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Teaching the Spiritual Dimension of Nursing Care: A Survey of Associate Degree
Nursing Programs in the Southeast United States

A dissertation
presented to
the faculty of the College of Nursing
East Tennessee State University

In partial fulfillment
of the requirements for the degree
Doctor of Philosophy in Nursing

by
Nancy LaBine
December 2015

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Dr. Patti Vanhook
Dr. Florence Weierbach
Dr. Beverly Lunsford

Keywords: Spirituality, Spiritual Care, Spirituality in Nursing Curriculum

ABSTRACT

Teaching the Spiritual Dimension of Nursing Care: A Survey of Associate Degree Nursing Programs in the Southeast United States

by

Nancy LaBine

Spirituality is a subject which is often neglected in nursing education. The purpose of this study was to determine associate degree nursing faculty's perception of their ability to teach the spiritual dimension in the delivery of nursing care. The study explored whether faculty have received training related to spiritual care, how and where nursing programs integrate spirituality education into the curriculum, nursing faculty's understanding of the terms spirituality and spiritual care, and faculty members perception of whether they receive sufficient support and guidance in teaching related to spirituality and spiritual care.

Survey research was used in this study. The participants were recruited from publicly funded associate degree nursing programs in the southeast who are accredited by the Accrediting Commission for Education in Nursing (ACEN). The number of faculty participants was 206.

The *Spirituality and Spiritual Care Rating Scale* (SSCRS,) (McSherry & Jamieson, 2011) was used to explore nursing faculties' understanding of the terms spirituality and spiritual care. The findings showed that participants had very strong beliefs about spirituality and its intrinsic value to patients.

The *Spiritual Care Content Scale* (SCCS; Lemmer, 2002) explored what content was taught in nursing programs, the content most often covered included (a) the influence of cultural beliefs on spiritual care (77.9%), (b) spiritual needs of the dying and their families (76.2%), (c) the assessment of spiritual needs (71.3%), and (d) active listening as a means of spiritual care (66.2%).

Integration of spirituality education into the nursing curriculum was also, addressed. Not surprisingly, lecture was the main method for teaching the spiritual dimension, followed by discussions, clinical and reading assignments, nursing models, role play and guest speakers.

The final question sought faculty member's perception of whether they receive sufficient support and guidance in teaching related to spirituality and spiritual care. The majority of the faculty said no (84.1%, n=146).

These findings support the literature regarding the lack of perceived training and support for nurses related to the spiritual dimension and the need for greater integration of spirituality and spiritual care in the nursing curriculum. Providing guidelines for the provision of spiritual care and continued research in this area is warranted.

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DEDICATION

This dissertation is dedicated to my wonderful husband David, and my children, Matthew & Iris LaBine Stepp. It is their ever present encouragement and support that has enabled me to complete this project. To my mother who is always proud of me and never ceases to tell me that I can do anything. Also, to the many extended family members who have encouraged me along the way.

“We are not human beings on a spiritual journey, but spiritual beings on a human journey.” ---
Pierre Teilhard de Chardin

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CHAPTER 1

INTRODUCTION

Spirituality is an integral part of every person, therefore it is very important for nurses to be aware and responsive to the spiritual needs of their patients. According to Murray and Zentner (1989), spirituality is a universal phenomenon that is unique and deeply personal to each individual. It is a sensitive area and applies to all people, including those with or without a religious affiliation. As nurses who strive to provide holistic care for individuals, it is important to include care for their physical, psychological, social, and spiritual needs. Florence Nightingale, who is espoused to be the founder of modern nursing, considered that “the spiritual aspect of human beings is intrinsic to their nature and that the provision of spiritual care provides a potent resource for healing” (Nightingale, as cited in Meyer, 2003, pg. 185).

Spirituality is not only important when dealing with health issues but is also an integral part of overall wellness. Information on the University of California, Riverside web site (2014) states that,

Spiritual wellness is a personal matter involving values and beliefs that provide a purpose in our lives. While different individuals may have different views of what spiritualism is, it is generally considered to be the search for meaning and purpose in human existence, leading one to strive for a state of harmony with oneself and others while working to balance inner needs with the rest of the world (para.1).

Ways to improve spiritual wellness are listed as: a) exploring what you believe is your own sense of meaning and purpose; b) utilizing a path to spiritual wellness which

may involve meditation, prayer, affirmations, or specific spiritual practices that lend support to your connection to a higher power or belief system; c) developing compassion, the capacity for love and forgiveness, altruism, joy, and fulfillment so you may better enjoy your spiritual health; and, d) exploring your religious faith, values, beliefs, principles, and morals help to define your spirituality (University of California, Riverside, 2015).

