measure in this study's sample of nurses (Polit & Beck, 2008).

An additional strength of this study is the knowledge it has added to the body of nursing science through the serendipitous findings of significant correlations between the demographic factors of the acute care nurses'—commitment to personal spiritual practices, and their confidence in providing spiritual care—with the primary research variables, i.e. spiritual well-being, spiritual care perspective and provision of spiritual care. Although similarities exist among terms such as *personal spirituality*, *intrinsic and extrinsic religiosity*, and *commitment to spirituality* which might indicate an individual's *commitment to [his/her] personal spiritual*

practices, it is clear that these terms are not interchangeable. Based on a review of the literature, no study was found that concentrated on acute care nurses' commitment to personal spiritual practices, or confidence in providing spiritual care. Although none of these variables constituted a part of the primary research variables, it was most valuable to explore and discover their relationships to and effects on the primary research variables.

Another strength of this study lies in the unexpected discovery that the spiritual care perspectives of acute care nurses had a significant mediating effect on their spiritual well-being, their commitment to personal spiritual practices, as well as on their confidence and comfort in providing spiritual care. It is certainly exciting to learn that the nurses' spiritual care perspectives is such a forceful catalyst for their spiritual care practice as it hinges on the predictors of spiritual well-being, commitment to personal spiritual practices, and confidence and comfort in providing spiritual care. There is no indication that such findings were ever before reported in the body of empirical nursing literature. This addition to the body of nursing knowledge should provide greater leverage for leaders in nursing academia, administration and the clinical setting to confidently advocate for resources to explore and develop the spiritual care perspectives (attitudes, values, and beliefs) of nurses across all spectrums of the profession. Development of this variable in nurses may enhance compliance with expectations for spiritual care education and inclusion of spiritual care in every sphere of the nursing profession.

Limitations of Study

Limitations of this study are apparent in the fact that there was such a low response rate from among the AMSNs' over 11,500 members. Although the sample size ($n = 130$) was sufficient to answer the research questions and there are no indications that the findings would have been different had there been a larger representation of nurses, there are suggestions that

the multicollinearity issues encountered may have been abated with a more robust sample size (Bannon, 2013).

It should also be noted that the multicollinearity problem might also have stemmed from more than one survey instrument measuring the same or similar constructs in the research sample. In review of the SCPS-Rv and the demographic/work related survey used in this study, there was a noticeable repetition of the item pertaining to respondents' comfort level in providing spiritual care. It was therefore not coincidental that there were such strong correlations between spiritual care perspectives and comfort in providing spiritual care ($r_s = .52, p = .0001$). The very strong correlation between the demographic combo-variables of confidence and comfort in providing spiritual care ($r_s = .76, p = .0001$) might also have presented a problem with measuring similar concepts on the same survey instrument. It is likely that pilot-testing the researcher-drafted demographic/work related survey instrument might have raised concerns about similarities in these items before the study was formally opened to participants (Andres, 2012).

Summary

The findings from this study have provided evidence that there are moderate to strong relationships between registered nurses' spiritual well-being, spiritual care perspective, and their provision of spiritual care to patients in the acute care setting. There were no significant results among the primary research variables and the scores of four select demographic covariates, namely the nurses' age, level of education, practice specialty, or number of years providing patient-care. However, three other demographic factors showed moderate to strong significant positive correlations among each other as well as with the primary research variables. These findings provided new evidence that acute care nurses who are committed to their personal spiritual practices, confident and comfortable in providing spiritual care will also score high on

their sense on spiritual well-being, spiritual care perspective (or attitude towards spiritual care) and the actual provision of spiritual care. Regression analysis on the data for this study has provided validating evidence for related studies conducted among oncology nurses, and nursing students. This study corroborates that the spiritual care perspective of acute care nurses is the best predictor of their provision of spiritual care to the patients in the acute care setting. New evidence founded on the results of this study signified that the spiritual care perspective variable exerts a mediating effect on acute care nurses' spiritual well-being, commitment to personal spiritual practices, confidence and comfort in providing spiritual care, and their spiritual care practices.

Responses to the open-ended item in the SCPQ Part I have provided validating evidence to earlier studies that existential spiritual care is an acceptable form of care for patients in spiritual distress, and that existential care is being employed by acute care nurses. The responses to this item emphasized the fact that the acute care nurses who participated in this study were abreast with the concept that spiritual care may also involve non-traditional activities such as active listening, respecting others views, empathetic touch and quiet presence.

Chapter VI

Summary, Conclusions, Implications and Recommendations

A descriptive correlational design was employed to explore the relationships between and among registered nurses' spiritual well-being, spiritual care perspectives (or attitudes), and their provision of spiritual care to patients in the acute care setting. This chapter provides a summary of the study findings, implications, and recommendations for further research studies, nursing education, clinical practice, and policy making.

Summary of Findings

Analyses of data collected from a sample of 130 acute care nurses (via three established research instruments and a demographic/work related survey) revealed statistically significant positive relationships between and among those nurses' spiritual well-being, spiritual care perspectives, and their provision of spiritual care to patients in acute settings. Additionally, significant positive relationships were serendipitously found between and among three demographic variables and the primary research variables. The demographic/work related factors of the nurses'—commitment to personal spiritual practices, confidence in providing spiritual care, and comfort in providing spiritual care—showed moderate to strong correlations with their sense of spiritual well-being, spiritual care perspectives and provision of spiritual care. There were no significant findings among the originally selected demographic variables of the nurses' age, level of education, practice specialty, or number of years in nursing practice.

Pearson's correlation, Spearman Rho rank-order correlation, multiple regression analyses, and one-way analysis of variance were used to analyze data for this descriptive correlational study. Data were collected electronically through the Survey Monkey[®] web-site

from a sample ($n = 130$) of acute care nurses who are members of the Academy of Medical Surgical Nurses.

Spiritual Well-Being

For the independent variable of spiritual well-being, findings from the correlation analyses revealed: (a) a moderate to strong positive relationship between spiritual well-being and spiritual care perspective; (b) a moderate positive relationship between spiritual well-being and provision of spiritual care; (c) a strong positive relationship between spiritual well-being and commitment to personal spiritual practices; (d) a moderate correlation between spiritual well-being and confidence in providing spiritual care, and (e) a moderate correlation between spiritual well-being and comfort in providing spiritual care. These findings indicate that nurses who have a high sense of their own spiritual well-being demonstrate a positive attitude towards spiritual care, and provide spiritual care to their acutely ill patients. These nurses are likely to be strongly committed to their personal spiritual practices and will deliver spiritual care with a moderate degree of confidence and comfort. In parts these findings corroborate those of Cimino's (1992), who reported that nurses who had a high level of spiritual well-being also had a positive attitude towards providing spiritual care ($p = .005$), and a high degree of comfort in providing spiritual care.

