NURSES' PERCEPTIONS OF SPIRITUALITY AND SPIRITUAL CARE

A Dissertation
Presented to
the School of Education
Drake University

In Partial Fulfillment
of the Requirements for the Degree
Doctor of Education

by Kim Diane Oswald
August 2004
NURSES' PERCEPTIONS OF SPIRITUALITY AND SPIRITUAL CARE

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An abstract of a Dissertation by
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The problem: Spirituality and spiritual care are vital components of holistic healthcare (body, mind, and spirit). The rise in technological advances, the ongoing time constraints, and the continued shortage of nurses hinder the provision of holistic healthcare. Nursing faculty acknowledge current educational programs provide limited training in the areas of spirituality and spiritual care. Such dilemmas warrant further exploration of nurses’ perceptions of spirituality and spiritual care within healthcare.

Methodology: A descriptive, survey design was used to elicit responses from nursing professionals in two Midwestern healthcare settings. Perceptions of nurses were investigated using the Spirituality and Spiritual Care Rating Scale (SSCRS) developed by Wilfred McSherry (2000). A total of 533 nurses out of 612 completed the survey for a response rate of 87%. Data were analyzed using both means and standard deviations. Statistical tests for significance using analysis of variance ($p = .05$) were completed in three areas including the nurses’ location of practice, length of service, and educational training.

Findings: Research outcomes found nurses’ perceptions of spiritual care were clearly identified while perceptions of spirituality were uncertain. The research demonstrated statistically significant differences in the nurses’ perceptions of spirituality based upon years of service within the profession. Nurses’ perceptions of spirituality and spiritual care did not differ statistically based upon the location of practice (sectarian versus nonsectarian) or the educational level of the nurse.

Conclusions: Findings from this study suggest that nurses have a solid understanding of spiritual care giving practices. Outcomes from this study also suggest as nurses progress through their career their perceptions of spirituality become more defined. The location of practice and educational level of the nurse had no effect upon nurses’ perceptions of spirituality and spiritual care.

Recommendations: Additional studies, employing quantitative and qualitative research methods in multiple healthcare settings, may lend further credence to better understanding the concept of spirituality and spiritual care from the nursing perspective. Further research may also focus upon identifying individual differences in nurses’ perceptions regarding spirituality and spiritual care from the nursing perspective through qualitative interview processes.
ACKNOWLEDGEMENTS

Completion of this project would not have been possible without the ongoing support of my esteemed faculty and colleagues. A special thank you to my dissertation chair, Dr. James Romig, whose ongoing support, expertise, and encouragement allowed me to fulfill my life goal. To Dr. Carl Smith, committee member, I also express my sincere gratitude for his insight and kindness. Committee member Sister Maurita Soukup provided me compassionate guidance while serving as a mentor for professional nursing practice. My heartfelt appreciation is extended to each of these individuals.

A special note of gratitude is extended to Wilfred McSherry, author of the SSCRs survey tool from the University of Hull in the United Kingdom and Elsevier Publishers. Their openness in approving the use of the SSCRs in my doctoral research is an example of true compassion and kindness. Research completed by Wilfred McSherry has provided invaluable insight into better understanding the phenomenon of spirituality in nursing.

This study was also dependent upon countless individuals approving access to the survey locations, i.e., the administrators and nursing managers. I also thank my esteemed nursing colleagues who provided invaluable insights into the essence of nursing.

I end with acknowledgement to my Lord, my family, and my friends, they have been the inspiration and foundation of support during my life journey. I want to thank the Lord for placing a call upon my life to enter the nursing profession. Thank you my loving and supportive husband whose sacrifice and support encouraged me during the joys and challenges and my loving parents whose unconditional love and inspiration provided me strength and courage to believe that dreams really do come true. Such work is a tapestry inspired by many caring and loving individuals very dear to my heart.
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Chapter 1

INTRODUCTION

Spirituality, as a phenomenon, is universal. The nursing profession has strong historical foundations built upon spirituality. Nightingale (1969) recognized spiritual care and spirituality as major nursing functions in her historical writings (p. 125). Since the Nightingale initiative, spirituality within the nursing field has received limited attention in the literature, research, and practice setting.

Freidemann, Mouch, and Racey (2002) described the association between the nursing profession and spirituality as being “intimately intertwined” but acknowledged “as nursing established itself as a profession, the emphasis shifted from spirituality to scientific reasoning” (p. 326). In the current literature, attempts are being made to address the role of spirituality within the nursing profession (Freidemann et al., 2002; Van Dover & Bacon, 2001; Greasley, Chiu, & Gartland, 2001).

Nursing Directives in Providing Spiritual Care

The importance of addressing spiritual needs is a vital component in both nursing education and practice settings. The American Association of Colleges of Nursing (1998) indicated in The Essentials of Baccalaureate Education for Professional Nursing Practice nursing graduates should be able to perform a holistic assessment including the patient’s spiritual status to incorporate practices focused on meeting those identified spiritual needs. They recommended the education of professional nurses should ensure their ability to “comprehend the meaning of human spirituality in order to recognize the relationship of beliefs to culture, behavior, health, and healing in order to assess, plan, and implement this type of care” (American Association of Colleges of Nursing, 1998, p. 5). In a similar manner, the American Nursing Association (1998) Standards of Clinical Nursing Practice identified spirituality as an important aspect of the nursing assessment process.
Within the clinical setting, agreement exists concerning the importance of addressing spiritual care practices as a vital aspect of holistic medical care. For example, Ross (1994) clearly identified spiritual assessment and spiritual care as a nursing responsibility and not an “optional extra” (p. 441). More recently, authors such as Lemmer (2002) confirmed the role of spirituality in nursing by stating, “Nurses are continually expected to assess for spiritual needs and intervene to provide spiritual care” (p. 483). Consensus, therefore, exists that a vital part of nursing practice is the “exploration of the spiritual domain as well as the physical, emotional, and social aspects of being human” (Long, 1997, p. 507).

Spirituality and Spiritual Care in Nursing

Facing recommendations established by The American Association of Colleges of Nursing and The American Nurses Association, practitioners find limited substantive research on spirituality within the nursing profession. Many factors are worthy of consideration when examining spirituality in nursing. These factors, detailed below, include (a) recent historical trends, (b) absence of quantitative research, (c) limits in training of the nurse, (d) nursing practice issues, (e) impact of the individual’s own spiritual development, and (f) rise in international research on spirituality.

Historical Trends

Consensus exists that quality nursing practice should include a spiritual assessment and the provision of spiritual care for the patient (Van Dover & Bacon, 2001; Long, 1997; Ross, 1995). Ross (1995) reported well established nursing research from a spiritual care perspective “is very much in its infancy” (p. 461). His research indicated a patient considers the nurse a key individual in addressing spiritual needs, however, the nurse often felt inadequate and therefore unwilling to address spiritual issues with the patient (Ross, 1995, p. 466). McSherry and Draper (1998) documented a historical demise in spirituality within nursing linked to three historical trends. These include the (a) rise of modernism focused upon the tangible and materialistic facets of human nature,
(b) replacement of traditional values with a reductionistic approach to healthcare, and (c) rise in technological advances overshadowing a concern for spiritual needs (pp. 686-688). Although the nursing profession was founded upon spiritual principles providing “a rich spiritual tradition,” the profession is also facing challenging trends (McSherry & Draper, 1998, p. 686).

Absence of Quantitative Research

The majority of spirituality research within nursing has focused upon descriptive and qualitative research studies (Albaugh, 2003; Narayanasamy & Owens, 2001; Ross, 1997). There also exists a large number of literature reviews attempting to define the key components of spirituality (Hodge, 2001; Baldacchino & Draper, 2001; Dyson, Cobb & Forman, 1997). This type of research has a definite role in both defining and examining relevant issues surrounding the elusive concept of spirituality, however quantitative research continues to be lacking examination of spirituality and spiritual care from a nursing perspective within the United States. Therefore, the nursing profession faces a clear dichotomy between the established directives of the American Association of Colleges of Nursing and The American Nurses Association and the lack of quantitative research on spirituality and spiritual care in nursing.

Educational Training of the Nurse

Another factor worthy of consideration in examining spirituality focuses upon the limited educational preparation of nurses in both the academic and the practice setting. This limitation evolves from a lack of knowledge in teaching spiritual assessment and patient care practices. Nursing faculty members remain unclear in their understanding of the spiritual dimension (Lemmer, 2002, p. 488). Uncertainty exists due to the lack of consensus on a clear definition of spirituality and spiritual care practices (Martsolf & Mickley, 1998, p. 295; McSherry & Cash, 2004, p. 151). In a study of 250 baccalaureate nursing programs, Lemmer (2002, p. 485) found “most programs did not have an agreed upon definition of either spirituality (84.4%) or spiritual nursing care (93.8%).”
Nursing faculty acknowledged barriers impeding the development of the nurse such as the lack of a well developed spiritual care curriculum, little integration of spirituality throughout curriculum, and ineffective methods in teaching spirituality (Catanzaro & McMullen, 2001, p. 225). Piles (1990) conducted a study finding the “level of practice of spiritual care is positively related to the degree of educational exposure in the nurse’s basic program” (p. 38). Uncertainty in both defining and teaching spiritual care practices clearly impacts the nursing profession.

Others such as Oldnall (1996) reflected, “American literature appeared to be lacking any formal research methodology and tended to rely on previous literature, which is mainly subjective, in creating a hypothesis that nurses are unprepared for assessing, planning, implementing, and evaluating the spiritual needs of patients” (p. 141). Catanzaro and McMullen (2001) highly recommended further study aimed at “filling the spiritual vacuum that exists in nursing education” to effectively integrate spirituality into the nursing curriculum (p. 225). Understanding the impact of varying educational levels in providing spiritual care is another factor to consider in expanding the knowledge surrounding spirituality and spiritual care in the nursing profession.

**Nursing Practice Issues**

Constraints in ability of the nurse to conduct a spiritual assessment and provide spiritual care are documented throughout the literature. Time constraints, inherent to the nursing profession, produce difficulty in nurses addressing the spiritual needs of their patients. Van Dover and Bacon (2001) confirmed patients value the nurse helping with their spiritual needs, yet recognized nurses were often too busy with priorities being placed upon meeting physical needs (p. 19). Time constraints often lead to spiritual care practices being deferred to the pastoral care department within healthcare settings (Oldnall, 1996, p. 142). With the rise in demands and the continued shortage of nurses, barriers exist in adequately assessing and addressing the spiritual needs of each patient.
Practitioner comfort in addressing spirituality as a part of the nursing role is cited as another important consideration. Whether the nurse is an educator or a practitioner, research confirms generalized lack of comfort in providing high quality spiritual care (Catanzaro & McMullen, 2001; Oldnall, 1996). Reasons for this discomfort center on nurses feeling uncomfortable in discussing spirituality because they perceive themselves to be not in touch with their own spirituality (Sheldon, 2000, p. 103). Lemmer (2002) suggested the developmental stage of the nurse and the nurses’ life experiences may also affect the provision of spiritual care (p. 489). Literature acknowledges that practitioner comfort with their own spirituality and their developmental stage are critical factors to examine in providing spiritual care (Tuck, Pullen, & Wallace, 2001, p. 603).

The nurse’s own personal belief system also influences participation in addressing spiritual care. Narayanasamy and Owens (2001) found nurses who report a “personal approach to building the nurse-patient relationship” made a greater effort in assisting patients to overcome their spiritual distress (p. 451). Musgrave and McFarlane (2003) confirmed the impact of the nurse’s spirituality by stating, “Nurses who experienced spiritual well-being may be predictive of their attitudes toward spiritual care” and thus influence the overall provision of spiritual care for the patient (p. 527). Ross (1994) also demonstrated that nurses claiming religious affiliation were more likely to identify spiritual needs than those claiming none (p. 445), however, half of these nurses chose to refer the patient to someone else such as a chaplain or pastor to address the patients’ spiritual needs (Ross, 1994, p. 445). The impact of personal beliefs and religious affiliation in meeting the spiritual needs of the patient is worthy of further consideration.

Other research suggests spirituality does not rely upon secular, religious, or agnostic themes but is a part of the essence of the human person irrespective of the ideology the individual embraces (Oldnall, 1996, p. 140). Spirituality is viewed from a much broader perspective. The impact of providing spiritual care for the patient varies...
depending not only upon the expectations of the nurse but also the expectations of the healthcare institution itself (Van Dover & Bacon, 2001, p. 19). The presence or absence of an organizational spiritual philosophy, i.e., sectarian versus non-sectarian, and the resultant impact on the nurse’s perceptions of spirituality are worthy of further study.

*International Research*

International researchers lead the knowledge development surrounding spirituality and spiritual care. Carroll (2001) found the majority of spirituality research originates outside the United States with “a dearth of published studies [originating] from the United Kingdom” (p. 83). Within the past three years, worldwide efforts aimed at exploring the patient’s spiritual needs are on the increase with the role of the nurse becoming increasingly prominent (McSherry, Draper, & Kendrick, 2002; Hodge, 2001; Narayanasamy & Owens, 2001). Based upon these trends, opportunities exist to expand nursing research in the area of spirituality, spiritual assessment, and spiritual care.

*Purpose*

The primary purpose of this research was to better understand nurses’ perceptions of spirituality and spiritual care. For the purposes of this study, spirituality was defined as a need to find meaning and purpose in life, a need for hope and a will to live, and the need for a belief or faith in self, others, a Higher Power, or God. Spiritual care was defined as the practices or procedures employed by nurses to meet the spiritual needs of their patients. This study explored nurses’ perceptions of spirituality and spiritual care within a hospital (sectarian) and a private practice (nonsectarian) setting to increase the knowledge base surrounding the phenomenon of spirituality.