Individuals, who demonstrate high spiritual well-being, usually have a sense of their own place in the universe. They express a feeling of connection to something larger than themselves. This allows for them to find meaning in life and to keep life in perspective. Spiritual well-being means that the individuals pursue wisdom and maintain a regular spiritual practice, whether formal or informal, religious or non-religious. (Towson University, 2015).

The value and strength of spirituality and spiritual wellness in the lives of patients who are coping with various life changing situations has been demonstrated in a variety of different populations. A few examples include patients with spinal cord injury, cancer, rheumatoid arthritis, sickle cell disease, veterans with posttraumatic stress disorder, patients with eating disorders, and among culturally diverse domestic violence survivors.

Patients with Spinal Cord Injury

Patients with spinal cord injury reported that using existential spirituality, or spirituality not associated with religion, assisted them to a higher quality of life. Existential spirituality was also found to positively influence life satisfaction, general health, and social quality of life (Matheis, Tulskey, & Matheis, 2006). The researchers

concluded that the use of spirituality may be a coping strategy helping patients with acceptance and adjustment to their life, post injury. Ninety-eight percent of the participants with spinal cord injury reported engaging in some type of spiritual belief or practice. Therefore, they encouraged healthcare professionals to assess and support the use of spirituality among patients with spinal cord injuries as a coping strategy in order to experience a more satisfying life (Matheis, et al., 2006).

Patients with Cancer

Meraviglia (1999) defined spirituality as “the experiences and expressions of the spirit in a unique and dynamic process reflecting faith in God or a supreme being; connectedness with oneself, others, or nature, and integration of the dimensions of mind, body, and spirit” (p. E2). She maintained that meaning in life and prayer represented two experiences as well as expressions of spirituality.

With this definition in mind, Meraviglia (2004, 2006) conducted studies with women diagnosed with breast cancer and patients with lung cancer respectively. Using the *Life Attitude Profile-Revised (LAPR)* developed by Reker and Peacock (1981) based on Frankl’s (1988) *Motivational Theory of Meaning*, one of the spiritual variables, meaning in life was assessed. In addition the *Index of Well-Being* assessed the cognitive and affective dimensions of the patients’ sense of well-being (Campbell, Converse, & Rodgers, 1976). In both cases it was found that meaning in life and prayer had a positive impact on their psychological well-being. Moreover, as the individual’s level of meaning in life increased their symptom distress decreased.

Patients with Chronic Conditions

Adegbola (2011) explored relationships between spirituality, self-efficacy and quality of life in adults with Sickle Cell Disease (SCD). Individuals who claimed higher levels of spirituality and self-efficacy also reported higher levels of quality of life (QOL). Similarly, patients with rheumatoid arthritis reported that spirituality had a social, emotional, and physical impact on their health perceptions and well-being (Potter & Zauszniewski, 2000).

Thus, spirituality has been shown to help different patient populations with various disease processes to a greater sense of well-being and quality of life. Healthcare professionals are encouraged to become aware, assess, and offer assistance to patients who are coping with a life crisis or end of life issues.

Nurses as Spiritual Care Providers

As healthcare delivery has become more scientific and technologically oriented, the nurse's responsibilities have increased, often taking precedence over the provision of spiritual care. The nurse, more than any other healthcare professional, has primary responsibility for meeting multiple and immediate patient needs, and although the importance of spirituality has been addressed in the nursing literature, it is reported that nurses feel: a) hesitancy or inadequately prepared to assess and promote spiritual health because of lack of knowledge and experience (Narayanasamy, 2006), b) discomfort or confusion related to their own spirituality or the patients' belief system (Branch, 1995; Hoffert, Henshaw, & Mvududu, 2007; Narayanasamy, 2006), and c) that they experience a lack of time and opportunity (Lovanio & Wallace, 2007; Narayanasamy, 2006). This supports Sawatzky and Pesut's (2005) statement that one

of the greatest barriers to spiritual nursing care may be a narrow understanding of spirituality and the impact it can have in the lives of patients.

Spirituality in Nursing Curricula

Spiritual content in nursing curricula can help nurses learn to meet patient's spiritual needs (Baldacchino, 2008; Hoffert, et al., 2007; Lovanio & Wallace, 2007; Narayanasamy, 2006). Curricula that allow nursing students to evaluate their personal spirituality and identify and plan interventions with patients who experience spiritual distress, and equip them with information and resources to deal with issues related to spirituality will enhance nurses' ability to provide for the spiritual needs of their patients.