Spiritual Care Perspectives

For the independent variable of spiritual care perspectives, the analyses provided evidence of: (a) strong positive correlations between spiritual care perspectives and provision of spiritual care, confidence in providing spiritual care, and comfort in providing spiritual care; and (b) a moderate to strong positive correlation was found between spiritual care perspectives and commitment to personal spiritual practices. These findings give credence to Neuman's

theoretical perspective that as one's spiritual domain is nourished and developed, power will be generated to help others to the extent that its own positive energy source is maintained (Neuman, 1995).

Provision of Spiritual Care Correlations between the dependent variable (provision of spiritual care) and three demographic factors, namely,—commitment to personal spiritual practices, confidence in providing spiritual care, and comfort in providing spiritual care—showed statistically significant moderate to strong positive relationships. These findings indicate that the nurses in this sample who were committed to their personal spiritual practices were also confident and comfortable in providing spiritual care to their acutely ill patients.

Findings from the first and second hierarchical multiple regression models showed demographic factors and spiritual care perspectives predictors with significant predictive power on the dependent variable. However, upon entering the spiritual well-being variable into the third regression model, none of the predictor variables demonstrated significant predictive power on the dependent variable. Such results were justified cause for concerns regarding multicollinearity issues. Upon resolving those issues, a simple linear regression showed that spiritual care perspective was the best predictor of provision of spiritual care, accounting for 40% of the variance in the dependent variable. This finding underscores the notion that nurses who have a positive outlook on spiritual care are most likely to provide spiritual care to their acutely ill patients. Additional series of regression analyses revealed that in this sample of nurses, the predictor—spiritual care perspective—was a strong mediator between the nurses' spiritual well-being, commitment to personal spiritual practices, confident-comfort in providing spiritual care, and their actual provision of spiritual care.

Implications for Further Research

Further studies examining the relationships between acute care nurses' spiritual care perspectives and their provision of spiritual care are indicated, especially in light of the fact that there were opposite results in the sample of acute care nurses in Ronaldson et al.'s (2012) study compared to their counterparts in the present study. Implications for further study also exist with regards to whether or not factors such as the acute care nurse's age, practice specialty, number of years in practice, and level of nursing education are significantly related to their spiritual well-being, spiritual care perspectives or provision of spiritual care, because there are inconsistencies in the literature which were also reflected in the findings of this study. Findings from this study were in agreement with some of the earlier studies and in disagreement with others.

This study's results are in agreement with previous studies regarding a modest positive correlation between the nurses' spiritual care perspectives (attitudes, values, and beliefs) and their spiritual care practices. However, there is a trend toward an overall low performance in providing spiritual care despite the nurses' high scores for spiritual care perspectives. This study has shown that the spiritual care perspective of acute care nurses is a significant mediator between various predictor variables and the dependent variable provision of spiritual care. Nevertheless further investigation is needed to determine why there is such a deficit in the general practice of spiritual care interventions even among populations of nurses who possess this core essential, evidenced by overall high scores and positivity in spiritual care perspectives (attitudes, values, and beliefs). Studies exploring nurses' spiritual care perspectives in relation to their spiritual care practices and caring behavior (Chism & Magnan, 2009; Vance, 2001), their sense of spiritual well-being (Musgrave & McFarlane 2004), as well as barriers to spiritual care practices (Gallison et al., 2014; Robertson et al., 2012; Vance, 2001) have been done, yet none

were found aimed at investigating the linkage between the nurses highly positive attitude towards spiritual care and relatively low provision of spiritual care.

Implications for Nursing Education

Implications for nursing academia to take decisive steps to ensure that nursing students at all levels of their educational trajectory are educated on how to clarify and develop positive spiritual care perspectives (attitudes, values, and beliefs) are supported by evidence from this study, which indicates that the nurse's spiritual care perspective (attitudes, values, beliefs) is not only the best predictor of provision of spiritual care, but is also a pivotal mediator between various predictor variables and spiritual care practices. Findings from the current study corroborate that of other studies showing an overall deficit in the nurses' actual provision of spiritual care. Such findings are disconcerting, especially because there is consensus in the nursing literature that spiritual care is an integral aspect of holistic nursing care (Baldacchino, 2010; Neuman, 2002; Pesut, 2009; Ross, 1994). The results from this study have added support to the literature that in general, nurses are ill-prepared, lack confidence and are uncomfortable in providing spiritual care to patient in the acute care setting. In order to convey the importance of providing spiritual care with confidence and comfort, it might be necessary for colleges of nursing to include core courses on spiritual care in the undergraduate curriculum, and to offer elective courses in spiritual care at the graduate and post graduate levels. Considering that the American Association of Colleges of Nursing (AACN) has included spiritual care education as a basic requirement in undergraduate nursing education as outlined in the most recent Baccalaureate Essentials (2008), it may not be enough to merely thread elements of spiritual care throughout courses in the undergraduate program. Moreover, there are several nursing philosophical frameworks that lend theoretical support to educational courses in spiritual care

(Henderson, 1961; Neuman, 1995; Travelbee, 1971; Watson, 2006). There are also well developed courses on the topic of spiritual care in nursing (Baldacchino, 2008; Taylor, Mamier, Bahjri, Anton, & Petersen, 2009; van Leeuwen, et al., 2009; Wallace et al., 2008) as well as in the discipline of medicine (Anadarajah, & Hight, 2001; Graves, Shue, & Arnold, 2002) which may be tailored to suit the curriculum for various nursing programs. Implications for the inclusion of spiritual care courses in nursing curricula based on this study's findings may well serve to better meet the AACN requirements for spiritual care education, while preparing nurses at all levels to provide spiritual care with comparable effectiveness, confidence and comfort to which care is provided in the physical, psychological, developmental, and sociocultural domains.

It was not surprising that such a high percentage (92.3%) of acute care nurses participating in this study felt underprepared by their nursing education program to provide spiritual care to their patients. However, it was heartening to note that despite being educationally underprepared in this area, 39% of the sample felt confident in providing spiritual care, and 42.5% indicated feeling either comfortable or somewhat comfortable with providing spiritual care. From such results it was evident that some acute care nurses were either finding alternative means of educating themselves to provide spiritual care to their patients or that some semblance of spiritual care education is being provided to the nurses in the clinical environment.