This study presents information for both the nurse educator and the practicing nurse. Assessment of the nurses’ perceptions of spirituality provides both the educator and the practicing nurse quantitative data, which has previously been limited, about nurses’ beliefs, feelings, and attitudes concerning important aspects of their patients’ spirituality. The findings from this study may be used to facilitate professional
discussions and increase knowledge about spirituality in the academic and practice setting.

Research Questions

McSherry (2000) identified spirituality as a phenomenon including four subscales, i.e., religiosity, spirituality, spiritual care, and personalized care in his development of the Spirituality and Spiritual Care Rating Scale or SSCRS (McSherry, 2000, p. 172). Using the SSCRS survey tool the following four research questions guided the research on spirituality and spiritual care:

1. What are the nurses’ perceptions of spirituality and spiritual care in the hospital and private practice setting?

2. Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the employing institution [i.e., hospital (sectarian) and private practice (nonsectarian)] setting?

3. Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon years of service within profession, that is, less than 1 year, 1 to 5 years, 6 to 10 years, 11 to 24 years, and 25 years or greater?

4. Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the completed educational degree [i.e., Associate Degree (A.D.), Bachelors Degree (B.S.), Masters Degree (M.S.), or Doctoral Degree (Ph.D., Ed.D.)] in nursing?

Importance of Spirituality Research in Nursing

Spirituality remains an elusive concept. The importance of conducting research surrounding spirituality from a nursing perspective is based upon three factors. These factors, as discussed below include the (a) initiative to provide holistic healthcare practices supporting patient health and well-being, (b) limited existing research and a need to better understand the nurses’ perceptions of spiritual care, and (c) researcher’s
personal interest in expanding knowledge in order to openly address the spiritual needs of the patient.

**Focus on Holistic Care**

Narayanasamy (2001) acknowledged viewing an individual as a “biopsychosocial-spiritual being is gaining recognition…based upon the premise that there must be a balance of mind, body, and spirit for the maintenance of health” (p. 447). In this setting, imbalance in any of the three areas affected the other requiring a “holistic approach in restoring the harmonious balance” (Narayanasamy, 2001, p. 447). The importance of conducting research from a holistic perspective focuses upon unifying nursing care aimed at meeting not only the physical needs of the patient but also the psychological and the spiritual needs of the individual. Coyle (2002) found that addressing the spiritual needs of patients helps them to adapt and cope with illness (p. 595). Spirituality is, therefore, recognized as a key aspect to address in the delivery of holistic care to improve the quality of life for patients.

**Limited Research**

The importance of understanding the nurses’ perceptions of spirituality and spiritual care stems from limited research conducted from this viewpoint. The majority of research focused on qualitative studies defining the key components of spirituality (Hodge, 2001; Albaugh, 2003). Although such studies have a role within nursing, the expansion of quantitative research is warranted. In this manner, Oldnall (1996) questioned the accuracy of a nurse’s skill in conducting a patient assessment and care planning if they were unable to identify the spiritual needs of the patient (p. 142). Based upon this assessment, he cited the presence of “very little quantitative or qualitative research…on spirituality from a nursing perspective” (Oldnall, 1996, p. 142). Therefore, further study is needed to quantify and expand the knowledge base surrounding spirituality.
Personal Interest of the Researcher

The final consideration in conducting the study was based on the researcher’s personal interest in the subject. It is the belief of the researcher that high quality nursing care, which addresses the spiritual needs of the patient, resides in the comfort level of the nurse combined with a well developed skill in dealing with the patients spiritual concerns. The desire to further develop practitioner expertise stemmed from a longstanding commitment and a heartfelt desire to advance the knowledge of spiritual care practices within the nursing profession. Van Dover and Bacon (2001) reflected similar sentiment by stating, “Spiritual care addresses the core of the human being, the human spirit; therefore, nurses who give spiritual care are engaging the core of who they are in caring for others” (p. 28). From this personal interest, further research was warranted surrounding spirituality from a nursing perspective.

Research Plan

This research study provided descriptive information obtained from the application of the Spirituality and Spiritual Care Rating Scale or SSCRS to assess nursing perceptions of spirituality and spiritual care of their patients (see Appendix A). The survey was administered to nurses in a hospital (sectarian) and a private practice (nonsectarian) institution. The survey elicited quantifiable data concerning spirituality and spiritual care from the nursing perspective. The descriptive survey method was chosen in order to gather information from a large group of nurses in a relatively short period of time. This was deemed appropriate because of the limited information currently available from a quantitative research perspective.

Definition of Terms

Spirituality: A review of the literature reveals that spirituality is a highly subjective concept dependent upon one’s world view with varying interpretations (McSherry et al., 2002, p. 723; Martsolf & Mickley, 1998, p. 294). Multiple definitions of spirituality exist within the literature. Three specific components reoccurred within the
literature including: (a) a need to find meaning, purpose, and fulfillment in life or illness; 
(b) a need for hope and a will to live; and (c) the need for a belief or faith in self, others, 
or a Higher Power or God (Friedmann et al., 2002; McSherry & Ross, 2002; Ross, 1994). 
For the purposes of this study, spirituality will be defined as including any of the above 
identified components. 

**Spiritual Care:** Spiritual care was defined as the practices and procedures nurses 
employ to meet the above identified spiritual needs of their patients. These practices stem 
from a holistic view of medical care in which the physical, mental, and spiritual needs of 
the patient are addressed to support optimal health and well-being (Narayanasamy, 1999, 
p. 125).

**Perception:** Perception involved attaining a deeper level of awareness or 
understanding of a presenting concept (McSherry et al., 2002, p. 731). In the research 
study, perception was limited to the nurses’ perception. It was implied that the perception 
of the nurse involved the processes by which healthcare providers identified a patient’s 
spiritual need pertaining to their medical care (Anandarajah & Hight, 2001, p. 84).

**Nurse:** For this study, the operational definition of a nurse was defined as an 
individual who completed an accredited educational program thereby receiving an 
Associate, Bachelors, Masters, Doctoral, or other identified degree in nursing. The nurse 
was operationally defined as an individual who successfully completed all licensure 
requirements, including the registered nurse licensure examination approved by the state.

**Limitations**

Consideration of the potential limitations of a research study was an important 
aspect of the research process. This descriptive, exploratory study was non-experimental 
by design. This study provided valuable descriptive information in the form of nurses’ 
perceptions from the identified population in order to better understand spirituality and 
spiritual care of patients. Such information can be used to encourage dialogue among 
nursing professionals, thereby supporting the essence of the nurse-patient relationship.
The researcher recognized the convenience sample of nurses participating in this study was representative of nursing professionals as a larger group, however, the researcher also acknowledged that the overall interaction and close proximity between the hospital and private practice groups may have supported similar research outcomes. The value of information obtained in this study offers inherent value to further define the phenomenon of spirituality and spiritual care which may be replicated by nursing professionals in other locations and healthcare settings.

The SSCRS survey tool was based upon several identified components of spirituality. McSherry et al. (2002) extracted the components based upon a thorough review of the literature suggesting there may be “several main components of spirituality that may be universally transferable to all individuals” (p. 731). They also acknowledged the stability of the identified components “requires further testing out in subsequent research” (McSherry et al., 2002, p. 731). Another potential limitation of the study was the reliance on a tool which may warrant further refining including additional statistical analysis to assure the included components are indeed representative of spirituality and spiritual care within the nursing profession.

Lastly, a potential limitation of this study involved the respondent’s awareness that they were being surveyed concerning their perceptions of spirituality and spiritual care within nursing. This has been described as the Hawthorne effect when participant’s respond in a different manner than they would have if they were unaware they were being surveyed (Gall, Gall, & Borg, 2003, p. 376). By requesting voluntary participation in the research study and explaining details of the project, heightened awareness surrounding the phenomenon of spirituality may affect participant response thereby serving as another potential limitation of the research study.

Summary

This chapter describes spirituality as a phenomenon ingrained in the nursing profession. Nursing, as a profession, has well developed directives documenting the
importance of addressing the spiritual needs of the patient. However, these directives face opposing forces within the nursing profession preventing the development and understanding of spirituality as a phenomenon. The opposing forces included recent historical trends in nursing, absence of quantitative research, limited educational training surrounding spiritual care practices, nursing practice issues such as time constraints, and the impact of the nurse’s own spiritual development. The purpose and research questions are presented followed by the definition of terms included in the study. Lastly, the researcher provided an overview of the research plan and the study limitations.

In the next chapter a literature review is presented on the phenomenon of spirituality and spiritual care in nursing. The review provides a historical overview of the nursing literature and research. Information included in the literature review includes pertinent articles, research studies, and key writing supportive to the role of spirituality and spiritual care in the nursing profession.
Chapter 2

REVIEW OF THE LITERATURE

Within the nursing profession an interest in spirituality has increased. In order to better understand the emerging literature, a historical overview of spirituality within the field of nursing will be presented. It is evident there have been specific periods of heightened interest as well as periods witnessing limited interest in the role of spirituality and spiritual care in nursing. This review focuses on the early beginnings of spirituality in nursing. The researcher will then proceed to examine the return of spirituality during the 1900s. The review will conclude with current literature and research conducted between 2000 and 2004.

Spirituality in Nursing (Middle Ages to the 1900s)

Nursing was built upon spirituality as a vital component of the profession. During the Middle Ages nurses entered monasteries or military nursing orders (Taylor, 2002, p. 43). The Renaissance and Post-Reformation eras found the practice of nursing becoming highly institutionalized (Taylor, 2002, p. 34). From the Renaissance through the 1800s, difficult working conditions and long working hours shifted nursing practice from religious institutions to caring for people in homes and poorhouses (Taylor, 2002, p. 35). In the nineteenth century Florence Nightingale emerged as a proponent of healthcare reform (Taylor, 2002, p. 35). Nightingale, whose training was based in religious institutions, was described as “a deeply spiritual and Christian woman...[who] advocated holistic nursing asserting that the spiritual dimension is an integral part of being human and spiritual care as essential to healing” (Taylor, 2002, p. 35). Her work provided a foundation for spirituality in nursing acknowledging the importance of addressing patient’s spiritual needs.

Decline of Spirituality

During the mid-twentieth century a shift occurred with the decline of religion and spirituality in nursing. Taylor (2002) described this shift in the following quotation:
Religion became less visible as a component of nursing. The development of modern scientific methods and technological advances in health care served to devalue interventions that could not be easily controlled or quantified, including those essential to spiritual caregiving. Technological advances emphasized the “doing” rather than “being” aspects of nursing. (p. 36)

The modernism and secularism seen in this era encouraged the nurse to focus primarily upon the “temporal, tangible, and materialistic facets of human nature” (McSherry & Draper, 1998; Wilt & Smucker, 2001; Taylor, 2002).

This materialistic sentiment was also noted in the emerging nursing theories developed during this era. Goddard (1995) stated, “Most nursing theories espouse holistic care as a central disciplinary tenet, yet the human spiritual dimension was often neglected or mentioned only perfunctorily” (p. 808). In a review of the prominent nursing theories developed during this era, Martsolf and Mickley (1998) found limited mention of spirituality or spiritual care. They summarized their findings by stating:

Four models or theories…say little or nothing about spirituality (Orlando, Peletier, King, Peplau, and Orem). Four others…present spirituality as an embedded concept (Levine, Johnson, Roy, Leninger, Rogers). Only one conceptual model (Neuman) and one theory (Watson)…include spirituality as a major concept. (p. 300)

Initially, during this era, spirituality held prominence in both the literature and practice setting. However, this era closed with limited attention to the role of spirituality and spiritual care within the nursing profession.

Return of Spirituality (1900s to 2000)

Over the last century there has been a renewed interest in spirituality and the provision of spiritual care in nursing. Developments during this era culminate with a widespread commitment to holistic healthcare inclusive of spirituality and spiritual care practices.
Defining Spirituality

This era began with acknowledgement to the decline of spirituality in nursing. Ross (1995) stated, “Nursing research on spiritual care is very much in its infancy” (p. 461). Goddard (1995) and Oldnall (1996) voiced similar sentiment calling for the nursing profession to advance the knowledge base through rigorous study of spirituality and a focus on the development of the spiritual care concept. The majority of research conducted during this time, centered on perfunctory definitions of concepts, themes, and components of spirituality and spiritual care. Ross (1994), a leading researcher, during this era conducted an exploratory study highlighting the themes definitive to spirituality and spiritual care. His themes included: (a) a search for meaning, purpose, and fulfillment; (b) a hope and a will to live; and (c) a belief and faith in self, others, a Higher Power or God (Ross, 1994, p. 439). A year later, Ross (1995) confirmed these defining themes as key components in his extensive literature review (p. 459).

Continued attempts, during this era, focused upon methods to define spirituality and spiritual care. However, the defining characteristics of spirituality begin to shift from a religious definition to an all inclusive, more encompassing definition. For example, Goddard (1995) described spirituality as “integrative energy” in which the recognition of its transcendent, universal nature facilitates a more and complete understanding of the concept (p. 814). Likewise, Oldnall (1996) advocated a holistic focus when defining spirituality by arguing spirituality is:

Broader than the confines imposed from a purely religious or humanistic perspective, since the perceived spirit within each individual may be considered as the driving force that gives meaning to life for that individual and in doing so helps to create a set of values and beliefs that can influence the conduct of their lives...it is apparent that each individual has spiritual needs regardless of whether they are spiritual or not. (p.139)
The Patient Perspective

Beginning in 1997, research on spirituality continued to further define the essential components of spirituality in healthcare. Authors expanded their definitions of spirituality and spiritual care with research focusing on new concepts such as hope (Dyson et al., 1997; Benzein & Saveman, 1998) and connectedness (Goldberg, 1998). The definition moved from a descriptive analysis of the components of spirituality to an examination of the concept from the patient’s perspective. For example, Ross (1997) studied a group of elderly patients to explore their perspectives on spiritual needs while in the hospital. He found the patients experienced spiritual needs while in the hospital and felt they needed to talk with someone such as a chaplain about those needs (Ross, 1997, p. 710). None of the elderly patients received help from nurses with their spiritual needs (Ross, 1997, p. 710). Ross (1997) highly recommended further research comparing nurses’ and patients’ perceptions of spiritual needs in order to gain better insight surrounding spiritual care in nursing (p. 714).