Given the importance of spirituality to health and the need for greater consideration of the importance and knowledge of spirituality by nurses, it is vital that nursing students are exposed, didactically and clinically, to the spiritual care of patients.

The purpose of this study was to determine associate degree nursing faculty's perception of their ability to teach nursing students about the spiritual dimension. Also being investigated are questions related to faculty's perception of the terms spirituality and spiritual care, how and where the nursing programs integrate spirituality education into the curriculum, if faculty feel educationally prepared to teach about the spiritual dimension of patient care, and if they feel they have the support needed to effectively teach this content.

Spirituality

Nurses are charged to provide spiritual care to their patients, yet there are still barriers to providing that care. The nurse's hesitancy or lack of education related to spiritual care has been discussed as potential reasons for the lack of spiritual care.

Nursing curricula is an avenue for teaching spiritual care and assisting new nurses as they obtain their basic skills for patient care.

In order to more fully understand the issues related to providing spiritual care the definitions of spirituality are very important. In the next section a variety of definitions are discussed.

Definitions of Spirituality

Narayanasamy (2006) a nursing researcher offered this definition of spirituality: Spirituality is rooted in an awareness which is part of the biological make-up of the human species. Spirituality is present in all individuals and it may manifest as inner peace and strength derived from perceived relationship with a transcendent God or an ultimate reality or whatever an individual values as supreme. The spiritual dimension evokes feelings which demonstrate the existence of love, faith, hope, trust, awe and inspirations, therein providing meaning and a reason for existence. It comes into focus particularly when an individual faces emotional stress, physical illness or death (p. 845).

Other authors offer variations of this definition of spirituality. Matheis et al., (2006) lists two types of spirituality. First, religious, defined as a relationship with God or a higher power (Colon, 1996), typically observed among individuals attending organized religious services with a community of other people. Second, existential spirituality which is not directly related to a specific place of worship or set of widely accepted ideals, referring to a worldview or perspective in which individuals seek purpose in their life and come to understand their life as having ultimate meaning and value (Brady, Peterman, Fitchett, & Cella, 1999). Good and Willoughby (2006) defined religiosity as

church attendance and spirituality as personal beliefs in God or a higher power. Meyer, (2003) maintained that spirituality is the core essence of the self, capable of experiencing inner peace and unifying interconnectedness with a higher power. Rankin and DeLashmutt, (2006) stressed that although abstract and difficult to define, spirituality is generally acknowledged to be a uniquely human attribute that is individually manifested and continually expressed as life is lived (Meraviglia, 1999) and it brings meaning to life by addressing the existential needs of man (Rankin & DeLashmutt, 2006). According to O'Brien (2004) nurse researcher and theorist spirituality is the expressed essence of human beings made visible in relationships both vertical (with a Higher Power) and horizontal (human ties), the consequences of which is love, faith, hope, and a purpose for being. Hoffert, et al., (2007) defined spirituality as a personal sense of meaning, value, purpose, and interconnection. Betty Neuman (1995) stated that spirituality is the totality of one's belief system, or what a person values. It may or may not be identified with a higher force or deity. Spirituality is a way of describing the organizing center of a person's life, bringing unity, and helping to make sense of life.

The many definitions of spirituality have similar attributes. Some of the common attributes of spirituality are: uniqueness to each individual, provides transcendence (Neuman, 1995), interconnectedness (Hoffert, et al., 2007), gives meaning and purpose to life (DeLashmutt, 2000; Meraviglia, 1999; O'Brien, 2004), and allows the individual to experience peace and strength in their own personal situation (Meyer, 2003). A patient whose spiritual wellbeing is being threatened by their situation are said to be

experiencing spiritual distress (Neuman, 1995). In the next section spiritual distress will be discussed.

Spiritual Distress

In compilations of Carpenito (2013), the nursing diagnosis of spiritual distress is considered “the state in which the individual or group experiences or is at risk of experiencing, a disturbance in the belief or value system that provides strength, hope, and meaning to life” (p. 850). Factors related to spiritual distress include: a) pathophysiologic which may include separation from the patient’s spiritual ties secondary to the loss of a body part or function, terminal illness or debilitating disease, pain, trauma or miscarriage/stillbirth; b) modes of treatment which may cause a conflict between what is prescribed and the patient’s beliefs (e.g. abortion, surgery, blood transfusions, isolation, amputation, dietary restrictions, and certain medications); and c) situational, both personal and environmental, which may include death or illness of a significant other, barriers or embarrassment at practicing spiritual rituals, the availability of special/food diet, and confinement to bed (Carpenito, 2013).