While the nurses' source of spiritual education is still unclear, the findings of this study were in agreement with earlier studies showing that nursing academia is not effectively preparing nurses to provide spiritual care to their patients in the acute care setting (Barry, 2010; Chism & Magnan, 2009; Lind et al., 2011; O'Shea et al., 2011; Wallace et al., 2008; van Leeuwen et al., 2008). Based on the findings of their study on nursing students' spiritual well-being, spirituality and spiritual care, Abassi et al. (2014) concluded that including spiritual care courses in the

curricula of nursing students will add to the students' understanding, and better enable their provision of spiritual care.

Implications for Clinical Practice

Findings from this study have provided validating evidence for conclusions of related studies confirming that there is a shortfall in the spiritual care practices of nurses employed in the acute care setting (Gallison et al., 2013; Ronaldson et al., 2014; Vance, 2001). This emerging knowledge about nurses' spiritual care practices in acute care environments should not be ignored, especially because providing holistic nursing care is an ethical responsibility (Pesut, 2009). An individual's lifestyle, value system and religious beliefs should be considered in planning health care with and for each patient admitted to a Healthcare Organization (HCO).

Addressing the deficit in provision of spiritual care in the practice of acute care nurses is essential for the following reasons: (a) researchers such as Barnes, Plotnikoff, Fox, and Pendleton, (2000) have pointed out that provision of spiritual care should never be restricted to solely patients who are in end-of-life situations; (b) surveys have shown that a high percentage of patients would like to have their spiritual values integrated into their health plan of care (Tovino, 2005); (c) systematic reviews of empirical and theoretic studies have shown that patients whose spiritual needs are addressed do have better healthcare outcomes than those whose spiritual needs are neglected (Burkhart et al., 2011; Levin, 2001; McSherry & Jamieson, 2011); (d) The Joint Commission has mandated that a careful assessment of the patients' spiritual need should be done upon their admission to healthcare facilities; (e) the ANA (2001) code of ethics dictates that the measure of care given by nurses must enable the patient's spiritual well-being. The ANA (2015) code of ethics emphasizes that a person's value system and religious beliefs should be

taken into consideration when planning care for each patient; and (f) the ICN insists that nurses should “promote an environment in which...spiritual beliefs of individuals are respected” (ICN, 2006).

Descriptive findings from this study indicated that the nurses received their professional RN license on average of 15.08 years ago. This suggests that most nurses who participated in this study graduated prior to the AACN (2008) directives for the inclusion of spiritual care in undergraduate nursing curricular, and so may not have had formal education in providing spiritual care during their years of basic nursing education. It was evident that some nurses were uncertain about their role in providing direct one-to-one spiritual care to their acutely ill patients.

Implications for clinical practice based on these findings may require thoughtful actions from clinical nurse educators in acute care settings to provide in-service spiritual care training to registered nurses employed to deliver direct patient care. In order to maintain at least a satisfactory level of spiritual care performance among these nurses, and to help nurses clarify their role, perspective, and practice in providing spiritual care, the Department of Nursing Education (in each HCO) may need to consider including spiritual care training in the orientation program for newly hired nurses. Additionally, annual updates on best practices in providing spiritual care to the hospitalized patient could be included in the annual competencies for nurses. Tantamount to administrative requirements for nurses to attend educational endeavors geared towards upgrading their nursing knowledge regarding care in the physiological domain, it might also be helpful for these requirements to be extended to care in the spiritual domain.

Implications for Policy Making

The fact that leading stakeholders of nursing education and healthcare practices (such as the AACN, and The Joint Commission) have already stipulated expectations regarding provision

of spiritual care, is an indication that the foundational cornerstones have been laid for building policies and guidelines regarding spiritual care in nursing academia and clinical practice.

Therefore, formulating and implementing college-wide policies as well as policies at the state and national levels to incorporate core courses in provision of spiritual care into the undergraduate nursing curricula would be appropriate steps in bringing nursing program contents in alignment with the requirements of the AACN Baccalaureate Essentials. Similarly, the State Department of Health overseeing various healthcare organizations (HCOs) could ensure that each HCO in its domain has policies in place to ensure provision of spiritual care to the hospitalized patient.

Such recommendations are warranted when one considers the findings of this study in which only 7.7% of the sample population felt adequately prepared by their nursing education to provide spiritual care to their acutely ill patients. Additionally, the majority of respondents provided spiritual care below the *ideal mean* score of 32, indicating that most nurses in this sample were not involved in providing spiritual care “*often*” or even “*occasionally*.”

Overall Summary/Conclusion

This descriptive correlational study aimed to explore the relationships between and among acute care nurses’ spiritual well-being, spiritual care perspectives and their provision of spiritual care. The study was motivated by documented evidence in the literature regarding the lack of spiritual care provision among nurses. Additionally, gaps in the current literature disclosed a scarcity of empirical studies on the topic of spiritual well-being, spiritual care perspectives (attitudes, beliefs, values), and spiritual care practices among acute care nurses. The spiritual domain of the Neuman System Model provided a suitable framework for this study.

Bivariate analyses of the study data revealed moderate to strong positive correlations between and among the participants' spiritual well-being, spiritual care perspectives, commitment to personal spiritual practices, confidence and comfort in providing spiritual care, and their provision of spiritual care to patients in the acute care setting. Given these significant correlations a series of regression analyses was employed to determine the best predictor for the nurses' provision of spiritual care. Findings from the regression analyses demonstrated that the participants' spiritual care perspectives (attitudes, beliefs and values), in addition to being the best predictor for spiritual care practices, also had a significant mediating effect on the nurses' spiritual well-being, commitment to personal spiritual practices, confidence and comfort in providing spiritual, and their actual provision of spiritual care. It is noteworthy that the nurses scored well-above average in their sense of spiritual well-being and spiritual care perspectives, but below the *ideal mean* for provision of spiritual care. This finding signifies the need for further research regarding other foundational elements which may be hindering the provision of spiritual care, even among nurses who possess a sense of high spiritual well-being and a positive attitude towards spiritual care (both of which are strong determinants to provision of spiritual care).

For this sample of nurses, there were no correlations between and among the select demographic variables of the nurses' age, practice specialty, years of nursing practice, educational level, and the primary research variables. These findings are consistent with earlier studies done among nursing students and acute care nurses (Chisim & Magnan, 2009; Vance, 2001), but contradicted findings of studies done among NPs and palliative care nurses (Ronaldson et al., 2012; Stranahan, 2001). These inconsistencies are indications that additional

research is needed to clarify relationships between certain demographic factors and provision of spiritual care among nurses in general as well as in acute care nurses in particular.

Findings from this study have added fresh evidence to the body of nursing knowledge regarding the mediating effects of acute care nurses' spiritual care perspectives on aforementioned predictors and their provision of spiritual care. Unexpected results concerning the positive relationships that exist between and among the predictor variables (i.e. commitment to personal spiritual practices, confidence in providing spiritual care, and comfort in providing spiritual care) and the spiritual care practices of acute care nurses could be valuable in the education and practice of nurses.