Nursing Ethics and Spirituality

Nursing ethics were tied to spirituality during the late 1900s. Paralleling the entry of ethics emerged an initiative calling for the nursing professional to address his/her own spirituality in order to provide quality patient care. Cusveller (1998) examined the spiritual and ethical pluralism present in nursing practice by concluding:

We need to see nurses’ spirituality not as an unprofessional bias, but as sources of contributions to the best possible care...[which] requires a willingness to account for one’s performance of nursing care, for the way one interprets and implements the values and norms inherent to nursing and the way this is influenced by one’s spirituality. (p. 272)

Cusveller (1998) became a driving force in the movement toward examining the nurses’ perspectives on spirituality and spiritual care. Likewise, Long (1997) recommended nurses explore and reflect on their own spirituality through posing the question, “Have
we, as a group, shied away from the spiritual aspect, perhaps seeing it as something
different from being human, hence fearing it rather than embracing it” (p. 508)? Again,
we see the role of ethics as an influencing force surrounding the research on spirituality
in nursing.

*Spirituality Debate*

Throughout history ongoing debate was found in the literature on spirituality.
During the 1900s this debate continued among the religious and nonreligious proponents
(Sheldon, 2000) and the proponents of reciprocal interaction and the simultaneous action
worldviews (Martsolf & Mickley, 1998). Martsolf and Mickley (1998) examined the
reciprocal interaction world view which described spirituality “as a part of the dimension
of a person which interacts with other parts of the individual in a holistic way” (p. 295).
The simultaneous action worldview, in opposition to the reciprocal interaction view,
examined “spirituality within the context of patterns” (Martsolf and Mickley, 1998, p.
295). Both viewpoints were found in the spirituality literature during this era.

Sheldon (2000) examined the ongoing debate between the religious and the
nonreligious proponents by defining the latter as “coming from within our spirit, full of
humility, love, passion, care, and hope” while the former was seen as “more structured”
(p. 101). Burkhart and Solari-Twadell (2001) completed an extensive review of the
religious and nonreligious literature on spirituality concluding, “It may be appropriate to
conceptualize spirituality as a broader concept and religiousness as a subset of
spirituality” (p. 49). By the end of the 1900s, the debate among the world views was
beginning to fade.

*A Liberated, Inclusive View of Spirituality*

Emerging from the spirituality debate was a renewed commitment to a broader
and more liberated focus on spirituality and spiritual care. Stoll (1989) developed an
inclusive model of the spiritual dimension consisting of two levels defined as a vertical
dimension linked to the individual’s transcendent relationship with an “ultimate other”
and a horizontal dimension which reflected a person’s beliefs, values, lifestyle, and those human environmental elements and interactions of our existence (p. 7). McSherry and Draper (1998) stated spirituality was a “unifying force at the foundation of holistic philosophy...so intimately interwoven into the individual’s existence” that a broad definition with continued study was warranted (p. 683). Likewise, Narayanasamy (1999) continued expansion of the spirituality concept in the development of a conceptual model which incorporated the whole person, i.e., body, mind, and spirit, by recommending when discussing spirituality the concept should be viewed from a broader perspective (p. 125).

With the close of this era, five main themes emerged in the literature on spirituality in the nursing profession. The first theme involved defining and redefining the essence of spirituality and spiritual care in nursing. Next, we saw a shift in focus to the patient’s perspective surrounding spirituality and spiritual care in nursing. The third theme identified the role of ethics and spirituality. Fourth, the debate continued between various world views and spirituality in nursing. At the close of this era there emerged a more liberated, inclusive, and holistic view of spirituality and spirit care in nursing.

Recent Trends of Spirituality in Nursing (2000 to 2004)

The beginning of this era found a consensus among authors to embrace a broad definition of spirituality inclusive of all world views in addressing patient’s needs. Kendrick and Robinson (2000) confirmed this expanded view of spirituality by stating, “Spirituality is not reliant upon religious, secular, or agnostic themes but forms the very essence of the human person irrespective of which ideology the individual chooses to embrace” (p. 702). Recent writings by McSherry and Cash (2004) cite concern in “constructing a blanket definition of spirituality...[which] may be come so broad in meaning that it loses any real significance” (p. 151).

Three new trends have emerged within the spirituality literature. The first trend sees a beginning attempt to focus on the nursing professional and their perception of
spirituality and spiritual care, the self exploration of the nurse’s spirituality, and the further development of spirituality and spiritual care practices within specialty nursing fields. The second trend highlights initial attempts to create spirituality and spiritual care assessment instruments. Lastly, there is a focus on developing nursing skills in the area of spirituality and spiritual care combined with the establishment of standards of practice in the delivery of spiritual care.

*The Nursing Professional*

Research, focusing on the nurse as a professional, is a notable trend. Authors found that nurses believe spirituality is an integral part of their practice and greater attention must be paid to the spiritual dimension of the person (Tuck et al., 2001; Van Dover & Bacon, 2001). Confronting this focus on spirituality as a part of the nursing role is the recognition of barriers in meeting the spiritual needs of patients. These barriers included the (a) lack of quality research focused upon spiritual care (Van Dover & Bacon, 2001), (b) difficulty in defining what spiritual care should entail as well as the role of the nurse (Narayanasamy & Owens; 2001; Strang, Strang, & Ternestedt, 2002), and (c) multiple demands and time constraints forcing nurses to place priority on physical health needs thereby depending upon clergy or religious agents to provide spiritual care (Narayanasamy & Owens, 2001; Van Dover & Bacon, 2001). In addition, Narayanasamy and Owens (2001) found that despite the nurse’s belief in spiritual care, the nurse often feels unprepared and thereby delivers spiritual care “haphazardly and unsystematically” (p. 454). Such practices have been linked to lack of adequate training in the area of spirituality and spiritual care with a need for education as a higher priority (Baldacchino & Draper, 2001; Tuck et al., 2001; Strang et al., 2002).

The role of the nurse’s own spirituality is another theme in current literature. Carroll (2001) conducted a phenomenological exploration of spirituality and spiritual care practices of hospice nurses finding that it was “…important for nurses to develop an understanding of their own spirituality in order to understand the spiritual needs of
others” (p. 95). She found hospice nurses who receive training acknowledged their own beliefs and uniqueness to develop a clearer understanding of the nature of spirituality which was then reflected in their practice through trusting, empathetic relationships (Carroll, 2001, p. 96). Freidemann et al. (2002) also acknowledged the importance of nurses developing a “keen awareness of their own beliefs and values” in providing spiritual care for patients (p. 330).

The development of spirituality and spiritual care practices recently expanded to the specialty nursing fields. Increased research in spirituality and spiritual care is noted in current nursing literature in the areas of oncology, hospice, and mental health. General consensus among all specialty research cites increased benefit to the patient when nurses address spirituality and spiritual needs. These benefits included the promotion of the patient’s well-being and assisting patients to address spirituality and therefore make meaning or resolve issues related to the illness (Albaugh, 2003; Musgrave & McFarlane, 2003; Taylor, 2003; Somlai & Heckman, 2000; Greasley et al., 2001).

*Spirituality Assessment Tools*

Conducting an effective assessment of the patient is a critical component of nursing practice. Beginning attempts to develop effective spirituality assessment tools is the second theme emerging in current literature. Two qualitative and one quantitative assessment tools currently exist in the spirituality literature. The qualitative tools use open-ended questions to obtain rich information through interviews and transcribed datum (Gall et al., 2003, p. 439). The first tool, although originally developed for social workers, was entitled the Interpretive Anthropological Framework which assisted practitioners to “better understand the subjective reality of spirituality in clients’ lives” (Hodge, 2001, p. 208). This tool consists of a narrative and an interpretive portion allowing practitioners to “explore the various components of spirituality and create an
awareness of the potentiality of clients’ spirituality” (Hodge, 2001, p. 208).

A second qualitative tool was found in the field of medicine, called the HOPE assessment. Anandarajah and Hight (2001, p. 86) offered the HOPE tool as a practical guide for physicians, residents, and practitioners to conduct a spiritual assessment covering four basic areas including the:

1. “H” which pertained to a patient’s basic spiritual resources, such as sources of hope, without immediately focusing on religion or spirituality.

2. “O” which referred to areas of inquiry on the importance of organized religion in patient’s life.

3. “P” which referred to specific aspects of their personal spirituality and practices that are most helpful.

4. “E” which pertained to the effects of a patient’s spirituality and beliefs on medical care and end-of-life issues.

Example questions in each of the above identified areas were provided to the practitioner encouraging dialogue and discussion surrounding the spiritual needs of the patient. Although the Interpretive Anthropological Framework and the HOPE tool have been presented as viable assessment instruments, neither tool has been validated by research.

Researchers in the United Kingdom acknowledge difficulty in developing an effective spirituality assessment instrument. Based on an extensive review of the literature, McSherry and Ross (2002) provided insightful recommendations on the essential features of a spiritual assessment tool. Based on their work in the field of spirituality and spiritual care, McSherry and Ross (2002, pp. 485-486) recommended a spirituality assessment tool should be:
1. Adaptable to suit different care contexts and client needs.

2. Separated by parts including an in-depth spiritual assessment and a descriptive religious inquiry.

3. Non-intrusive in nature with consideration given to the type of questions and the mode of delivery.

4. Designed to not alienate or discriminate between different religious groups.

5. Systematic in nature with the possibility of one healthcare professional doing the assessing and a ‘spiritual care specialist’ readily available to provide and facilitate spiritual care for patients.

In that same year, McSherry et al. (2002) conducted research on 559 nurses in the United Kingdom. They tested a quantitative spirituality assessment tool, which they developed from their extensive review of the literature, called the Spirituality and Spiritual Care Rating Scale or SSCRS. The SSCRS explored nurses’ perceptions of spirituality and spiritual care with four factor subscales identified as spirituality or existential elements, spiritual care, religiosity, and personalized care (McSherry et al., 2002, p. 730). The authors recommended further research in this area to establish transferability with the SSCRS. This was the only quantitative spiritual survey instrument found within the current nursing literature to date which has been validated through research.

Advancement of Spirituality Training and Standards of Practice

The final theme emerging in recent literature focused on the advancement of training and development of spirituality and the trend toward establishment of standards of practice for the delivery of spiritual patient care. Earlier research conducted by Piles
found the “level of spiritual care is positively related to the degree of educational exposure in the basic nurse’s educational program” (p. 37). In more recent literature in the academic setting, Lemmer (2002) documented a viable concern presently surfacing whether “nurses have the necessary knowledge and skills to effectively address clients’ spiritual needs” with the implication stemming from whether “nursing education programs were [adequately] preparing students to meet those needs” (p. 482). Likewise, in the practice setting, Coyle (2002) clarified a relationship between spirituality and health so practitioners may “better understand and actively explore the content of spirituality with patients” (p. 589).

The first step, then, in assessing how to teach the spiritual care dimension lies in “faculties broadening their understanding of the concept of spirituality...with faculty playing a vital role in future nurses’ understanding of providing spiritual care” (Lemmer, 2002, p. 489). Catanzaro and McMullen (2001, p. 225) summarized this need by recommending the nursing profession in both the academic and practice setting must:

1. Fill the spiritual vacuum that currently exists in nursing education.
2. Become comfortable with the language of religion and spirituality.
3. Provide opportunities to reflect on the interconnectedness between religion and spirituality in both the classroom and the clinical setting.
4. Establish a firm knowledge base of spirituality with students.

The establishment of standards of practice in the delivery of spiritual care is beginning to emerge within the nursing profession in response to the perceived lack of nurse training. Hunt, Cobb, Keeley, and Ahmedzai (2003) formed a multidisciplinary group within a hospice setting to draft a spiritual care standard based upon three distinct
levels of assessment (p. 212). To enable the healthcare team to best assess a patient’s spiritual needs, Hunt et al. (2003) recommended a three-tiered approach as a practice standard for spiritual assessment which included:

1. Routine assessment for all patients conducted at the time of admission.

2. Multidisciplinary assessment, particularly sensitive to spiritual issues, which may be initiated by the patient, the caretaker, or by other members of the multidisciplinary team.

3. Specialist level assessment by a chaplain or pastoral care department to explore the more complex issues requiring advanced knowledge.

It is reasonable to assume further development of spirituality assessment practices incorporating a multidisciplinary team approach would be beneficial in better understanding spirituality and spiritual care in nursing.

Tanyi (2002) summoned the nursing profession to continue the development of spirituality as a concept and refine effective spiritual assessment tools to “overcome some of the barriers impeding spiritual care” (p. 506). In the last three years we witnessed another shift in the focus of spirituality in the research literature. This shift saw an increased focus on the nurse and his/her own spiritual self-reflection and its impact upon the patient’s spiritual status. The emergence of few spirituality assessment instruments and the advancement of training with the establishment of standards of practice in the delivery of spiritual care are areas for future study.

**Summary**

The literature surrounding spirituality and spiritual care in nursing has undergone dramatic change from the days of Nightingale to the present era. This evolution of change
is presented in a historical overview from The Middle Ages to the present. Whether it be defining the phenomenon of spirituality or establishing standards of care, the role of spirituality remains present in the field of nursing and worthy of continued study.