There is often confusion related to differentiating between spirituality and religion. In the next section the similarities and differences in spirituality and religion will be discussed.

Spirituality and Religion

Spirituality is not synonymous with religion, but individuals may express their spirituality through religious beliefs and practices. Spirituality is a much broader concept than religion. Spirituality and religion are similar in many ways; both involve transcendence, connectedness and the search for meaning and purpose in life (Coyle,

2002). According to Goddard, (2000, p. 975) “Spirituality encompasses all aspects of human beings and is a means of experiencing life”. Spirituality is considered experiential, and may be manifested in experiences with nature, in relationships with others, the self or a higher power (Macrae, 1995).

Matthews and Clark (1998) listed several distinctions between spirituality and religion. Religion is said to focus on community while spirituality is more individual. Religion can be identified and objectively measured; it is more formal, systematic, and authoritarian in its directions, worship, and in prescription of certain behaviors. Spirituality is more emotion-based and focused on the individual’s inner experiences. Since we live in a multicultural society that is diverse in spiritual and religious differences it is important that nurses provide competent spiritual care to all individuals (Cobb & Robshaw, 1998).

King, Speck, and Belcher (1994) pointed out that using the word religious in assessment has caused a failure to recognize the importance of a broader understanding of the word spiritual. Assuming that if someone fails to express a religious faith they have no spiritual understanding or spiritual need will cause practitioners to miss the signs of spiritual distress and allow those needs to go without acknowledgement. Nursing is only one of the disciplines that are concerned with spirituality and the provision of spiritual care. In the next section spirituality across disciplines will be discussed.

Spirituality across Disciplines

Across disciplines researchers have written about spirituality and its impact on their specific populations. Some examples include psychology (Young, Wiggins-Frame,

& Cashwell, 2007), counseling (Steen, Engels, & Thweatt, 2006), social work (Hodge, 2001), career development (Duffy, 2006), education (Campbell, 2005; Estanek, 2006), medicine (Sierpina & Boisaubin, 2001), physical therapy (Sargeant & Newsham, 2009), and athletic training (Udermann, 2000).

Examples of studies related to spirituality in psychology, counseling, physical therapy and medicine are discussed. These examples include both practice and academic shortcomings to incorporating spirituality as well as one example by Sierpina and Boisaubin (2001) that offers academic recommendations.

According to Young and associates (2007), many mental health professionals neglect issues related to religion and spirituality, due to: a) a conflict between the objective perspective of psychology and the transcendent, subjective aspects of religion; b) issues of separation of church and state (Gall, 2006; Lantz, 2007); and c) a lack of formal training in working with spiritual and religious issues in counseling with the exception of pastoral counselors (Gall, 2005; Hodge, 2001; Steen, et al., 2006; Young, et al., 2007). Young and associates (2007) further stated that if the issues of spirituality and religion are not addressed in counseling then a vital aspect of the patient's life has been ignored.

According to Sargeant and Newsham (2009), the physical therapy classroom is a place to include education related to the spiritual dimension and meeting patient's spiritual needs. She listed several recommendations for inclusion: increasing student's awareness of patient's spiritual needs, assisting students in recognizing the importance of spirituality and religion in patient recovery, offering students opportunities to explore definitions of spirituality, and exploring their own beliefs and biases. The discipline of

physical therapy has many of the same issues as nursing when it comes to providing spiritual care: perceived lack of training, discomfort with discussing spiritual distress, not enough time and concerns about separation of church and state.

A multidisciplinary approach to teaching medical and nursing students about spirituality was proposed by Sierpina and Boisaubin (2001). Using case studies and discussion groups, the students are introduced to taking spiritual histories on their patients, making appropriate referrals to chaplains and other religious leaders, and studying the empirical evidence and on-going research related to spirituality and healthcare.

Spirituality has been acknowledged as an integral part of each individual. Researchers have discovered the benefits of the spiritual dimension in finding meaning and purpose in life, and as a coping strategy in a variety of populations. Meeting individual's spiritual needs is encouraged by professionals in many health care professions and recommendations for including the spiritual dimension in curricula are available. This study will further contribute to the literature related to the instruction of spiritual care.

Background

The history of spiritual care in nursing can be traced as far back as the 6th century B.C. Greek mythology is said to differentiate between medicine and nursing in the tale of The God Aesculapius, son of Apollo. He was usually pictured with a caduceus intertwined with serpents. He was also linked to four female figures that have been associated with nursing. His wife, the soothing one, and three daughters, the Goddess of Health, the Goddess of Healing, and the Goddess of Health Preservation

(Sellew & Nuesse, 1951).