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Appendix A

TABLE 1-1. THE SPIRITUAL VARIABLE

Spiritual variable considerations are necessary for a truly wholistic perspective and a truly caring concern for the client/client system. An analogy of the "seed" can be used to further qualify and clarify the statement that the spirit controls the mind and the mind controls the body as it relates to the Neuman Systems Model spiritual variable.

It is assumed that each person is born with a spiritual energy force, or "seed," within the spiritual variable, as identified in the basic structure of the client system. The seed or human spirit with its enormous energy potential lies on a continuum of dormant, unacceptable, or undeveloped to recognition, development, and positive system influence. Traditionally, a seed must have environmental catalysts, such as timing, warmth, moisture, and nutrients, to burst forth with the energy that transforms it into a living form that then, in turn, as it becomes further nourished and developed, offers itself as sustenance, generating power as long as its own source of nurture exists.

The human spirit combines with the power of the Holy Spirit as a gift from God when the innate human force, or "seed," becomes catalyzed by some life event such as humility, joy, or crisis; this energy begins to magnify and becomes recognizable within the thought patterns as something whose truths must become known and tested in life situations. Ideally in the testing, mental and physical expressions such as understanding, compassion, and love become manifested.

As thought patterns are positively affected, the body becomes increasingly nourished and sustained through positive use of spiritual energy empowerment. For example, it has been proven that a joyous thought enhances the immune system; the opposite also is true, with a negative outcome for the body.

Thus, it is assumed that spiritual development in varying degrees empowers the client system toward well-being by positively directing spiritual energy for use first by the mind and then by the body.

The beginning of spiritual awareness and development can take place at any stage of the life cycle. The supply of spiritual energy, when understood and positively used by the client system, is inexhaustible except for the death of the living system as we know it. The human spirit returns to the God source to live on into eternity when death occurs and it is no longer needed to empower the living mind, soul, and body.

The spiritual variable positively or negatively affects or is affected by the condition and interactive effect of the other client system variables, such as grief or loss (psychological states), which may arrest, decrease, initiate, or increase spirituality. The potential exists for movement in either direction on a continuum.

Through careful assessment of client needs in the spiritual area, followed by purposeful intervention, such as fostering hope that affects the will to live, the relation between the spiritual variable and wellness may be better understood and utilized as an energy source in achieving client change and optimal system stability.

Appendix B

80

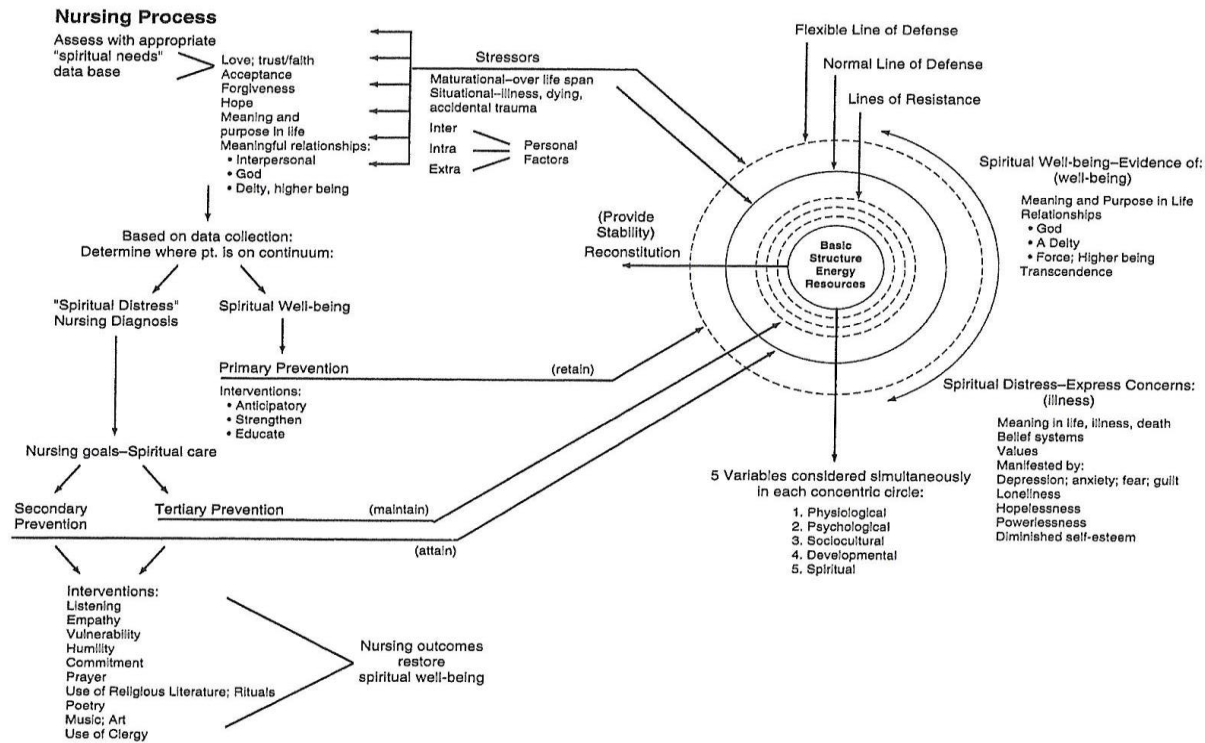


Figure 3-1 Adaptation of selected components of Neuman Systems Model for Spirituality—based on literature review. © 1994 Ruth Ann B. Fulton, RN, DNSc.

*Appendix C***Introductory Message for AMSN Media to Members of the Academy**

Dear Academy of Medical Surgical Nursing Member:

This is an invitation to participate in a research study on Spiritual Care in Acute Care Settings. The study will be conducted by Barbara Kitchener, RN, MA, who is a PhD candidate in the College of Nursing at Seton Hall University in New Jersey. You are invited to share your views about Spiritual Care in the Acute Hospital Setting.

Your participation in this study will be greatly valued especially because the information provided will enable a better understanding of the how the nurse's spiritual well-being and attitude towards spiritual care influence the spiritual care that nurses provide for their patients.

The purpose of the study is to explore the relationships between nurses' spiritual well-being (SW), spiritual care perspectives (SCP) and their provision of spiritual care to adult patients in the acute care setting. A review of the nursing literature indicates that research studies on the topic of spiritual care have largely been conducted among nurses who are employed in hospice, palliative, oncology and long term care. With very few studies on spiritual care of nurses employed in acute care settings, a study of this nature is most timely because there is a need to understand factors which influence the provision of spiritual care among acute care nurses.