The next chapter presents the research methodology. The methodology is based upon quantitative methods aimed at exploring nurses’ perceptions of spirituality and spiritual care. Information included in the next chapter focuses on the research plan including the sample population, the data gathering plan, and the methods of data analysis.
Chapter 3

METHODOLOGY

The overall research design “outlines the plan for addressing a research question and includes specifications for enhancing the integrity of the study” (Polit & Hungler, 1999, p. 713). In this study, nurses were surveyed in order to explore their perceptions of spirituality and spiritual care. To adequately address the phenomenon of spirituality and spiritual care from the nursing perspective, a descriptive survey methodology was employed. Gall et al. (2003) confirmed that a non-experimental, descriptive design was “appropriate when the purpose is to create a detailed description of a phenomenon” (p. 287). This research plan was used to examine nurses’ perceptions of spirituality and spiritual care within both a sectarian and a nonsectarian healthcare organization. The researcher used statistical analysis to determine relationships between spirituality and spiritual care as related to the following variables: (a) employing institution, i.e., sectarian, hospital and nonsectarian, private practice location, (b) length of service in the nursing profession, and (c) educational level of the nurse.

A descriptive design involves reporting the characteristics of one sample at one point in time (Gall et al., 2003, p. 291). For the purposes of this study, data were collected at one time, that is, April 2004, from nurses employed in two healthcare organizations. The primary reason for choosing the descriptive design was the ability to establish a descriptive baseline for spirituality research in the nursing profession. Additional reasons for choosing the descriptive design included the flexibility, feasibility, convenience, and cost-effectiveness inherent to this type of research.
A survey, employing the use of the SSCRS questionnaire, was used to gather information from nurses in two healthcare organizations. Questionnaires are effective tools for gathering data by affording decreased costs in sampling respondents over a wider geographic area and decreased time in collecting the data (Gall et al., 2003, p. 222). Gall et al. (2003) cited numerous advantages to the participants including the ability to complete the survey at their convenience, answer questions in any order, and take time to answer each of the presented questions (p. 222).

A research plan served as a blueprint for this research study. Specific steps, detailed below, included in this plan were: (a) sample description, that is, participants to be included, agreement with participants, and chosen sites, including access to the sites; (b) data gathering plan, that is, identifying the instrument to be used in the study and quality control measures included in the research design; and (c) data analysis plan.

Sample Description

The setting for this study included two large healthcare organizations located in a large Midwestern city. These sites included a sectarian (religious) hospital setting employing approximately 1000 nurses and a nonsectarian (nonreligious), private practice employing approximately 200 nurses.

The sample chosen for this study was based upon convenience sampling methods. In this type of sampling, the researcher selects a sample suited to the purposes of the study with specific reasons for choosing the convenience sample (Gall et al., 2003, p. 175). The reasons for choosing each of the healthcare organizations included the (a) locations proximity to the researcher’s workplace, (b) administrators who approved the study were colleagues of the researcher, (c) familiarity of the researcher with both
settings, and (d) availability of a large number of nurses, typical to the nursing profession who have experienced the phenomenon under study.

Gall et al. (2003) stated, "If a convenience sample is used, the researchers and readers of their report must infer a population to which the results might be generalized" (p. 175). For the purposes of this study, convenience sampling was deemed appropriate to represent nursing professionals. The nurse was identified as an individual who (a) was employed by either healthcare organization, (b) successfully graduated from a registered nursing program at a college or university setting, and (c) successfully completed the state licensure examination thereby inferring the status of a registered nurse within the state. This sample was deemed appropriate for the research study based upon the proposed research questions and the convenience sample indicative of the population being studied. Based upon this sample one must be careful in making broad generalizations, however, findings from this study may suggest nursing thoughts, beliefs, or their perceptions related to the phenomenon of spirituality and spiritual care.

Participants were selected through collaborative methods with nursing administrators and departmental nursing managers. Factors considered to ensure a large, representative sample size of the nursing group included the selection of participants from all available nursing departments and across all adult nursing specialty locations. Only those nurses caring for adult patients and available to complete the survey during the designated data collection month in April 2004 were included in the sample.

After determining the study location and participant group, the researcher met with organizational nursing administrators, chief operating officers, and directors of human resources to request their approval to conduct the research study in their
organization. Upon verbal approval from administrators, the researcher attended departmental nursing manager meetings at each location to provide an overview of the study and request their assistance. E-mail notifications were sent to departmental nursing managers to confirm their agreement for their service to participate in the study (see Appendix C). Departmental managers, who failed within fourteen days to acknowledge the e-mail, were contacted verbally by the researcher to encourage participation in the study. Departmental meetings were scheduled with the nursing managers to distribute the survey to the nursing staff. The targeted population included approximately 200 nurses from the private practice location and approximately 1000 nurses from the hospital location for a combined total of approximately 1200 nurses.

In addition to the survey, specific demographic data was obtained from participants related to each of the research questions (see Appendix D). The first type of demographic data focused upon employment location asking whether the nurse worked in a hospital (sectarian) or a private practice (nonsectarian) organization. This is an important factor to consider based upon the emerging research focusing on influence of religious and nonreligious philosophies in the provision of spiritual care to patients. Ross (1994) demonstrated that nurses claiming religious affiliation were more likely to identify spiritual needs than those claiming none (p. 445). The impact of religious affiliation in meeting the spiritual needs of the patient was deemed worthy of consideration. The second type of collected demographic data focused upon the nurse’s total number of years of service within the nursing profession. This is important because literature suggested factors such as the developmental stage of the nurse and the nurse’s life experience may affect the provision of spiritual nursing care (Lemmer, 2002, p. 489). The
third type of collected demographic data focused upon the educational background of the nurse including the completion of an Associate, Bachelor, Masters, Doctoral, or other identified degree in nursing. Because literature cited the level of practice of spiritual care is positively related to the degree of educational exposure in the nurse’s educational program, it is appropriate to examine the educational level of the participants reflecting time spent within the educational setting (Piles, 1990, p. 38).

Data Gathering Plan

The tasks of selecting and developing a data gathering plan are among the most challenging in the research process (Polit & Hungler, 1999, p. 309). Data were collected through a survey. Authors described the survey as requiring less time to administer, more standardized, and less costly (Gall et al., 2003, p. 222). Because the study described nursing perceptions in two different locations, the advantage of a shorter timeframe and standardization of results were considerations felt worthy to warrant the survey format. The results obtained from the survey provided both numerical and descriptive data identifying nurses’ perceptions of spirituality and spiritual care. The survey instrument is further detailed below.

SSCRS Instrument

The Spirituality and Spiritual Care Rating Scale or SSCRS survey instrument was selected by the researcher as a well-developed quantitative tool to assess nurses’ perceptions of spirituality and spiritual care (see Appendix A). McSherry (2000) developed the SSCRS based upon nine key areas associated with spirituality and spiritual care including (a) hope, (b) meaning and purpose, (c) forgiveness, (d) beliefs and values, (e) spiritual care, (f) relationships, (g) belief in God or deity, morality, and (h) creativity
or self-expression (p. 171). This survey was designed by McSherry (2000) for the purpose of exploring nurses’ perceptions, i.e., beliefs and values of spirituality and spiritual care. In a subsequent quantitative study of British nurses McSherry et al. (2002) used the SSCRS to “discover and explore nurses understanding of and attitudes toward the concepts of spirituality and spiritual care” (p. 724).

The validity and reliability of the SSCRS survey tool was carefully examined by the researcher to support quality research. McSherry (2000) cited in his research “the SSCRS obtained an alpha coefficient of 0.77…indicating an acceptable level of reliability for a newly developed instrument” (p. 149). In addition, item analysis indicated appropriate distribution of questions and the establishment of “construct validity of a rating scale assessing nurses’ perceptions of spirituality and spiritual care” as stated by McSherry et al. (2002, p. 731). Subsequent research by McSherry et al. (2002) using the SSCRS demonstrated a “reasonable level of internal consistency and reliability” suggesting the “SSCRS could be used as a newly constructed instrument” (p. 731). Based upon this information the researcher felt comfortable in choosing the SSCRS survey tool as a reliable and valid quantitative instrument to adequately assess nurses’ perceptions of spirituality and spiritual care. Permission to use the SSCRS was obtained from McSherry and Elsevier Publishers in September 2003 (see Appendix B).

The SSCRS was constructed based upon an extensive literature review covering key areas associated with spirituality and spiritual care in nursing (McSherry, 2000, p. 171). The 17 items in the instrument were randomized using random number tables and individualized beginning with “I believe spirituality…” or “I believe nurses can provide spiritual care by…” (McSherry, 2000, p. 172). McSherry (2000) prevented response-set
bias by also phrasing items in the negative such as, “I believe that spirituality is not concerned with a belief and faith in a God or supreme being” (p. 172). Respondents were asked to indicate or score to what extent they agree or disagree with presenting statements identifying their responses as (a) “strongly disagree” corresponding to a score of one, (b) “disagree” corresponding to a score of two, (c) “uncertain” corresponding to a score of three, (d) “agree” corresponding to a score of four, and (e) “strongly agree” corresponding to a score of five (McSherry, 2000, p. 172). The SSCRs instrument identifies the nurses’ feelings and beliefs related to the posed statements with their responses scored and grouped according to statements relating to spirituality and spiritual care. Such scoring methods were supported by previous research using the SSCRs and the factor analysis processes described by McSherry (2000, p. 172) and McSherry et al. (2002, p. 731). This researcher was reassured that employing quantitative scoring techniques as identified by McSherry (2000) were both reasonable and applicable to identify the key concepts related to spirituality and spiritual care.

The researcher pilot tested the SSCRs with five randomly chosen nurses. Each nurse was requested to complete a survey for data analysis, to test the survey method, and to ensure clarity and validity of the tool. All obtained pilot responses were analyzed by the researcher and then excluded from the data collection process of the research study. No additional changes were warranted from the pilot testing process.

Quality Control Measures

After approval from both the study sponsored University, the hospital, and the physician office practice institutional review boards (see Appendixes E and F), the data collection process began in April 2004. The surveys were distributed to participating
nurses with cover letters explaining the research study and consent form. Individual
participant responses were not monitored, however, the researcher returned to each
nursing unit to remind participants to participate in the research project and the study
completion deadline date. Participants were requested to place completed surveys in an
unidentified, sealed envelope. The researcher collected surveys based upon the manager’s
request. Collection processes focused upon collecting the surveys at the end of
departmental meetings or by the researcher returning at a later date to collect the
completed survey envelopes from the manager.

Protection of participants.

Careful attention to protect each participant was considered by the researcher
throughout the research plan. Included in the data gathering plan was detailed methods to
protect each subject. These included the assessment of the risk-benefit ratio, careful
selection of the participants, obtaining informed consents, and assurance to participant
privacy and confidentiality (Gall et al., 2003, p. 67-72).

The assessment of the risk-benefit ratio took into account the balance between the
exposed risk to the participants and the benefits resulting from the study (Gall et al.,
2003, p. 68). The researcher determined no physical, psychological, or legal risks were
involved by nurses participating in completing the SSCRS survey. Although there were
no perceived risks to the participants, some risk might be involved if responses were not
kept confidential. This was avoided by the researcher instituting and closely monitoring
measures to ensure responses were kept confidential throughout the research project.
Anonymity of participants when answering the survey and disclosure of summary results
of the entire group rather than individuals were deemed appropriate measures to support
confidentiality of participants. Consideration of participants’ time was also monitored with the survey process taking an average of less than 10 minutes.

Benefits from this study included the satisfaction of the individual nurse in participating and advancing the knowledge base surrounding spirituality and spiritual care in the delivery of holistic care. Findings from this study may also be replicated in other healthcare organizations to further define spirituality and spiritual care practices within the nursing profession.

The selection of participants was another consideration of the research process. The researcher offered a population of approximately 1200 nurses, who cared for adult patients, the opportunity to participate in the study through convenience sampling methods. Although the researcher cannot eliminate all sample bias, the total number of possible participants was felt to be representative or typical to the nursing profession. Therefore, convenience sampling methods were deemed appropriate for the research.

Informed consent involved disclosing information related to what occurred during the research study, how the information was disclosed, and the intended use of the research data (Gall et al., 2003, p. 69). Because all participants in the research study were adults, issues related to minors were deemed not applicable. A detailed informed consent was obtained from each participant prior to the study. The consent form outlined the (a) details of the purposes of the study, (b) freedom to withdraw from participation at any time with no consequences, (c) right to participant privacy and confidentiality, and (d) statement that participation or lack of participation would have no affect on the participant’s current job (see Appendix G).
Data Analysis

Data analysis involved decisions about the type of statistical methods employed in the research design. Gall et al. (2003) stated, "...statistical analysis requires a great deal of judgment" (p. 127). Decisions made by the researcher on the type of statistical methods used in this research study were made prior to data collection. Each research question and previous research using the SSCRS survey tool determined the type of statistical methods used for the data analysis process. Each research question and the applied data analysis methods are presented in the remaining part of this chapter.

Research Question One: What are the nurses' perceptions of spirituality and spiritual care in the hospital and private practice setting? This question focused on collecting baseline, descriptive, quantitative data on the phenomenon of spirituality and spiritual care from a nursing perspective. Statistical methods selected for this question included descriptive statistics for the calculation of the mean and standard deviation for the entire sample of nursing participants. The determination of the mean and standard deviation scores of spirituality and spiritual care for the total group will determine the perceptions identified and the certainty or uncertainty of nurses' beliefs corresponding to the posed spirituality and spiritual care statements in the SSCRS. Utilizing a Likert scoring system a score of a "3" would be reflective of an uncertain response where a score of a "4" would reflect an "agree" or a more certain response to the posed statement.

For the purposes of this study, the researcher previously defined a nurses' perception to include a "level of awareness or understanding of a presenting concept" (McSherry et al., 2002, p. 731). The researcher wishes to assess whether nurses have an understanding, clarity, or an awareness of the presenting concepts identified by McSherry
(2000) as reflective of spirituality and spiritual care in nursing. The information gained from this analysis may then be used to suggest possible areas of additional research to further clarify conceptual meaning in the nursing profession.