Through the centuries pre-Christian or druid worshipers were expert with using herbs in health and in communicating with deities. Early Roman Christians also demonstrated links between spirituality and nursing. From early Roman socialites through the dark ages and medieval times curative therapies were not available, but nursing care was available to offer a bed, board, bath, and prayer in hopes of alleviating pain. A hospital in medieval times was basically a monastery that focused on alleviating pain and suffering, or healing the soul in death. (Mimkowski, 1992, as cited in Barnum, 1996).

The deaconess movement began in 441 A.D. and was a place where single women and widows could participate in Christian service. Christianity has been considered the first religion to understand care of the ill as a spiritual charge. In 529 A.D. St Benedict founded monasteries requiring that they have an infirmary, therefore establishing the first hospitals (Kalisch & Kalisch, 1986).

From 476-1096 AD there were Byzantine and Islamic influences apparent in medicine. Because of the Moslems (spelling as included in the publication) love for learning, books that were brought in caravans were translated from Greek and Latin into Arabic. Some of the first great medical schools were established in Bagdad, Cairo, and Spain. About 1060 AD, Constantinus Africanus brought many medical books to Italy, spurring a medical revival. The medical school established at Salerno, Italy was the leading school, training both physicians and nurses. Nursing, obstetrics and midwifery were studied at this school through the 12th century (Kalisch & Kalisch, 1986).

In 1633, the Sisters of Charity were established by St. Vincent de Paul. This was the beginning of modern nursing. Sisters of Charity came to the United States in 1809. The Sisters took simple vows binding themselves to the care of the sick. In 1822, the Bon Secours group of sisters was organized by the Archbishop of Paris. The Sisters of Bon Secours were charged to care for the sick in their homes and the orphaned in asylums. During the 1840s this group began service in the United States (Kalisch & Kalisch, 1986).

During the 1800's, Protestant ministers revived the deaconess movement, which had ended around the time of Christ. The deaconesses were the first Faith Community or Parish Nurses. There were three classes of deaconess members. The first class devoted themselves to the sick and poor, and the rescue of fallen women through Magdalene homes. The second class was teachers and the third class served as visitation deaconesses. In 1836, the move for modern nursing education began in Kaiserswerth, Germany. The deaconesses were trained to care for discharged prisoners. This set the stage for Florence Nightingale who cared for soldiers from the Crimean War (Kalisch & Kalisch, 1986).

Florence Nightingale was very dedicated to improving the conditions of hospitals and nursing education. She had expertise in the field of public health, was administratively skilled, and presented a therapeutic presence that has gained her recognition as the founder of modern nursing. She was also a pioneer in research-based nursing practice (Kalisch & Kalisch, 1986).

In 1867, Johns Hopkins established a local university and a hospital that would be linked to a medical school. The hospital was established according to charitable

goals, to serve the indigent sick without regard to sex, age, or race. Hopkins visited the Nightingale School for nurses, and was very impressed with the work that they were doing. He then contracted cholera during the 1832 epidemic in Baltimore, and was cared for by the Sisters of Charity. These two experiences led to his demand for the creation of a training school for female nurses to provide care in the hospital. Hopkins a native of Maryland and a Quaker, made a special request for the influence of religion to be impressed upon the whole management of the hospital (Risse, 1999).

It would take a century before another movement that emphasized spiritual care in nursing would emerge. Faith Community Nursing (FCN) (2013) is a specialized practice of professional nursing that focuses on intentional care of the spirit by promoting (w)holistic health as well as preventing or minimizing illness. The guiding principles of FCN are that:

- a) effective healthcare requires more than medical treatment of disease or illness;
- b) promotion of health and healing are part of the mission and service of a faith community to its members and;
- c) wellness and wholeness can only fully be achieved when we acknowledge the close connection between body, mind and spirit (para. 1).

Faith Community Nursing (2013) as we know it was founded by Granger E. Westberg in 1984. Westberg, a Lutheran clergyman, hospital chaplain, professor of practical theology, and a teacher of medical students pioneered and founded the parish nurse movement. Westberg believed that true healing involves the whole person in the context of their environment (p.1).

Faith Community Nurses focus on helping patients (individual, family or the entire congregation) as they strive to achieve health, healing, and wholeness by participating in promotion and disease prevention practices. The FCN's (2013) practice focuses on certain roles that include: (a) integrator of Faith and Health, (b) health educator, (c) personal health counselor, (d) referral agent, (e) trainer of volunteers, (f) developer of support groups, and (g) health advocate/healthcare navigator. FCN has continued to contribute to the spiritual dimension of nursing care through the years (p. 1).