All participants in this study are asked to complete a brief demographic questionnaire and 3 short survey instruments. A total of 25-30 minutes should be allotted to complete all 3 research instruments and the demographic questionnaire. To gain access to a letter of solicitation, and the study surveys please click on this link: [\[REDACTED\]](#)

Appendix D

Letter of Solicitation Inviting Nurses to Participate in the Study

Dear Fellow Registered Nurses:

This is an invitation to participate in a research study on Spiritual Care in Acute Care Settings.

1. **Researcher's affiliation:** The research study will be conducted by Barbara Kitchener, RN, MA, who is a PhD candidate in the College of Nursing at Seton Hall University in New Jersey. As a fellow nurse I am inviting you to share your views about Spiritual Care in the Acute Hospital Setting.
Your participation in this study will be greatly valued especially because the information provided will enable a better understanding of the how nurses' spiritual well-being and attitude towards spiritual care influence the spiritual care that nurses provide for their patients who are acutely ill.
2. **Purpose:** The purpose of the study is to explore the relationships between and among registered nurses' spiritual well-being and spiritual care perspectives and their provision of spiritual care in the acute care setting. A review of the nursing literature indicates that research studies on the topic of spiritual care have largely been conducted among nurses who are employed in hospice, palliative, oncology and long term care. With very few studies on spiritual care of nurses employed in acute care settings, a study of this nature is most timely because there is a need to understand factors which influence the provision of spiritual care among acute care nurses.
3. **Procedure:** All participants in this study are asked to complete a brief demographic questionnaire and three short survey instruments which are accessible via a link in Survey Monkey which is a secure survey website.
Duration: A total of 25-30 minutes should be allotted to complete all 3 research instruments and the demographic questionnaire.
4. **Instruments:** (a) The Spiritual Well-Being Scale (Paloutzian & Ellison 1982), is a 20 item Likert-scaled instrument designed to measure a person's perceived spiritual quality of life from a religious and non-religious view point. Example of question is: *I feel a sense of well-being about the direction my life is headed in.*
(b) The Spiritual Care Perspective Scale-Revised (E. J. Taylor, personal communication, and unpublished document obtained via e-mail on October 15, 2014) is a 10 item Likert scale measuring nurses' attitudes related to the importance of including spiritual care in their practice. One such item states: *Spiritual care is a significant part of nursing practice* and (c) the Spiritual Care Practice Questionnaire Part I (Vance 2001), has one open ended item and 10 Likert-type items all measuring the frequency with which nurses perform spiritual assessment and provide spiritual intervention to their patients. One item states: *I plan my patients' care giving consideration to those spiritual and/or religious practices that impact their medical treatment.*

5. **Voluntary nature:** Participation in this study is completely voluntary.
 6. **Anonymity:** All responses to the surveys will be anonymous; this will be ensured by a set feature on the Survey Monkey website.
 7. **Confidentiality:** Your participation in this research study is voluntary and confidential. Completing and submitting the on-line surveys pertaining to the study is an indication of your voluntary consent to participate. Survey Monkey is a secure survey site, designated to ensure confidentiality and anonymity of all respondents. To further safeguard confidentiality all data will be stored only on a UBS memory key and stored in a locked drawer in the researcher's office. Data will be available only to the researcher.
 8. **Risks or discomforts:** There are no anticipated risks involved in your completion and submission of the survey instruments. If you start the survey and then decide not to complete it, you may log out of Survey Monkey; no data will be submitted or saved. However if you are unable to complete the surveys in one sitting and wish to re-enter the survey site to complete unfinished surveys you will be prompted by a set feature in Survey Monkey "save and continue later".
 9. **For Questions or Concerns:** If you have questions or concerns regarding any aspect of this study, you can contact:
 - Barbara Kitchener at [REDACTED] or phone [REDACTED]
 - Dr. Jane Dellert (Dissertation Chairperson) at [REDACTED] phone: [REDACTED]
 - For questions about your rights as a research participant, you can contact Dr. Mary Ruzika (Director, Seton Hall University IRB) at [REDACTED] or by phone: [REDACTED]
 10. **Benefits:** There are no direct benefits that participants can expect to receive. However the potential benefits that can be expected from your input being incorporated into the body of nursing knowledge might be most rewarding. Additionally, upon completion of the study the researcher has agreed to share the study findings at an educational event facilitated by the Academy of Medical Surgical Nurses.
 11. **Remuneration:** There is no payment available for your assistance.
- Many Thanks for taking time to participate in this study. Your in-put is greatly appreciated and highly valued.

Sincerely,

Barbara Kitchener, MA, RN

[REDACTED]

Appendix E

Spiritual Well-Being Scale

For each of the following statements circle the choice that best indicates the extent of your agreement or disagreement as it describes your personal experience:

SA = Strongly Agree MA = Moderately Agree A = Agree	D = Disagree MD = Moderately Disagree SD = Strongly Disagree
---	--

- | | | | | | | |
|--|----|----|---|---|----|----|
| 1. I don't find much satisfaction in private prayer with God. | SA | MA | A | D | MD | SD |
| 2. I don't know who I am, where I came from, or where I'm going. | SA | MA | A | D | MD | SD |
| 3. I believe that God loves me and cares about me. | SA | MA | A | D | MD | SD |
| 4. I feel that life is a positive experience. | SA | MA | A | D | MD | SD |
| 5. I believe that God is impersonal and not interested in my daily situations. | SA | MA | A | D | MD | SD |
| 6. I feel unsettled about my future. | SA | MA | A | D | MD | SD |
| 7. I have a personally meaningful relationship with God. | SA | MA | A | D | MD | SD |
| 8. I feel very fulfilled and satisfied with life. | SA | MA | A | D | MD | SD |
| 9. I don't get much personal strength and support from my God | SA | MA | A | D | MD | SD |
| 10. I feel a sense of well-being about the direction my life is headed in. | SA | MA | A | D | MD | SD |
| 11. I believe that God is concerned about my problems. | SA | MA | A | D | MD | SD |
| 12. I don't enjoy much about life. | SA | MA | A | D | MD | SD |
| 13. I don't have a personally satisfying relationship with God. | SA | MA | A | D | MD | SD |
| 14. I feel good about my future. | SA | MA | A | D | MD | SD |
| 15. My relationship with God helps me not to feel lonely. | SA | MA | A | D | MD | SD |
| 16. I feel that life is full of conflict and unhappiness. | SA | MA | A | D | MD | SD |
| 17. I feel most fulfilled when I'm in close communion with God. | SA | MA | A | D | MD | SD |
| 18. Life doesn't have much meaning. | SA | MA | A | D | MD | SD |

19. My relation with God contributes to my sense of well-being.

SA MA A D MD SD

20. I believe there is some real purpose for my life.

SA MA A D MD SD

(Paloutzian & Ellison 1985)

Appendix F

Spiritual Care Perspectives Scale –Revised

Please circle the number that best reflects your perspective.