Research Question Two: Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the employing institution, that is, hospital (sectarian) and private practice (nonsectarian) setting? The purpose of this question was to explore whether nurses’ perceptions vary significantly based upon their location of practice in a religious or a nonreligious institution. Group comparisons were made using means, standard deviations, and analysis of variance or ANOVA with a $p$ level of less than .05.

Research Question Three: Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon years of service within profession, that is, less than 1 year, 1 to 5 years, 6 to 10 years, 11 to 24 years, and 25 years or greater? The purpose of this question was to determine whether nurses’ perceptions vary significantly based upon the number of years they had worked in the healthcare setting. Comparisons between each of the groups were made using means, standard deviations, and analysis of variance or ANOVA with a $p$ level of less than .05.

Research Question Four: Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the completed educational degree, that is, Associate Degree (A.D.), Bachelors Degree (B.S.), Masters Degree (M.S.), or Doctoral Degree (Ph.D., Ed.D.) in nursing? Group comparisons were determined using means, standard deviations, and analysis of variance or ANOVA with a $p$ level of less than .05.
Summary

Nursing professionals at two healthcare organizations were surveyed using the SSCRS tool to explore their perceptions of spirituality and spiritual care. Comparisons were made between nursing groups based upon the location of practice, the length of service in the nursing profession, and the completed educational degree. The SSCRS survey instrument developed by McSherry (2000) was distributed to the selected participants with methods focused upon ensuring quality research and the protection of each subject. The chapter ended by examining the data analysis plan including the statistical methods to address each of the proposed research questions.

In the next chapter the researcher outlines the findings of the study. Analysis of the demographic data and the SSCRS survey responses will be described in detail. Each of the research questions will then be analyzed to determine significance in the sample population.
Chapter 4

ANALYSIS OF THE DATA

This research study focused upon understanding nurses’ perceptions of spirituality and spiritual care. Participant group responses were compared based upon the: (a) location of practice, that is, sectarian or hospital setting and nonsectarian or private practice setting; (b) years of service in the nursing profession, that is, less than 1 year, 1 to 5 years, 6 to 11 years, 11 to 24 years, and 25 years or greater; and (c) completed educational degree, that is, Associate Degree (A.D.), Bachelors Degree (B.S.), Masters Degree (M.S.), or Doctoral Degree (Ph.D., Ed.D.). The SSCRS tool developed by McSherry (2000) was used to survey a convenience sample of nursing responses in two healthcare locations.

Analysis of the data begins with a demographic review of the participants in the study. A summary of the total group responses is also presented. Last, each research question is analyzed through outlining pertinent statistics.

Demographic Data

Convenience sampling methods allowed the researcher to survey a large number of nurses at both healthcare organizations. The researcher determined approximately 1200 nurses met the criteria for inclusion in the study. A total of 533 completed surveys out of the 612 distributed yielding a response rate of 87%. Half of the total available group participated in this study with the researcher identifying factors for this number. These factors included the researcher encountering a wide variety of work schedules ranging from days to nights and weekends, a relatively large number of on-call and part-time employees, and nurses being sent home due to low patient census. The relatively
large response rate was felt to be in part due to the methods of distribution, that is, face-to-face contact with the participants through introduction of the study by the researcher in departmental meetings. The demographic data were then grouped according to location of practice, years of service in nursing, and educational level of the nurse (see Table 1).

Table 1

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<tr>
<th>Summary of Participant Demographic Data</th>
<th>Nurses (n = 533)</th>
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<tr>
<td><strong>Location of Practice</strong></td>
<td></td>
</tr>
<tr>
<td>Hospital (Sectarian)</td>
<td>431</td>
</tr>
<tr>
<td>Private Practice (Non-Sectarian)</td>
<td>102</td>
</tr>
<tr>
<td><strong>Years of Service</strong></td>
<td></td>
</tr>
<tr>
<td>Less than one year</td>
<td>15</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>80</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>98</td>
</tr>
<tr>
<td>11 to 24 years</td>
<td>206</td>
</tr>
<tr>
<td>25 years or greater</td>
<td>134</td>
</tr>
<tr>
<td><strong>Educational Level</strong></td>
<td></td>
</tr>
<tr>
<td>Diploma (D)</td>
<td>80</td>
</tr>
<tr>
<td>Associate (AD)</td>
<td>246</td>
</tr>
<tr>
<td>Bachelor (BS)</td>
<td>172</td>
</tr>
<tr>
<td>Masters (MS)</td>
<td>34</td>
</tr>
<tr>
<td>Doctorate (Ph.D., Ed.D.)</td>
<td>1</td>
</tr>
</tbody>
</table>

The number of nurses who participated in the survey totaled 533. The majority of nurses were employed in a hospital or sectarian organization (80.9%) with 19.1% employed in a private practice or nonsectarian location. The nurses employed for 11 to 24
years made up 38.7% of the group with nurses employed 25 years or greater making up 25.1% for a combined total representing 63.8% of the entire sample. A small number of the total surveyed had been a nurse for 6 to 10 years (18.4%) or 1 to 5 years (15%) with only 2.8% employed as a nurse for less than 1 year. Almost half of the nurses surveyed held an Associate Degree (46.1%) followed by the nurses with a Bachelors Degree (32.3%) for a combined total of 78.4% of the total group. The third largest group were nurses with a Diploma Degree (15%) followed by a Masters Degree (6.4%). Only one nurse held a Doctoral Degree (0.2%). Advanced level degrees, that is, Masters and Doctoral Degrees, accounted for only 6.6% of the total group. The demographic statistics provide valuable background information in examining nurses’ perceptions of spirituality and spiritual care using the SSCRs survey.

SSCRS Total Group Analysis

The purpose of this study was to explore nurses’ perceptions of spirituality and spiritual care using the SSCRs survey. The SSCRs survey, developed by McSherry (2000), consisted of 17 statements related to spirituality and spiritual care. Survey responses were scored and then grouped into two categories, namely, those questions related to spirituality and those questions related to spiritual care. Total group calculation of means, standard deviations, and analysis of variance will be discussed below.

Total Group Analysis Related to Spirituality

The SSCRs survey consisted of 17 Likert scale items ranked from one to five. On the SSCRs survey participant responses corresponded to the following rankings: (a) a “1” corresponded to strongly disagree, (b) a “2” corresponded to disagree, (c) a “3” corresponded to uncertain, (d) a “4” corresponded to agree, and (e) a “5” corresponded to
strongly agree (McSherry, 2000, p. 172). The determination of the mean and standard deviation scores related to spirituality and spiritual care for the total group will determine the certainty or uncertainty of nurses’ perceptions related to the posed spirituality statements in the SSCRS. Utilizing a Likert scoring system, a score of a “3” would be reflective of an uncertain response, a score of a “4” would be reflective of an agreement response, and a “5” would be reflective of a strongly agree response. Scores of a “4” or a “5” would identify more certain responses to the posed spiritual care statements.

In order to examine the total group in relation to the concept of spirituality the researcher categorized the responses from those statements addressing spirituality, that is, statements C, D, E, F, I, J, L, M, O, P, and Q from the survey. A total of 11 items represented questions relating to nurses’ perceptions regarding spirituality. Statistical analysis of the total group of nurses’ perceptions related to spirituality determined a mean score of 3.31 and a standard deviation of 0.33 falling within the category of an uncertain response according to the SSCRS survey scale (see Table 2).

Total Group Analysis Related to Spiritual Care

Analysis of the total group mean and standard deviation in relation to the concept of spiritual care involved categorizing the remaining six statements on the SSCRS survey. Assuming the same Likert ranking system from one to five for the category of spiritual care, the researcher categorized the remaining six statements, that is, A, B, G, H, K, and N to obtain a mean and standard deviation for the total group relating to spiritual care. The determination of the mean and standard deviation scores of spiritual care for the total group will determine the perceptions identified as the certainty or uncertainty of nurses’ beliefs corresponding to the posed spiritual care statements in the SSCRS.
Utilizing the same Likert scoring system, a score of a “3” would be reflective of an uncertain response, whereas a score of a “4” would reflect an agree, and a score of a “5” would reflect a strongly agree or a more certain response to the posed statements.

Data were again analyzed using Excel software to determine statistical analysis yielding a total group mean for the category of spiritual care of 4.38 with a standard deviation of 0.50. This score found that nurse’s ranked spiritual care within the “agree” category inferring a more definitive response compared to the mean score related to spirituality (3.31) ranking an “uncertain” as previously identified. Comparisons between the means and standard deviations were identified for spirituality and spiritual care for the total group (see Table 2).

Table 2

<table>
<thead>
<tr>
<th></th>
<th>Spirituality</th>
<th>Spiritual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td>Mean</td>
<td>3.31</td>
<td>4.38</td>
</tr>
<tr>
<td>Standard Deviation</td>
<td>0.33</td>
<td>0.50</td>
</tr>
</tbody>
</table>

A 3.31 mean with a standard deviation of 0.33 identified two-thirds of the nurses’ responses fell within a range of 2.98 to 3.64 identified as uncertain. In contrast, nurses as a total group scored spiritual care statements with a mean of 4.38 and a standard deviation of 0.50 identifying two-thirds of respondents fell within a scoring range of 3.88 to 4.88 closely identified with the agree category determining a more definitive response. Reviewing the total group responses to the SSCRS survey indicated nurse’s perceived spirituality as an uncertain concept while spiritual care practices were definitively and clearly determined by the surveyed nurses.
Analysis of the Research Questions

The analysis of the collected data will begin by specifically addressing each of the four research questions. The first research question will explore nurse’s perceptions related to spirituality and spiritual care. The aim of this researcher was to examine the clarity of nurses’ perceptions related to spirituality and spiritual care. Research questions two through four will be analyzed to determine if statistically significant differences existed between the nurses’ perceptions of spirituality and spiritual care based upon the location of practice, the years of service in the nursing profession, and the educational level of the nurse.

*Research Question One*

The first research question asked, “What are nurses’ perceptions of spirituality and spiritual care in the hospital and private practice setting?” Total group participant mean scores were calculated for statements relating to spirituality and spiritual care. A total group mean and standard deviation were then determined as described in Table 2. The mean score for spirituality from the total group was a 3.31 with a standard deviation of 0.33 while the mean score for spiritual care was a 4.38 with a standard deviation of 0.50. These scores indicated that nurses’ perceptions concerning spirituality are uncertain or less clearly defined. Their perceptions related to spiritual care, in contrast, demonstrate definitive answers depicting clarity of understanding to spiritual care practices in nursing.

*Research Question Two*

The second research question asked, “Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the employing institution, that is, hospital (sectarian) and private practice setting (nonsectarian) setting? To answer
this question, the researcher began by sorting the nurses’ responses by location using Excel software. Mean scores and standard deviations were calculated for the hospital and the private practice groups (see Table 3).

Table 3

*Means and Standard Deviations by Location*

<table>
<thead>
<tr>
<th>Location</th>
<th>Spirituality</th>
<th>Spiritual Care</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>M</td>
<td>SD</td>
</tr>
<tr>
<td>Hospital</td>
<td>3.32</td>
<td>0.11</td>
</tr>
<tr>
<td>Private Practice</td>
<td>3.30</td>
<td>0.11</td>
</tr>
</tbody>
</table>

The results demonstrated the hospital group identified spirituality questions with a mean score of 3.32 and a standard deviation of 0.11. Likewise, the private practice nurses identified the spirituality questions with a mean score of 3.30 and a standard deviation of 0.11. The spiritual care questions also showed little difference between the means and standard deviations. The mean score for spiritual care of hospital nurses was a 4.38 with a standard deviation of 0.24 similar to the private practice nurses mean score of a 4.39 with a standard deviation of 0.27. Therefore, the analysis of the data by location of practice showed little difference in the nurses’ perceptions of spirituality and spiritual care (see Table 3).

ANOVA data analysis was also determined appropriate to identify whether significant differences existed between the nurses’ perceptions for the hospital and private practice groups related to spirituality and spiritual care (see Table 4). The results
showed neither the nurses’ responses from the hospital (sectarian) nor the nurses’ responses from the private practice (nonsectarian) group were significantly different in relation to spirituality ($p$ value of 0.7) or in relation to spiritual care ($p$ value of 0.8).

Table 4

*Analysis of Variance by Location*

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirituality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>1</td>
<td>0.01</td>
<td>0.11</td>
<td>0.7</td>
</tr>
<tr>
<td>Within Groups</td>
<td>531</td>
<td>0.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>1</td>
<td>0.01</td>
<td>0.04</td>
<td>0.8</td>
</tr>
<tr>
<td>Within Groups</td>
<td>531</td>
<td>0.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: $p < .05$*

*Research Question Three*

The third research question asked, “Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon years of service within the profession, that is, less than 1 year, 1 to 5 years, 6 to 10 years, 11 to 24 years, and 25 years or greater? Once again the researcher began by sorting the nurses’ responses based upon years of service using Excel software. Mean scores and standard deviations were calculated for the groups (see Table 5).
<table>
<thead>
<tr>
<th>Service</th>
<th>Spirituality</th>
<th></th>
<th>Spiritual Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>$M$</td>
<td>$SD$</td>
<td>$M$</td>
<td>$SD$</td>
</tr>
<tr>
<td>Less than 1 year</td>
<td>3.29</td>
<td>0.07</td>
<td>4.30</td>
<td>0.46</td>
</tr>
<tr>
<td>1 to 5 years</td>
<td>3.26</td>
<td>0.11</td>
<td>4.33</td>
<td>0.15</td>
</tr>
<tr>
<td>6 to 10 years</td>
<td>3.32</td>
<td>0.08</td>
<td>4.33</td>
<td>0.24</td>
</tr>
<tr>
<td>11 to 24 years</td>
<td>3.29</td>
<td>0.10</td>
<td>4.37</td>
<td>0.26</td>
</tr>
<tr>
<td>25 years or greater</td>
<td>3.39</td>
<td>0.13</td>
<td>4.49</td>
<td>0.27</td>
</tr>
</tbody>
</table>

The results demonstrated variation in the means concerning spirituality among the service groups. From these groups, the “less than 1 year,” “1 to 5 year,” and the “11 to 24 year” groups had the lowest means with a 3.29, 3.26, and a 3.29 respectively. The means for the “6 to 10 year” and the “25 year or greater” service groups scored higher with a 3.32 and a 3.39 respectively. Results for the service groups in relation to the spiritual care also showed variation among the means. The “less than 1 year” group identified the lowest mean of a 4.30 with the “25 year or greater” service group identifying a mean score of a 4.49 which was the highest mean. The remaining service groups demonstrated similar means from a 4.33 to a 4.37. Analysis of the data in relation to service groups identified differences in mean scores for spirituality and spiritual care (see Table 5).