Overall, nursing as a profession has enjoyed a rich spiritual heritage. The spiritual dimension was a major component when nursing care and nursing education were conducted primarily under religious orders (Branch, 1995). Increased training and research has brought nursing and nursing education into the 21st century, and in many cases where technology has triumphed, the provision of spiritual care has been ignored (Narayanasamy, 2006).

Because healthcare has become so technologically oriented the emphasis has shifted and the spiritual dimension is often overlooked or given less importance in many cases. Although the importance of spirituality has been addressed in the literature, it is reported that nurses feel inadequately prepared for assessment and intervention in the patient's spiritual needs (Baldacchino, 2008; Branch, 1995; Hoffert, et al., 2007; Lovanio & Wallace, 2007; Narayanasamy, 2006). It is important to continue the legacy of nursing by offering holistic care which includes training nursing professionals in the provision of spiritual care.

Hoffert and colleagues (2007) posited that if the gold standard of nursing is to provide holistic, individualized care, it is important for nursing faculty to incorporate

spiritual care in a meaningful deliberate manner in the nursing curriculum. Lantz (2007) agreed that with an increased focus on spirituality, nurse educators must teach the art and science of spiritual care: the definition of spirituality versus religion, spiritual assessment techniques, and nursing diagnosis related to spirituality, religious diversity, and methods to implement and evaluate spiritual care. According to Mitchell, Bennett, and Manfrin-Ledit (2006), “Nurses or nursing students who demonstrate spiritual competence experience professional and personal growth as well as healing for their patients” (p. 370).

The history of nursing and the provision of spiritual care are rich and extensive, confirming the need for nurses who provide competent spiritual care. There are various studies about spirituality and spiritual care related to nursing students. Some researchers have concentrated on nursing students’ ability to provide spiritual care and their perception of the spiritual dimension (Hoffert, et al., 2007; Rankin & DeLashmutt, 2006). However most of the studies conducted are with nursing students from private religious-based settings; therefore, it is perceived that the ability to identify spiritual issues and the emphasis on the spiritual dimension would be apparent (Baldacchino, 2008; Burkhart & Schmidt, 2012; Hoffert, et al., 2007). Lemmer (2002) is the only researcher who included public colleges and universities, and no studies were found that included community colleges. Research related to spiritual care in community colleges will expand the knowledge and highlight the need for current and effective training for nurses.

Statement of Problem

Over the years, the health literature available on the topic of spirituality and

the provision of spiritual care has grown. Much has been written in the past decade about the lack of education and the nurse's inability or unwillingness to provide spiritual care (Lemmer, 2002; McSherry & Jamieson, 2011; Narayanasamy, 2006). The development of FCN helped to alter this perspective and has created standards for practice to assist with spiritual care (FCN, 2013). Currently, the literature related to spirituality, spiritual care, and its relation to the nursing profession has grown exponentially and accrediting entities now mandate the inclusion of the spiritual dimension in nursing curricula. Nursing textbooks include chapters related to the provision of spiritual care, but researchers still say that spiritual care is lacking (Baldacchino, 2008; Burkhart & Schmidt, 2012; Hoffert, et al., 2007).

As stated formerly, many of the studies available are from private, religious-based colleges (Baldacchino, 2008; Burkhart & Schmidt, 2012; Hoffert, et al., 2007). Lemmer (2002) conducted the only study available that includes public colleges and universities. She surveyed faculty in baccalaureate nursing programs in the United States to determine how spirituality was incorporated in their particular curriculum. This leaves a gap in the literature related to associate degree programs.

The purpose of this study was to determine associate degree nursing faculty's perception of their ability to teach nursing students about the spiritual dimension of nursing care. Other questions for consideration were related to how and where the nursing programs integrate spirituality education into the curriculum. The study also explored whether faculty have received training related to spiritual care, nursing faculty's understanding of the terms spirituality and spiritual care, and faculty members perception of whether they receive sufficient support and guidance

in teaching related to spirituality and spiritual care?

Definition of Terms

Spirituality (conceptual) – Is unique to each individual, helps ascribe meaning and purpose to life, allows the individual to experience peace and strength in their situation, and provides transcendence and interconnectedness with a higher force or deity (Neuman, 1995; Young & Koopsen, 2005).