1. Spiritual care is a significant part of nursing practice:
strongly agree 1 2 3 4 5 **strongly disagree**

2. In general, patients have much spiritual need:
strongly agree 1 2 3 4 5 **strongly disagree**

3. The domain of nursing practice should include spiritual care:
strongly agree 1 2 3 4 5 **strongly disagree**

4. Spiritual care is only for religious persons:
strongly agree 1 2 3 4 5 **strongly disagree**

5. A patient's spiritual concerns are none of my business:
strongly agree 1 2 3 4 5 **strongly disagree**

6. Only clergy and chaplains should help patients with specifically religious activities:
strongly agree 1 2 3 4 5 **strongly disagree**

7. I should assist patients in using their religious or spiritual resources to cope with illness
strongly agree 1 2 3 4 5 **strongly disagree**

8. I provide spiritual care every day at work:
rarely or never 1 2 3 4 5 **every day at work**

9. My ability to provide spiritual care is:
weak, limited 1 2 3 4 5 **strong comprehensive**

10. While providing spiritual care, I feel:
very uncomfortable 1 2 3 4 5 **very comfortable**

(E. J. Taylor, unpublished document obtained via e-mail on 2014)

Appendix G

Spiritual Care Practice Questionnaire

Part I: Spiritual Assessment/Intervention

Instructions: Please circle the number next to the reference that most accurately describes your practice.

1. I observe for verbal and visual clues signifying my patients' spiritual and/or religious orientation (Examples: talks about God or god being, acknowledges a source of inner strength, spiritual and/or religious reading materials, symbols or articles in room).

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

2. I inquire about spiritual and/or religious practices that might have an impact on my patients' medical care (Examples: special dietary regimes, refusal of blood products, use of alternative health care practices).

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

3. I observe and/or inquire about past and present use of spiritual and/or religious practices and adaptive techniques (Examples: prayer, meditation, worship, receiving of sacraments, contact with clergy or chaplain, scriptural reading, music, guided imagery, contact with nature).

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

4. I assess for signs of spiritual distress (Examples: ambivalence about beliefs and values system, loss of purpose and meaning in life, loss of elements that animate and empower, detachment from God or god being).

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

Appendix G (continues)

5. I use therapeutic communication to assist my patients with reflecting upon their belief and value systems, purpose and meaning in life, and with exploring those elements which empower and strengthen them.

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

6. I provide or make arrangements for my patients to be able to participate in their spiritual and/or religious practices and adaptive techniques (Examples: contacting clergy or chaplain, providing environment conducive to meditation or prayer).

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

7. I document those spiritual and/or religious practices that may have an impact on my patients' medical treatment.

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

8. I plan my patients' care giving consideration to those spiritual and/or religious practices that impact their medical treatment.

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

9. I personally participate in spiritual and/or religious practices that enhance my patients' spirituality (Examples: praying with or for patient, reading to patient, providing guided imagery or visualization techniques).

1	2	3	4	5
very seldom	seldom	occasionally	often	very often

10. Please list any other nursing interventions you provide for the spiritual care of your patients?

(Vance 2001)

*Appendix H***Permission to Use the Spiritual Well-being Scale**

Ray Paloutzian <[REDACTED]>
 Sun 4/19/2015 4:39 PM
 Inbox
 To: Barbara Kitchener;

Hello Barbara,
 Thank you. It is nice to know all of that info is of some help.
 Ray

Barbara Kitchener
 Sun 4/19/2015 4:18 PM
 Sent Items

Good Afternoon Dr Paloutzian:
 Many Thanks for the wealth of information you have provided; it is truly appreciated. I have noted your stipulations for administering the survey electronically and will ensure that all stipulated guidelines are followed. I have already purchased a copy of the Specimen Set and will be in touch when I am in the data collection phase of my study. Thanks again for your help and detailed explanation.
 Barbara Kitchener

Ray Paloutzian <[REDACTED]>
 Mon 4/13/2015 3:56 PM
 Inbox

Barbara,
 I get many requests re the SWBS, so I wrote a long email that answers every question that anyone could ask. I copy and paste it below. It has more information than you asked, but some of it might be useful, so it is better than you have it all so that you can make the best decisions for for what you need. Here it is.

Permission is granted to use the SWBS subject to purchase of the number of copies (i.e., authorization to make the number of copies from a PDF file that you download) that you will use. See the website www.lifeadvance.com. It has information about the scale and the instructions to follow to obtain the Specimen Set that includes one examination copy of the scale, the manual for the SWBS that includes scoring instructions and interpretive information, and a research bibliography that is about 20 pages long. (For student research, a student is authorized to use the student discount procedure, which will give a 50% discount on all items.) When you go to the products page of the website, select the icon that indicates the number of copies of the scale that you are purchasing authorization to make from the PDF download that you retrieve

after processing your order. You will see on the Products Page that the cost per copy goes down as the N goes up, in steps of 50. After you select the icon that corresponds to your number of copies, you will go to the shopping cart page. Change the number to the correct number for your purchase and then punch the "update shopping cart button." Then follow the procedures, collect the PDF file download as indicated on the web page (or on the email that is also sent to you), and you are thereby authorized to make and use the number of copies that you purchased authorization to make.

See the chapter published in 2012 by Paloutzian et al., in the Oxford Textbook of Spirituality in Healthcare, edited by Cobb et al. This chapter is the latest statement on the topic. Also, its bibliography is good and it updates the research bibliography available on the website that comes with the specimen set. I have attached this chapter to this email.

Data Analysis: If you plan on doing statistical analysis on scale scores: One thing that I always recommend is to analyze your data not only according to the SWBS total scores, but also according to the RWB and EWB subscale scores separately, in addition to the total SWBS scores. Of course total SWBS is made up of RWB + EWB. Fine. But RWB and EWB correlate only modestly, which is why they are two separate factors. And sometimes the RWB and EWB scores behave differently from each other, and not exactly the same as the behavior of the SWBS total. This means that looking at those two subscales can tell you something psychologically interesting that the SWBS total score cannot do by itself, i.e., it allows you to dig deeper. So I strongly recommend that you look at your data and do the same analyses all three ways. See the review paper by Bufford, Paloutzian, and Ellison 1991 as a nice example of how the scores can be meaningfully broken down in this way.

Translations: If you need to make a translation of the SWBS from English into another language, contact me and I am able to authorize it. I have translations into Chinese, Arabic, Spanish, Portuguese, Norwegian, Malaysian, English Childhood Retrospective, Korean, Cebuano, and Tagalog.