ANOVA data analysis was determined appropriate to identify whether significant differences existed between the nurses’ perceptions for the service groups related to
spirituality and spiritual (see Table 6). The findings indicated nurses’ perceptions of spirituality were statistically significantly, with a determined $p$ value of 0.03, based upon years of service in the nursing profession. This researcher identified this finding as a significant outcome of the research study. Based upon the years of service in the nursing profession, the nurses’ perceptions of spirituality in this study were found to be significantly different. Although there also appeared a variation in the nurses’ perceptions of spiritual care based upon years of service the analysis of the data revealed there were no significant differences in nurses’ perceptions of spiritual care based upon the years of service in the profession ($p$ value of 0.07).

Table 6

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>$p$</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirituality</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>4</td>
<td>0.27</td>
<td>2.5</td>
<td>0.03*</td>
</tr>
<tr>
<td>Within Groups</td>
<td>528</td>
<td>0.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual Care</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>4</td>
<td>0.53</td>
<td>2.15</td>
<td>0.07</td>
</tr>
<tr>
<td>Within Groups</td>
<td>528</td>
<td>0.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

*Note: *$p < .05$

Research Question Four

The fourth research question asked, “Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the completed
educational degree, that is, Associate Degree (A.D.), Bachelors Degree (B.S.), Masters Degree (M.S.), or Doctoral Degree (Ph.D., Ed.D.) in nursing? Prior to data collection the researcher listed on the demographic sheet an additional educational category on the survey, named “other” followed by a blank line. This blank allowed participants to enter any additional or unlisted degrees. During analysis of the data the researcher noted an additional category, that is, a Diploma (D) Degree added by nurses. This educational level was subsequently added to the data analysis process to accommodate the entirety of participant responses.

The researcher began the data analysis by sorting the nurses’ responses based educational level using Excel software. The researcher determined data analysis at the doctoral level was inappropriate based upon one doctoral nurse participating in the research. The survey was subsequently eliminated. The mean scores and standard deviations were calculated for the groups based on educational level (see Table 7).

Table 7

*Means and Standard Deviations by Education*

<table>
<thead>
<tr>
<th>Education</th>
<th>Spirituality</th>
<th></th>
<th>Spiritual Care</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Spirituality</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Diploma Degree</td>
<td>3.30</td>
<td>0.13</td>
<td>4.39</td>
<td>0.32</td>
</tr>
<tr>
<td>Associate Degree</td>
<td>3.30</td>
<td>0.09</td>
<td>4.33</td>
<td>0.25</td>
</tr>
<tr>
<td>Bachelor Degree</td>
<td>3.33</td>
<td>0.11</td>
<td>4.44</td>
<td>0.20</td>
</tr>
<tr>
<td>Master Degree</td>
<td>3.36</td>
<td>0.13</td>
<td>4.45</td>
<td>0.24</td>
</tr>
</tbody>
</table>
The results demonstrated minimal variation by educational level of the nurse in relation to the means and standard deviations related to spirituality. Means ranged from a 3.30 for the Diploma Degree and Associate Degree to a 3.33 for the Bachelors Degree. The Masters Degree showed a mean of 3.36 identifying the highest mean for the group. Results for the educational levels in relation to the spiritual care showed slight variation among the means. The Associate Degree determined the lowest mean with a score of a 4.33 followed by the Diploma Degree with a mean of a 4.39. The Bachelor and Master Degrees demonstrated similar means with a 4.44 and a 4.45 respectively. Analysis of the data in relation to the educational level of the nurse identified minimal differences between in means and the standard deviations for spirituality and spiritual care.

ANOVA data analysis was determined appropriate to identify whether significant differences existed between the nurses’ perceptions for the identified educational levels related to spirituality and spiritual care. One doctoral nurse participated in the study with a resultant error occurring during the ANOVA analysis process. The survey was subsequently eliminated from the analysis process. Based upon the findings from the analysis there were no determined significant differences in nurses’ perceptions of either spirituality ($p$ value of 0.6) or spiritual care ($p$ value of 0.1) based upon the nurses’ educational degree (see Table 8).
Table 8

Analysis of Variance by Education

<table>
<thead>
<tr>
<th>Source</th>
<th>df</th>
<th>MS</th>
<th>F</th>
<th>p</th>
</tr>
</thead>
<tbody>
<tr>
<td>Spirituality</td>
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<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>3</td>
<td>0.06</td>
<td>0.5</td>
<td>0.6</td>
</tr>
<tr>
<td>Within Groups</td>
<td>528</td>
<td>0.11</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Spiritual Care</td>
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<td></td>
<td></td>
</tr>
<tr>
<td>Between Groups</td>
<td>3</td>
<td>0.47</td>
<td>1.9</td>
<td>0.1</td>
</tr>
<tr>
<td>Within Groups</td>
<td>528</td>
<td>0.25</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Note: p < .05

Summary

The primary purpose of this study was to better understand nurses’ perceptions of spirituality and spiritual care. Using the SSCRS survey, the researcher explored the perceptions of nurses in two Midwestern healthcare organizations. Analysis of the data revealed two major findings.

The first major finding identified nurses’ clearly perceive or recognize activities comprising spiritual care practices in the nursing profession while they are unclear regarding their perceptions of spirituality. Upon data analysis, spiritual care practices were identified by the participants with a mean score of 4.38 with a standard deviation of 0.50. This score fell within the “agree” category on the SSCRS thereby determining a definitive response when answering the presented spiritual care questions. The nurses are clear in their perceptions and understanding of spiritual care activities within nursing. In
contrast, nurses are unclear in their perceptions regarding spirituality. The group scores for spirituality had a mean of a 3.31 with a standard deviation of a 0.50. This score fell within the “uncertain” category identified by the SSCRS to the presented spirituality statements. This study found nurses’ perceptions remain unclear concerning their beliefs, attitudes, and ideas regarding spirituality in the nursing profession.

The second major finding from this study identified differences in nurses’ perceptions of spirituality based upon the years of service within the nursing profession. After performing analysis of variance tests, the researcher found statistically significant differences in nurses’ perceptions of spirituality based upon the years of service in the nursing profession with a $p$ value of .03. In this study, the data demonstrates nurses’ perceptions of spirituality were defined based upon the nurses’ experience. Nurses with 25 years or more experience in the profession demonstrated higher mean scores (3.39) to the spirituality statements compared to the less experienced nurse whose mean score ranged from 3.26 to 3.31. The years of service impact nurses’ perceptions of spirituality.

Statistical analysis of the remaining research questions found no statistically significant differences in nurses’ perceptions of spirituality based upon location of practice or educational level of the nurse. The researcher also found no statistically significant differences among the nurses’ perceptions of spiritual care based upon location of service, educational level, or years of service within the profession.

In Chapter 5, we will explore conclusions from these findings as well as discuss the limitations of the study. Possible implications including practical application of the findings and recommendations for future research will also be presented by the researcher.
Chapter 5

SUMMARY, CONCLUSIONS, DISCUSSION, RECOMMENDATIONS

The purpose of this study was to better understand nurses’ perceptions of spirituality and spiritual care. Nursing participants from two Midwestern healthcare organizations were surveyed using the SSCRS survey designed by McSherry (2000). Four research questions were formulated for the study to include:

1. What are the nurses’ perceptions of spirituality and spiritual care in the hospital and private practice setting?

2. Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the employing institution [i.e., hospital (sectarian) and private practice (nonsectarian)] setting?

3. Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon years of service within profession, that is, less than 1 year, 1 to 5 years, 6 to 10 years, 11 to 24 years, and 25 years or greater?

4. Are there significant differences among nurses’ perceptions of spirituality and spiritual care based upon the completed educational degree [i.e., Associate Degree (A.D.), Bachelors Degree (B.S.), Masters Degree (M.S.), or Doctoral Degree (Ph.D., Ed.D.)] in nursing?

Analysis of the survey data began using means and standard deviations. ANOVA statistical tests were used to reveal the existence of statistically significant differences among the identified groups. This chapter begins with the review and discussion of conclusions from the study. Specific limitations related to the study will then be presented followed by recommendations for future research.
Research Conclusions

The findings from quantitative research attempt "to advance the science base of the discipline by studying phenomena relevant to the goals of a discipline...to answer specific quantitative research questions...to draw conclusions about a broader base of people, events, or objects than those actually included in the particular study" (Munro, 2001, p. 3). Five conclusions will be presented in conjunction with the discussions generated from this study. This information may be used to support a greater understanding of spirituality and spiritual care practices in the nursing profession.

Research Finding One: Nurses Clearly Identify Spiritual Care Practices

The first research question identified nurses' perceptions of spirituality and spiritual care in two healthcare organizations. The data indicated nurses are clearly aware of those practices and activities comprising spiritual care inherent in the nursing profession becoming one of the major findings of this study. Although nurses remain unclear regarding their perceptions of spirituality, they are focused and decisive regarding the activities and practices of providing spiritual care for their patients. This finding has many implications, explored below, for the nursing profession.

The importance of understanding the essential components in spiritual care is vital to the essence of the nurse-patient relationship in meeting the identified needs of a patient, that is, providing for the totality of their healthcare needs. This research study supports the idea that nurses, indeed, are clearly aware of those activities and practices comprising spiritual care. Nurses consistently ranked the posed spiritual care questions with an "agree" or "strongly agree" response in this study. Such findings are consistent with Stephenson and Wilson (2004) who confirm the premise spiritual care is a positive
and essential component of nursing practice and “an important component of providing comprehensive nursing care” (p. 29).

The educational preparation of the nursing professional is based upon training individuals on care giving practices addressing the physical, mental/psychological, and spiritual needs of patients. This study supports the idea that nurses are able to identify these spiritual care practices and activities. Participant scores in relation to the presenting spiritual care questions consistently ranked between a “4” and a “5” with a total group mean of 4.38 and a standard deviation of 0.50. In this study, a “4” was identified as an agree and a “5” as a strongly agree response thereby supporting the idea that nurses’ recognize spiritual care giving practices. This finding was consistent with authors who reflect similar sentiment by acknowledging nurses who provide spiritual care address the “core of the human being, the human spirit; therefore nurses who give spiritual care are engaging the core of who they are in caring for others” (Van Dover & Bacon, 2001, p. 28). Such statements support the importance in the nurses’ ability to assess and identify care practices aimed at the spiritual nature of their patients. The data supported nurses are indeed aware and can clearly identify spiritual care practices. This finding reinforces the belief in providing holistic care for patients by focusing on physical, mental, and spiritual needs of the patient.

Research Finding Two: Nurses Remain Unclear in Defining Spirituality

The first research question also addressed nurses’ perceptions of spirituality. The data indicated nurses’ perceptions of spirituality as a total group were indecisive and inconclusive. These findings were not surprising based upon the expansive amount of research and articles devoted to identifying the concept of spirituality (Tanyi, 2002;
Dyson et al., 1997). Based upon the nurses’ perceptions in this research study, the data supported continued confusion on the essential components or the defining characteristics reflective of spirituality.

The nursing participants in this study found it difficult to clearly identify essential components of spirituality as evidenced by a total group mean of 3.31 with a standard deviation of 0.33 which was seen as “uncertain” on the SSCRS tool. Although one cannot surmise the reason for the nurses’ uncertainty, it may be reasonable to assume spirituality, as a concept, may not be clearly definable. Although researchers (Ross, 1994; Ross, 1995) have attempted to define essential components of spirituality to support knowledge and awareness of this concept, such attempts at defining this elusive phenomenon may no longer suffice. McSherry and Cash (2004) support similar thoughts by suggesting that “definitions and recommendations, rather than bring clarity, add to the confusion that surrounds the term spirituality” (p. 151). The authors developed a “spiritual taxonomy that may explain and accommodate the different layers of meaning found within nursing and healthcare definitions” (McSherry & Cash, 2004, p. 151). The findings emerging from this study seem to support a need for additional research to better understand spirituality from a nursing perspective.

*Research Finding Three: Nurses’ Perceptions of Spirituality and Spiritual Care are Not Significantly Different Based on Location of Practice*

The second research question addressed whether there were significant differences in the nurses’ perceptions of spirituality and spiritual care based upon the location of practice, whether it be a sectarian, hospital setting or a nonsectarian, private
practice setting. The data indicated nurses’ perceptions for both spirituality and spiritual care were similar and consistent in both organizations.

Although research (Van Dover & Bacon, 2001, p. 19) suggested both the expectations of the nurse and the healthcare institution concerning the nurses’ role in providing spiritual care may affect their beliefs and, therefore, provision of spiritual care, this study did not support such findings. The nurses’ perceptions in this study were similar with a mean for the hospital group of 3.31 and the private practice group with a mean of a 3.30. Through careful sampling procedures, this researcher felt the sample group was representative of the typical nursing professionals. Based upon the similar responses between the groups in this study, it is reasonable to conclude nurses’ perceptions of spirituality and spiritual care are not significantly different based upon the location of practice.