Spirituality (operational) – The *Spirituality and Spiritual Care Rating Scale* (SSCRS) used in this survey supports the position that spirituality is universal in that it is not just associated with a religious belief and religious practices but applies to everyone. (McSherry & Jamieson, 2011, p. 1761).

Spiritual care – Being with patients in their experiences of pain, suffering, or other problems or needs; listening to patients verbally express anxieties or emotions, such as fear, anger, loneliness, depression or sorrow which may be hindering their healing process; and touching patients either physically, emotionally or spiritually to assure them of their connectedness to others and/or “God” (O’Brien, 2004).

Spiritual distress – an alteration in spiritual health (e.g. spiritual pain, alienation, anxiety, guilt, anger, loss, despair) (Taylor, Lillis, & LeMone, 2001).

Spiritual well-being – the ability to find meaning, value and purpose in life. It relates to life-affirming relationships, contentment, the wholeness of an individual’s spirit, it is a unifying dimension of health, faith in a Higher Power, enhancement of the individual’s inner resources and inner strength (Burkhardt & Nagai-Jacobson, 2002). Spiritual well-being is not synonymous with belief or practice in the particular aspects of

a religion. Instead it is an affirmation of life in a relationship with God, self, community, and environment (Fehring, Miller, & Shaw, 1997).

Spiritual needs – often related to the “big” questions in life. Examples: Why is this happening to me? How do I make sense out of this situation? What gives me comfort and hope? Who do I trust? (University of Maryland Medical Center, 2013).

Nature of Study

A non-experimental survey design was used to explore how the spiritual dimension of nursing care is taught in associate degree nursing programs in the southeast United States. The survey also investigated nursing faculty perceptions of spirituality and spiritual care.

Various aspects of spirituality and spiritual care have been presented. It has been shown that spiritual care is important in patient’s lives especially in times of sickness and distress. Since there is still a deficit among nurses in the provision of spiritual care, this study will hopefully arouse interest and inspire nursing educators to more thoroughly attend to providing spiritual care education to nursing students.

CHAPTER 2

CONCEPTUAL FRAMEWORK AND RELATED LITERATURE

Conceptual Framework

The conceptual framework for this study is based on the work of Dr. Betty Neuman. The Neuman's Systems Model (1995) presents a comprehensive systems-based conceptual framework that represents individual patients within the systems (w)holistically and multidimensionality (see Appendix A). The Model illustrates five interacting variables which include the physiological, psychological, sociocultural, developmental, and spiritual. The patient is viewed as a "whole" whose parts are in dynamic interaction (Neuman, 1995).

The model is based on concepts of stress and the patient's reaction to stress. The patient as a system is composed of a core or basic structure of survival factors which is surrounded by protective concentric rings. The concentric rings are composed of similar factors yet serve varied purposes in retention, attainment, or maintenance of system stability and integrity. The outer circle for the patient is designated by protective normal and flexible lines of defense. These lines of defense ideally prevent stressors from invading the patient system, keeping the system free from stressor reactions or symptomatology. The basic structure is also protected by lines of resistance. These lines are activated following invasion of the normal lines of defense by stressors. An example is the body's mobilization of white blood cells or activation of immune system mechanisms (Neuman, 1995).

Neuman (1995) cites three levels of prevention. Primary prevention occurs when the nurse works with the patient to reduce the possibility of encountering stressors.

This strengthens the flexible lines of defense. Secondary prevention occurs when the nurse participates in early case finding and treatment of symptoms. The final phase is tertiary prevention which occurs after an encounter with stressors. In this phase the nurse assists the patient with readaptation, and reeducation to prevent further problems which will help maintain system stability. Interventions can occur before or after resistance lines are penetrated in both reaction and reconstitution phases. The reaction phase is how the client reacts to outside stressors. The reconstitution phase begins following treatment, when some degree of system stability has occurred. Interventions are based on the degree of reaction, resources, goals, and anticipated outcomes for the patient (Neuman, 1995).

The spiritual variable, which was added to the model in 1989, is viewed as an innate component of the basic structure of the patient whether or not it is ever acknowledged or developed (Neuman, 1995). The patient can move from complete unawareness of this variable and even denial, to a highly developed spiritual understanding that supports optimal wellness. The spiritual variable can be positively or negatively influenced by different types of stress such as grief or loss. This stress may cause the patient's awareness of spirituality to increase, decrease, or initiate moving them along on a continuum toward spiritual wellbeing (Neuman, 1995).

Neuman (1995) believes that spiritual development empowers the patient toward well-being by positively directing spiritual energy for use by the mind and then by the body. The beginning of spiritual awareness and development can occur at any stage of the life cycle. The supply of spiritual energy, when understood and used positively by the system is inexhaustible, except in death.