Electronic administration: It is OK to use the SWBS electronically with, e.g., Survey Monkey or similar. In this case, 1 electronic administration of the scale equals 1 paper copy of the scale, so (for example) if you have an electronic N = 100, the cost is exactly the same as for 100 paper copies. The website has to be protected so that only your authorized subjects have access to it, the scale cannot be copied or emailed or otherwise distributed, the copyright line should show electronically, and the scale should be removed from the website at the close of data collection.

OK, that is the end of the standard information. In addition, you may find it helpful to see the 2nd edition of Paloutzian and Park Handbook of the Psychology of Religion and Spirituality, 2nd ed., 2013, Guilford publishers. It as a chapter on religion and spirituality, measurement of R and S, and other topics that may be related to your needs. (Also, it just came out in paperback for only about \$40 USD.)

I hope this helps.

Thank you,

Ray Paloutzian (Ray)

*Appendix I***Permission to use Spiritual Care Perspective Scale-Revised**

Elizabeth Johnston Taylor [REDACTED]
 Wed 10/15/2014 8:37 PM
 Inbox

Hi Barbara,

Lovely to meet you here. I'm always gratified to learn of others who share my research interest in nurse-provided spiritual care. And I am most interested in your study!

I am always happy to share my tools. I only ask that any user make the appropriate promises-- that is, identify the tool and its author when making presentations of the data, provide me with an abstract when the study is done, and if requested, share the raw data collected with my tool via an electronic database so that further psychometric work can be done on the tool. If that later is requested, I would include you as an author on any publication resulting from this additional psychometric work.

Yes, I will attach the Nurse Spiritual Care Perspective Scale-Revised, which is what you are interested in. On my to do list for years has been writing it up, and I've just always been preoccupied with getting other things done. There is some reflection on this tool in a more recent critique publication that would be important for you to read. (See: Taylor, E. J. (2011). Commentary on Chan, M. F. (2010) Factors affecting nursing staff in practicing spiritual care. *Journal of Clinical Nursing*, 19, 2128-2136.) I never would have guessed how many grad students and others have requested this tool. I think it filled a void that still exists, even though it was hastily constructed.

Barbara Kitchener
 Wed 10/15/2014 9:59 AM
 Sent Items
 To: [REDACTED];
 Cc: [REDACTED]

Good Morning Dr. Johnston-Taylor,
 I am a PhD candidate at Seton Hall University. My dissertation topic is related to spiritual care perspectives and provision of spiritual care among RNs in the acute care settings.

I am seeking your permission to use the Nurse Spiritual Care Perspective Scale Part II to measure the attitudes and perspectives of RNs in the acute care setting. The need to use the instrument in its entirety (Parts I & II) is not indicated at this time. While my study also proposes

to measure provision of spiritual care, the use of Part I of the SCPS might create an overlap with the tool that I am hoping to use to measure "provision of spiritual care."

Also considering that I am planning to survey RNs in the acute care settings, I am also seeking your authorization to modify the instrument to reflect the population that will be participating in this study.

I was introduced to the SCPS while reading Dr. Susan Stranahan's (2001) research article, and felt Part II of this instrument would be most ideal in capturing the data I am seeking to measure.

Thanks in Advance for your consideration of my request. Looking forward to hearing from you.

Sincerely

Barbara J. Kitchener, RN

PhD Candidate SHU

██████████
██████████
██████████

Appendix J

Permission to use Spiritual Care Practice Questionnaire Part I

Barbara Kitchener

Fri 3/13/2015 4:41 PM

Sent Items

To: Diana Vance [REDACTED];

Hello Diana:

I have received the attachments. Thanks a million for your permission to use the Spiritual Care Practice Questionnaire. I will let you know the outcome. Barbara K

Diana Vance <[REDACTED]>

Fri 3/13/2015 4:39 PM

Good luck with your study!

Diana Vance MSN, RN, CCRN, CCNS

Acute & Critical Care Cardiology

NEOCS

[REDACTED]
[REDACTED]
[REDACTED]

13. On an average how many hours of direct patient care do you provide per week? _____ hours

14. Geographic region in which you practice nursing: (Check one)

- Urban Suburban Rural

15. Indicate your income level in dollar amount: \$ _____

16. What is the nurse-to-patient ratio for the nursing unit on which you are currently employed? (Check one) <2 patients to 1 RN 2-4 patients to 1 RN 5-7 patients to 1 RN
 8-10 patients to 1 RN >10 patients: 1 RN

17. Which of the following best describes the nursing unit on which you are currently employed? (Check one) General Medical- Surgical Emergency Care
 Critical Care Telemetry Respiratory Other _____

18. To what extent did your nursing education prepare you to provide spiritual care to your patients? (Check one)

- Fully prepared Somewhat Prepared Not at all Prepared

19. Do you feel confident about providing spiritual care to patients who are acutely ill? (Check one)

- Yes No Sometimes

20. Do you feel comfortable with providing spiritual care to patients who are acutely ill? (Check one)

- Yes No Sometimes

*Appendix L***Preliminary Questions to Ensure Participants Meet Inclusion Criteria**

Please indicate your response by checking “YES” or “NO”

1. Are you currently employed to provide direct patient care to children, new-born babies and/or maternity patients in the acute care setting? YES NO

2. Do you provide care exclusively to patients in hospice, palliative or long term care units?
 YES NO

3. Are you currently employed as a Nurse Manager, Nursing Supervisor, Patient Care Director, Administrator, Director of Nursing, or Nurse Educator? YES NO

*Appendix M***Message of Assurance from Academy of Medical Surgical Nurses**

Conducting a Nursing Research

Kristen Hensley [REDACTED]

Mon 4/27/2015 3:01 PM

To: Barbara Kitchener;

Action Items

Hello Barbara,

I hope the following information finds you well.

I reached out to Bob Massey, Coordinator of the AMSN Research Team and he suggests that you submit your research study request to AMSN without the IRB Approval for him to review.

If approved, then you can submit to your IRB and we will provide you with a letter or email stating we are recommending the use of the membership list for your survey.

If you have any additional questions, or need anything further, please let me know.

Thank you!

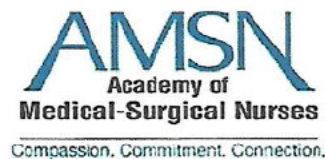
Kristen Hensley

Association Services Manager

Academy of Medical-Surgical Nurses (AMSN)

[REDACTED] Anthony J. Jannetti, Inc. which is
accredited by the Association Management Company Institute.

Please consider the environment before printing this e-mail.