*Research Finding Four: Nurses’ Perceptions of Spirituality Differ While Perceptions of Spiritual Care are Similar Based Upon Years of Service*

The third research question addressed whether there were significant differences in the nurses’ perceptions of spirituality and spiritual care based upon their years of service in the profession. The years of service were divided into increments to include less than 1 year, 1 to 5 years, 6 to 10 years, 11 to 24 years, and 25 years or greater.

The data indicated nurses’ perceptions for spirituality differed significantly based upon the length of service in the profession. The researcher recognized this outcome as a major finding in the study. The data indicated the more experienced nurses practicing 25 years or greater felt stronger about spirituality by scoring the spirituality questions more decisively choosing the more definitive responses on the Likert scale. This was further
evidenced by the experienced nurses ranking the spirituality statements on the SSCRS survey with a mean of 3.39 as compared to the less experienced nurses whose means were lower ranging between a 3.26 and a 3.32. Based upon this participant group, analysis of variance showed nurses’ perceptions of spirituality differed significantly based upon their years of service within the profession as evidenced by a $p$ value of .03.

Findings from this study support the idea that a nurses’ professional experience within the healthcare setting affects their beliefs, attitudes, and ideas shaping their perceptions of spirituality. Findings from this data support the possibility of a developmental process or cycle in the professional life of a nurse as he/she moves from the newly graduated nurse to the experienced and more seasoned professional. This supports previous research (Lemmer, 2002, p. 489; Tuck et al., 2001, p. 603) citing the developmental stage of the nurse, the nurses’ life experiences, and the spiritual development of the nurse are critical factors in understanding and providing spiritual care in professional nursing practice.

Results from this study also found nurses’ perceptions of spiritual care did not differ significantly and were similar irrespective of their years of service in the profession. Statistical significance using analysis of variance determined a $p$ value of .07 aligning near the statistically significant level predetermined for this study ($p < .05$). This value was not determined to be statistically significant, yet there exists a notable trend toward higher mean scores for spiritual care based upon service group. This trend upward in spiritual care scores was evidenced by range of mean scores from 4.30 (less than one year group) to 4.48 (greater than 25 year group). This researcher recognized this progression toward higher means as worthy of consideration and supportive of the idea
that as nurses progress through their career they become more experienced and therefore, become aware of the activities defining their care giving role as a nurse. This idea also seems to support the first research finding, discussed previously, which found nurses as a total group were clear and definitive in identifying spiritual care practices. The data from this study supports the idea that, as a group, nurses are aware of the care giving practices defining the nurses’ professional role.

Research Finding Five: Nurses’ Perceptions of Spirituality and Spiritual Care are Not Significantly Different Based on Educational Level

The fourth research question addressed whether there were significant differences in the nurses’ perceptions of spirituality and spiritual care based upon the completed educational degree in nursing. Specific educational levels identified in this study were the Diploma, Associate, Bachelor, Masters, and Doctoral Degrees. Because only one Doctoral nurse participated in the study, this insufficient number did not allow analysis at the Doctoral level. The data in this study indicated nurses’ perceptions for both spirituality and spiritual care did not differ significantly across educational levels.

Examination of the spirituality mean scores among the various educational levels represented in this study ranged from a 3.30 for the Diploma and Associate Degrees to a 3.33 for the Bachelor Degree and a 3.36 for the Masters Degree. Likewise, the spiritual care mean scores ranged from a 4.38 and a 4.33 for the Diploma and Associate Degree levels rising to a 4.44 and a 4.45 for the Bachelor and Masters Degrees respectively. This researcher recognized that no significant differences were found among the groups represented based upon educational level. Again, the mean scores for the groups indicated an upward trend in for spirituality and spiritual care among educational levels,
thereby reflecting more distinctive and clear perceptions related to spirituality and spiritual care. Piles (1990) suggested the “level of practice of spiritual care by the nurse correlates to the educational exposure in the nurse’s basic program” (p. 38). Whether the rising trend noted this study in the nurses’ perceptions reflected by their mean scores is due to educational exposure in the nurses’ educational program would be an area of further study.

The differences in nurses’ perceptions in this study in relation to the educational level of the nurse were based upon 46% of the participants graduating from an Associate Degree program, 15% graduating from a Diploma Degree program, 32% graduating from a Bachelors Degree program, and 7% graduating from a Masters Degree program. The majority of nurses (61%) found in this study centered on graduates from Diploma and the Associate Degree programs. Conclusions made from this study based on one large group without similar representation across all educational groups may have affected the overall results. Based upon this study, it is reasonable to conclude nurses’ perceptions of spirituality and spiritual care in this sample did not significantly differ based upon the completed educational degree. Such data supports the idea that nurses’ perceptions of spirituality and spiritual care may be in greater part due to professional experiences of the nurse as earlier identified rather than through the nurses’ educational preparation.

Research Discussion

The research process aims to advance professional knowledge and support sound clinical practice within the nursing profession. Based upon this research study, the researcher identifies key findings which will be further discussed below.
The first finding from this study focuses on the solid understanding of care giving practices by nurses. It is evident that nurses are keenly aware of how to provide spiritual care for their patients. Examples such as showing kindness, concern and cheerfulness when giving care, spending time with a patient giving support and reassurance, and listening and allowing patients time to discuss and explore their fears, anxieties, and troubles were identified by nurses on the SSCRS survey as important aspects of spiritual care. Nurses know and clearly identify what comprises spiritual care giving practices today as they did during the establishment of the profession in Florence Nightingales' era. Based upon this finding, the researcher recognizes that as nurses remain committed to providing spiritual care they must also continue to focus time and attention beyond meeting only the physical needs of their patients. Holistic care remains the center of quality patient care focusing on all aspects including the physical, mental, and spiritual needs of the patient.

The second finding from this study demonstrated to the researcher that as nurse's progress through their career, their perceptions of spirituality are more defined and embellished. The data supported the idea that a nurse experiences a developmental progression in feelings, beliefs, and attitudes related to spirituality based upon experience within the profession. This becomes critical in further understanding and subsequently developing programs for nurses to better understand and meet the spiritual needs of their patients. In addition, this finding may support further research aimed at exploring the nurses' various developmental stages from career entrance to retirement from the career.

The third and incidental finding from this study focuses on the commitment and desire of the participants to assist in advancing knowledge in the area of spirituality and
spiritual care. This researcher found overwhelming support by the participants to better understand spirituality and spiritual care from the nursing perspective. Nurses consistently agreed to participate, requested clarification in the research process, and were eager to know findings from the study. This interest supports the idea that nurses are committed to care giving and helping practices as a professional nurse aimed at assisting both their patients and other nurses within the profession. This researcher recognizes this ongoing commitment by nurses as an inherent value reflected in the nurses’ vocational choice or calling.

Limitations

Research limitations take into account variables which may influence the outcomes of research. This project was one of few research studies examining nurses’ perceptions of spirituality and spiritual care using the SSCRS in the United States. Limitations will be presented in this section including: (a) the homogenous sample of the participant group, (b) the lack of statistically significant results when, in fact, there might be individual and/or clinical significance, (c) the timeframe chosen for data collection to achieve adequate sample sizes, and (d) the time and attention requested by participants to complete the survey.

The homogenous sample completing the SSCRS survey was identified as a possible limitation of the research project. As mentioned earlier, the participants were chosen by convenience sampling from two healthcare organizations located in a metropolitan Midwestern city in close proximity to each another. Although the researcher felt the sample was representative of a typical nursing professional the unforeseen level of homogeneity between the groups may have influenced the research results. Replication
in other locations and with larger sample populations would lend further credence to the survey results found in this study.

A second limitation of the study may have been the presence of clinically significant individual differences among the participants thereby affecting the research outcomes. Although no statistically significant differences were found between the nurses’ perceptions of spirituality and spiritual care based upon location of practice or educational level upward trends were noted in the mean scores for the educational and service groups. Such trends may be due to the individual differences between the nurses such as the nurses’ world view, their espoused religious or nonreligious affiliation, or their personal values and ethics. If such individual differences exist, the results obtained in this study would not be typical of nurses. Additional research related to individual nursing characteristics would be worthy of continued study.

The third limitation of this study involved the timeframe for completion. Prior to data collection the researcher determined the mode of distribution would include hand delivery of surveys to the nurses during the month of April 2004. As the sole distributor of the SSCRS survey, the researcher chose to hand deliver rather than mass mail the survey tool in anticipation of higher completion rates. The result was, in fact, a completion rate of 87% which was felt to be significantly adequate. The researcher recognizes obtaining additional responses from nurses who completed a Masters or Doctoral program may have been achieved by extending the distribution timeframe ensuring access to an even larger representative number of nurses throughout all demographic categories included in this study.
A fourth identified limitation of the study focuses upon the time and attention requested by nurses to complete the survey. It is possible that requesting time from the nurses’ busy schedules to complete the survey may have influenced completion in a haphazard manner. Although the researcher primarily presented the survey to participants in departmental meetings, the researcher cannot account for the quality of responses from the participants. In addition, it is also possible that extraneous variables may have affected the overall participant results such as (a) bringing attention to the subject of spirituality and spiritual care, (b) discussions among the participants themselves concerning the study, and (c) support by departmental managers allowing nurses the time to participate in the study. These factors may have created a heightened awareness in the nurse which may have affected the results of this research.

Future Research Recommendations

McSherry and Cash (2004) stated, “It is evident that the term spirituality has become fashionable in nursing” (p. 151). In order to support a credible knowledge base related to spirituality and spiritual care in nursing, there exist multiple opportunities for future research. The results from this study suggested five areas for future research.

This study was a beginning attempt to better understand nurses’ perceptions of spirituality and spiritual care from the nursing perspective. Replication of this study across different population groups and locations would lend further credence to the results found in this study. Repeated attempts to better understand nurses’ perceptions of spirituality and spiritual care will create additional knowledge in the field of nursing. Such knowledge is important because consensus exists among practitioners that a vital part of nursing practice is the “exploration of the spiritual domain as well as the physical,
emotional, and social aspects of being human" (Long, 1997, p. 507). In order for the nursing professional to successfully meet patient identified spiritual needs, the nurse must begin by becoming aware of those practices and activities which support the spiritual nature and care of the patient. This researcher would like to see open dialogue among nursing professionals aimed at addressing the spiritual needs of the patient. In addition, the profession would benefit through creating focus groups dedicated to the development of quality programs focusing on nursing spirituality assessment and the provision of spiritual care for patients. Once those skills, abilities, and practices of the nurse have been identified and developed to address spirituality and spiritual needs, the nurse may alignment such practices with patient expectations to provide high quality nursing care. Nurses function in a vital role assisting patients to achieve optimal health. In this setting, continued research in this area supports knowledge generation which becomes the springboard to growth and increased understanding between nursing professionals, the multidisciplinary healthcare team, and the patient.

A second area of future research related to this study would involve expanding participant sample groups across longer timeframes. For example, only those nurses who were employed at healthcare organizations were included in this study. Based upon Piles (1990) research, it would be important to include nursing students from various types of educational programs and possibly follow their perceptions of spirituality and spiritual care throughout their employment as a nurse. Since statistically significant results were found based upon the years of service it would be interesting to compare more closely the nurses’ perceptions as a student nurse throughout his/her stages of development into a seasoned nurse. Such information would support knowledge and educational training of
nurses at various developmental stages from the beginning of their educational program throughout their clinical career.

An expansion in the collection of demographic data would be a third area of possible future research. This study focused upon the three categories of location of practice, educational level of the nurse, and years of service in the profession. There may be additional individual variables influencing nurses’ perceptions of spirituality worthy of consideration. Additional areas for quantitative or qualitative spirituality research might include the gender of the nurse, the circumscribed religious or spiritual affiliation of the nurse, the specialty field of nursing practice, or the philosophy of the nurse’s educational program. Such information would support defining characteristics influencing nurses’ perceptions of spirituality and spiritual care which, in turn, could be used to further develop and support effective nurse-patient interactions in the clinical setting.

A fourth area of future research, based upon this study, would involve examining current nursing educational curriculum surrounding spirituality and spiritual care. Based upon the documented confusion that currently exists in nursing educational programs and among faculty teaching in these programs, the assessment of existing teaching principles, strategies, and tools would be worthy of study. This researcher would like to see additional qualitative observational studies to identify effective teaching methods aimed at expanding knowledge related to the role of spirituality and spiritual care in nursing.

Additional future research also centers upon the SSCRS survey. The SSCRS was the only quantitative spirituality and spiritual care assessment tool found within the literature. The versatility, clearly written statements, and ease in participant completion are key strengths of this tool. In order to support consistency in the research conducted
using the SSCRS, McSherry et al. (2002) recommended that the components identified in the SSCRS related to spirituality and spiritual care be subsequently tested to determine stability in the identified factors (p. 731). Although this study supports previous research conducted by McSherry et al. (2002), it is reasonable to assume additional testing of the survey tool would lend further credibility to the SSCRS as a valid instrument for measuring nurses’ perceptions of spirituality and spiritual care.

The Researcher’s Future Agenda

This researcher acknowledges a personal commitment and passion to continue research in the area of spirituality and spiritual care in nursing. Additional spirituality research will focus in both the qualitative as well as the quantitative tradition. Future study conducted by this researcher will focus upon the nursing professional to develop a strong knowledge base in the area of spirituality and spiritual care.

The nursing professional assumes a vital role in care giving practices and interactions with the patient during times of healthcare crisis. The nursing professional focuses his/her care on meeting identified patient healthcare needs in order to support the development, creation, or maintenance of optimal health. The key to meeting patient needs is the development of keen assessment skills. This researcher would like to continue study in the area of assessment practices of the nurse specifically focusing on the spiritual needs of individuals. Findings from the present study supported the idea that nurses are clearly aware of their spiritual care giving practices. To provide spiritual care, the nurse must possess keen assessment skills to identify the spiritual care needs of the patient. By conducting qualitative observational research, this researcher would observe nursing professionals to identify spiritual care assessment practices. Once these practices
have been identified, this researcher would like to begin the formulation of an assessment tool that may be used in the clinical practice and educational settings.