Appendix N

Monday, August 31, 2015

[REDACTED] -
Barbara J. Kitchener, MA, BSN, RN
[REDACTED]

Re: Relationships Between and Among RNs' Spiritual Well-Being and Spiritual Care Perspectives and their Provision of Spiritual Care

Dear Barbara,

This letter is to inform you that your request to survey the members of the Academy of Medical Surgical Nurses (AMSUN) has been reviewed and approved by the Research Committee Chair.

Please note, AMSUN does not release our member email addresses. We will handle the distribution of your survey.

If you have any questions or concerns, please feel free to contact me.

Sincerely,

[REDACTED]
Kristen Hensley
Manager, Association Services
Academy of Medical Surgical Nurses (AMSUN)


Academy of Medical-Surgical Nurses (AMSUN)

East Holly Avenue Box 56 | Pitman, NJ 08071-0056 | (866) 877-2676 | amsn@ajj.com | amsn.org

*Appendix O***PEARSON**Permissions


May 18, 2015

PE Ref # 190378

Barbara Kitchener
SETON HALL UNIVERSITY


Dear Barbara Kitchener,

You have our permission to include content from our text, *THE NEUMAN SYSTEMS MODEL, 4th Ed. and 3rd Ed. by NEUMAN, BETTY; FAWCETT, JACQUELINE*, in your dissertation at SETON HALL UNIVERSITY.

Content to be included is:

Table 1.1 The Spiritual Variable, p; 16; Fig. 3.1, p. 80

Please credit our material as follows:

NEUMAN, BETTY; FAWCETT, JACQUELINE, THE NEUMAN SYSTEMS MODEL, 4th, ©2002, p. 16. Reprinted by permission of Pearson Education, Inc., New York, New York. NEUMAN, BETTY; FAWCETT, JACQUELINE, THE NEUMAN SYSTEMS MODEL, 3rd, (c)1995, p. 80. Reprinted by permission of Pearson Education, Inc., New York, New York.

Sincerely,

Vineta Lewis, Permissions Supervisor

Appendix P



September 30, 2015

Barbara J. Kitchener
[REDACTED]

Dear Ms. Kitchener,

The Seton Hall University Institutional Review Board has reviewed your research proposal entitled "Exploring the Relationships Between and Among Registered Nurses' Spiritual Well-Being and Spiritual Care Perspectives and their Provision of Spiritual Care in the Acute Care Setting" and has categorized it as exempt.

Enclosed for your records is the signed Request for Approval form.

Please note that, where applicable, subjects must sign and must be given a copy of the Seton Hall University current stamped Letter of Solicitation or Consent Form before the subjects' participation. All data, as well as the investigator's copies of the signed Consent Forms, must be retained by the principal investigator for a period of at least three years following the termination of the project.

Should you wish to make changes to the IRB approved procedures, the following materials must be submitted for IRB review and be approved by the IRB prior to being instituted:

- Description of proposed revisions;
- *If applicable*, any new or revised materials, such as recruitment fliers, letters to subjects, or consent documents; and
- *If applicable*, updated letters of approval from cooperating institutions and IRBs.

At the present time, there is no need for further action on your part with the IRB.

In harmony with federal regulations, none of the investigators or research staff involved in the study took part in the final decision.

Sincerely,

[REDACTED]
Mary F. Ruzicka, Ph.D. ✓
Professor
Director, Institutional Review Board

Appendix P (Contd)

cc: Dr. Jane Dellert

Please review Seton Hall University IRB's Policies and Procedures on website (<http://www.provost.shu.edu/IRB>) for more information. Please note the following requirements:

Adverse Reactions: If any untoward incidents or adverse reactions should develop as a result of this study, you are required to immediately notify in writing the Seton Hall University IRB Director, your sponsor and any federal regulatory institutions which may oversee this research, such as the OHRP or the FDA. If the problem is serious, approval may be withdrawn pending further review by the IRB.

Amendments: If you wish to change **any** aspect of this study, please communicate your request in writing (with revised copies of the protocol and/or informed consent where applicable and the Amendment Form) to the IRB Director. The new procedures cannot be initiated until you receive IRB approval.

Completion of Study: Please notify Seton Hall University's IRB Director in writing as soon as the research has been completed, along with any results obtained.

Non-Compliance: Any issue of non-compliance to regulations will be reported to Seton Hall University's IRB Director, your sponsor and any federal regulatory institutions which may oversee this research, such as the OHRP or the FDA. If the problem is serious, approval may be withdrawn pending further review by the IRB.

Renewal: It is the principal investigator's responsibility to maintain IRB approval. A Continuing Review Form will be mailed to you prior to your initial approval anniversary date. **Note:** No research may be conducted (except to prevent immediate hazards to subjects), no data collected, nor any subjects enrolled after the expiration date.

Appendix P (Contd)

REQUEST FOR APPROVAL OF RESEARCH, DEMONSTRATION OR RELATED ACTIVITIES INVOLVING HUMAN SUBJECTS

All material must be typed.

PROJECT TITLE: Exploring the Relationships Between and Among Registered Nurses' Spiritual Well-Being and Spiritual Care Perspectives and their Provision of Spiritual Care in the Acute Care Setting

CERTIFICATION STATEMENT:

In making this application, I(we) certify that I(we) have read and understand the University's policies and procedures governing research, development, and related activities involving human subjects. I (we) shall comply with the letter and spirit of those policies. I(we) further acknowledge my(our) obligation to (1) obtain written approval of significant deviations from the originally-approved protocol BEFORE making those deviations, and (2) report immediately all adverse effects of the study on the subjects to the Director of the Institutional Review Board, Seton Hall University, South Orange, NJ 07079.

[Redacted signature area]

Barbara J. Kitchener, MA, RN RESEARCHER(S)

9/14/2015 DATE

Please print or type out names of all researchers below signature. Use separate sheet of paper, if necessary.

My signature indicates that I have reviewed the attached materials of my student advisee and consider them to meet IRB standards.

[Redacted signature area]

Dr. Jane Cerruti Dellert, PhD, RN, PNP-BC, CPNP RESEARCHER'S FACULTY ADVISOR [for student researchers only]

9/9/15 DATE

Please print or type out name below signature

The request for approval submitted by the above researcher(s) was considered by the IRB for Research Involving Human Subjects Research at the Sept. 2015 meeting.

The application was approved [checked] not approved [] by the Committee. Special conditions were [] were not [checked] set by the IRB. (Any special conditions are described on the reverse side.)

[Redacted signature area]

DIRECTOR, SETON HALL UNIVERSITY INSTITUTIONAL REVIEW BOARD FOR HUMAN SUBJECTS RESEARCH

9/30/15 DATE