This researcher would also like to examine nurses' perceptions of spirituality and spiritual care across the professional career of the nurse. This interest is based upon the findings from the present research study which supported differences in the nurses' perceptions related to spirituality based upon years of service within the profession. This researcher would like to closely follow nurses who are at the beginning and the end of their careers. Longitudinal or observational research would allow this researcher to examine the existence of developmental stages in a nurses' career. Knowledge gained from this type of study could then be used to further develop mentoring roles within nursing in which a newly employed nurse is aligned with a seasoned nurse to support understanding surrounding spirituality and spiritual care in nursing. Presently, the nursing profession utilizes preceptor-type relationships for newly hired nurses to learn the technical skills required of the nursing role. This researcher would like to use a mentoring model to further develop the nurses' skills specifically in the area of spirituality and spiritual care. This may be best supported through a mentoring relationship established early in the nurses' career. Based upon these findings, the researcher would like to continue study in the area of spirituality and spiritual care by focusing on the developmental stages of nurses through their professional career.

Another area of future study would involve examination of the nurses' self awareness in understanding their spirituality and the effect of this on their professional practice. The current research project did not explore the nurses own spirituality but rather the perceptions of the nurse in relation to spirituality and spiritual care for their
patients. This researcher would like to expand study into the area of the nurses’ personal awareness of their own spirituality and the resultant effect upon the provision of spiritual care. Such research would focus on qualitative interviews with nurses to identify individual factors affecting the provision of spiritual care. Such factors for further study might include the nurses’ world view, their religious or nonreligious affiliation, and their personal ethics, their guiding philosophy, or their life experiences. This researcher desires to closely explore, on an individual level, those factors which may affect nurses addressing and meeting the spirituality or spiritual care needs of with their patients.

Summary

Spirituality and spiritual care are receiving increased attention both in the nursing literature and the clinical setting (McSherry & Cash, 2004, p. 151). Spirituality and spiritual care in the profession of nursing are closely aligned with focusing on the whole person, that is, the body, mind, and spirit in providing optimal and high quality medical care. The overall purpose of this study was to better understand nurses’ perceptions of spirituality and spiritual care within the healthcare setting.

Attempts continue within the literature and the practice setting to address the role of spirituality within the nursing profession (Freidemann et al., 2002). A major finding of this study found nurses, as a group, were clearly aware and decisive regarding the practices comprising spiritual care activities for their patients. This finding has clinical implications in becoming a foundation for defining the nursing role in the provision of optimal healthcare practices for patients displaying spiritual needs. In this study, nurses clearly identified essential care giving practices to meet the spiritual needs of patients. This finding assists practitioners to better understand the role of spirituality in healthcare.
A second major finding in this study involved the impact of years of service upon the nurses’ perceptions of spirituality. This study found the experienced nurses responded more strongly to the presented spirituality questions as compared to the younger, less experienced nurses. Authors suggest the nurses’ experiences may affect the provision of spiritual care (Lemmer, 2002, p. 489) while others acknowledge the developmental stage of the nurse is a critical factor to examine in providing spiritual care (Tuck et al., 2001, p. 603). The findings from this study support the idea that nurses perceptions of spirituality differed based upon their experiences within the nursing profession. This is an exciting area for continued study.

Spirituality and spiritual care are blocks built solidly into the foundational core of the nursing profession. Nursing professionals in this study provided invaluable insights into the spirituality and spiritual care perceptions of nurses. As nursing professionals we hold the essential and compassionate skills and abilities to support our patients overall well-being, physically, mentally, and spirituality.
References


For each question please circle one answer that best reflects the extent to which you agree or disagree with each statement.

a) I believe nurses can provide spiritual care by arranging a visit by the hospital chaplain or the patient's own religious leader if requested.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

b) I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

c) I believe spirituality is concerned with a need to forgive and a need to be forgiven.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

d) I believe spirituality involves only going to church/place of worship.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

e) I believe spirituality is not concerned with a belief in a God or a Supreme Being.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree

f) I believe spirituality is about finding meaning in the good and the bad events of life.

   Strongly disagree  Disagree  Uncertain  Agree  Strongly agree
Appendix A

SPIRITUALITY AND SPIRITUAL CARE RATING SCALE (SSCRS)

For each question please circle one answer that best reflects the extent to which you agree or disagree with each statement.

a) I believe nurses can provide spiritual care by arranging a visit by the hospital chaplain or the patient's own religious leader if requested.

   Strongly disagree * Disagree * Uncertain * Agree * Strongly agree *

b) I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care

   Strongly disagree * Disagree * Uncertain * Agree * Strongly agree *

c) I believe spirituality is concerned with a need to forgive and a need to be forgiven

   Strongly disagree * Disagree * Uncertain * Agree * Strongly agree *

d) I believe spirituality involves only going to church/place of worship

   Strongly disagree * Disagree * Uncertain * Agree * Strongly agree *

e) I believe spirituality is not concerned with a belief and faith in a God or a Supreme Being

   Strongly disagree * Disagree * Uncertain * Agree * Strongly agree *

f) I believe spirituality is about finding meaning in the good and the bad events of life

   Strongly disagree * Disagree * Uncertain * Agree * Strongly agree *
g) I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need

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h) I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in his or her illness

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i) I believe spirituality is about having a sense of hope in life

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j) I believe spirituality is to do with the way one conducts one’s life here and now

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k) I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties, and troubles

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l) I believe spirituality is a unifying force which enables one to be at peace with oneself and the world

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m) I believe spirituality does not include areas such as art, creativity, and self-expression

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n) I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient

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o) I believe spirituality involves personal friendships and relationships

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p) I believe spirituality does not apply to atheists or agnostics

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q) I believe spirituality includes people’s morals

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THANK YOU FOR YOUR TIME!

Appendix B

PERMISSION TO USE SSCRS

Date: September 22, 2003

Ms. Kim Oswald

Dear Ms. Oswald

Publication details: Spirituality and Spiritual Care Rating Scale from McSherry: MAKING SENSE OF SPIRITUALITY IN NURSING PRACTICE: AN INTERACTIVE APPROACH, © 2002 Elsevier Ltd.

As per your letter dated July 30, 2003, we hereby grant you permission to reprint the aforementioned material at no charge in your thesis subject to the following conditions:

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Yours sincerely,

Nicole McIntyre
for Elsevier

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Appendix C

DEPARTMENTAL NURSING MANAGER CONSENT TO PARTICIPATE

Dear Nursing Manager:

I am currently a Drake University doctoral candidate who is conducting my dissertation research on nurses’ perceptions of spirituality and spiritual care. Results from this study will allow us to better understand nurses’ beliefs regarding spirituality and spiritual care in healthcare.

I am particularly desirous of obtaining your permission to survey your nursing staff. For this study, I have defined spirituality and spiritual care as encompassing the following elements: (a) a need to find meaning, purpose, and fulfillment in life or illness, (b) a need for hope and a will to live, and (c) the need for a belief or faith in self, others, a Higher Power or God.

Data for this research will be collected using the Spirituality and Spiritual Care Rating Scale (SSCRS) developed in the United Kingdom. This survey is a 17-item, Likert scale instrument covering four main areas, namely, spirituality, spiritual care, religiosity, and personalized care.

Nurses’ responses are extremely important to provide valuable data to better understand spirituality and spiritual care. The survey has been pilot tested to ensure quality questioning and may be completed in approximately 10 minutes. My research has received approval from the Drake University Institutional Review Board and the nursing administrator of your organization.

I will request nurses to voluntarily participate in this research project. I would also request that you agree their participation is voluntary and that their participation or lack of participation will in no way negatively affect their present job. Nurses’ responses will be kept confidential with no individual results reported. If you are interested, I would be happy to provide you a summary of my results upon completion of the research project by contacting me at (515) 235-5052.

In order to survey your nurses, I am requesting your approval. If you approve, I will contact you to arrange a brief orientation meeting that will not disrupt patient care practice in your department. Please mark your decision and return via email by (insert date) to the address listed below. I appreciate both your time and cooperation and thank you for your part in advancing nursing knowledge surrounding the concept of spirituality!

Kim D. Oswald, RN, MSN, Ed.S.,
Doctoral Candidate
Drake University School of Education

_____ Yes, I do allow nurses on my unit to participate

_____ No, I do not allow nurses on my unit to participate

________________________  __________________________  ________________
Nursing Manager Name     Daytime Phone Number     Date

*** Please return this completed form to: koswald@iowaheart.com ***
Appendix D

DEMOGRAPHIC DATA SURVEY

Please provide the following demographic information. It is very important that you answer all the questions. There are no right or wrong answers to this survey. The survey should take you approximately 10 minutes to complete.

PARTICIPANT DEMOGRAPHIC INFORMATION
(Please check appropriate blank)

1. Employing institution:  
   ______ Hospital  
   ______ Private Practice

2. Completed nursing degree:  
   _____ Associate Degree (AD)  
   _____ Bachelor Degree (BS)  
   _____ Master Degree (MS)  
   _____ Doctoral Degree (Ph.D., Ed.D.)  
   _____ Other: Please list: _______________

3. Employment length in nursing:  
   _____ less than 1 year  
   _____ 1 to 5 years  
   _____ 6 to 10 years  
   _____ 11 to 24 years  
   _____ 25 years or greater
Appendix E

INSTITUTIONAL REVIEW BOARD APPROVAL
(DRAKE UNIVERSITY)

Kim Oswald

Dear Kim,

The Institutional Review Board of Drake University agreed that the following protocol is exempt from IRB committee approval: Nurses’ Perceptions of Spirituality and Spiritual Care. This protocol has been assigned the following ID number: IBR2003-04022. Please refer to this number in all future correspondence regarding this protocol.

Your study has been approved for the period of March 7, 2004 to March 7, 2005.

Changes in the protocol or consent form may not be implemented without prior IRB review and approval, except when necessary to eliminate immediate hazard to research subjects.

Each investigator is responsible for notifying the IRB whenever approval of the study or investigator is withdrawn by the sponsor, HHS or FDA. Also, the investigator shall notify the IRB if the study is discontinued at any time other than the scheduled completion date, and an investigator is required to report promptly to the IRB, within 24 hours, any serious adverse events occurring to subjects during time of the protocol.

Please contact me if I can be of further assistance.

Sincerely,

[Signature]

Jennifer McCrickerd
Chair, Institutional Review Board

5/7/04
Appendix F

INSTITUTIONAL REVIEW COMMITTEE APPROVAL
(HOSPITAL)

February 13, 2004

Kim Oswald, RN, MSN, Ed.S.

RE: “Spirituality and Spiritual Care Doctoral Dissertation” - Approval

Dear Ms. Oswald:

On February 13, 2004, the Institutional Review Committee approved, by majority vote, the IRC Protocol Application, Protocol (Details of the Study), Participant Consent, Departmental Nursing Manager Consent, and the Data Survey Instrument for the following:

“Nurses’ Perceptions of Spirituality and Spiritual Care”

We understand that this data will be used for your Doctoral Dissertation. The approved Survey and Informed Consents are enclosed. This approval is for the period of one year unless an earlier or more frequent review is deemed appropriate or you terminate the study. Any changes in the Protocol, Amendments, or survey must be forwarded to the IRC for approval.

All documentation will be maintained in the study file per FDA/DHHS Regulations and IRC Guidelines.

Sincerely,

Rosemary Mullin, R.N., M.S.
Coordinator, IRC, MMC-DM

RM/pc
Appendix G

PARTICIPANT CONSENT FORM

Dear Nursing Professional:

I am a doctoral candidate at Drake University conducting dissertation research that is aimed at exploring nurses’ perceptions of spirituality and spiritual care. The attached survey is part of a research study of 400 nurses being conducted in a hospital and private practice setting. Study results will be used to better understand nurses’ beliefs and feeling regarding spirituality and spiritual care in healthcare. This research project has been approved by the Mercy Medical Center, Des Moines Institutional Review Committee on February 2, 2004 and the Drake Institutional Review Board on March 17, 2004.

I am particularly desirous of obtaining your responses because of your experience as a nursing professional. Your answers are extremely important and will provide valuable insight concerning spirituality. The enclosed survey was pilot tested by nurses to ensure quality questioning which could be completed in a minimum amount of time. There are no anticipated risks to you as a participant. The benefits of participating in this project include the expansion of the knowledge base surrounding spirituality and spiritual care in healthcare.

Research data will be collected using the Spirituality and Spiritual Care Rating Scale (SSCRS). The SSCR is a 17-item, Likert scaled instrument covering the four areas of spirituality, spiritual care, religiosity, and personalized care. The survey takes approximately 10 minutes to complete.

All responses will be reported in summary format with individual responses kept strictly confidential. Your manager will not receive any individual results. If you feel the need to withdraw from this study, you may do so at any time without repercussion. In addition, your participation or lack of participation will in no way affect your current job, evaluation, or employment status.

I would be happy to provide you a copy of the research summary results upon request by contacting me at (515) 235-5052 or via email at koswald@iowaheart.com.

Your responses are extremely valuable. I would appreciate candid answers to the survey questions. In order to use the information in my dissertation paper and in the event the information may be included in an article submitted for publication, I will need your consent to participate in this study.

If you agree to participate, please sign and date below. Your signature serves as consent to participate and a willingness to complete the survey. I appreciate your time and want to thank you for your individual part in advancing nursing knowledge related to spirituality.

Kim D. Oswald, RN, MSN, Ed.S.
Doctoral Candidate
Drake University School of Education

I hereby give my consent to participate in a survey for this study on spirituality.

________________________________________  __________________________
Signature of Participant                        Date