To further expand the explanation of Neuman's (1995) spiritual variable two contributing authors Curran (1995) and Fulton (1995) from *The Neuman Systems Model* (Neuman, 1995) are cited. According to Curran (1995), Neuman's physiological, psychological, sociocultural, and developmental variables link with the spiritual variable to create a unique individual. Ideally, there is a balance and harmony in all variables which is seen as optimal wellness. There is great emphasis placed on the view that the spiritual variable is influenced by all other variables. Nurses are required to thoroughly assess all variables for their influence over the patient's health. Physical problems must be addressed before spiritual needs can be met (Curran, 1995).

The interrelationships of the spiritual variable, stressors, and reactions to stressors are seen as the means to strengthen the spiritual nature of the person. An example would be suffering, whether physical, mental, or spiritual that occurs as a result of stress. This suffering may serve as a source and motivation to develop and increase wellbeing (Curran, 1995).

The flexible lines of resistance related to the spiritual variable are the known and unknown resources at play within the whole person. These resources include the five physical senses and the mental or intellectual senses, which combine by the power of the mind to mediate, direct, support, and protect system integrity (Curran, 1995).

The normal line of defense is represented as the spirit or the soul. The human spirit is the aspect of the person which represents and develops the spiritual qualities as a part of optimal health. The effects of the human spirit to health are closely linked to the other variables and the environment.

All of these factors influence the conscious and unconscious response to stressors. The flexible line of defense which is the spirit of faith in the person, shields and strengthens the whole person as it extends outwards. Faith is an action that requires constant attention or it begins to weaken (Curran, 1995). Curran (1995) goes on to say that because the spiritual variable interacts in a dynamic relationship with the other variables, and is contextually bound to the web of human relationships, nurses must assess and consider the factors as an essential part of meeting all needs of the patient.

Fulton (1995) suggests that practicing nurses and nursing students are lacking in adequate education about spirituality. Many of these studies are cited in the literature review in this chapter. Fulton (1995) believes that nursing students and faculty have a minimum awareness about spirituality, but express a desire for further education.

The lack of educational preparation was a contributing factor for not meeting the spiritual needs of the patients. Two approaches are listed to help alleviate this problem. First, the nurses need to be made aware of their own spiritual self before they can recognize and care for the spiritual needs of patients. And second, incorporating Neuman's Model with the spiritual variable into the nursing curricula will help to organize course content which will meet the educational needs of nurses (Fulton 1995).

Fulton (1995) outlines the steps of prevention as they relate to the spiritual variable. Primary prevention involves, identification of patient coping strengths and support of health facilitating activities such education, role-play strategies, and anticipatory guidance. After the patient is assessed and the spiritual variable is found to be intact, the interventions will seek to minimize stressors and strengthen the flexible

lines of defense. This will help to retain and optimize the wellness level. Spiritual care at the secondary prevention stage involves collaboration between the patient and the nurse to set goals that alleviate symptoms of the maturational or situational stressors and avoid penetration of the flexible lines of defense, normal lines of defense and lines of resistance. The desired goals of secondary prevention are protection of the basic structure and restoration of spiritual wellness. Tertiary prevention is described as wellness maintenance which begins when treatment of stressors is underway and stability results. Intervention such as support and education about spiritual resources are used in order to maintain the patient's lines of resistance and lines of defense during stabilization and reconstitution. These interventions are directed toward the goal of maintaining optimal wellness (Fulton, 1995).

Though careful assessment of the patient's needs spiritually, followed by purposeful interventions such as fostering hope, that affects the will to live the relationship between the spiritual variable and wellness, the patient will be better able to achieve optimal system stability (Neuman, 1995). Neuman (1995) believes that considering the spiritual variable is necessary for a truly "(w)holistic" perspective of caring and concern for the patient.

The literature reviewed in this chapter demonstrates the importance of assessing and intervening when a patient has unmet spiritual needs. Nurses as healthcare professionals are a vital part of the multidisciplinary care team, and have a significant opportunity to provide spiritual care for patients who are experiencing spiritual distress. The literature points to a need for increased attention to the spiritual variable in nursing education, in order to better equip nurses to effectively deal with spiritual issues.

Neuman (1995) offers the conceptual support and direction to support this study. More supporting literature will be discussed in the next section.

Review of Related Literature

Within the literature review several aspects of spirituality and spiritual care are discussed. These include spirituality as a concept, professional mandates for spiritual care, spirituality in patients with different disease processes, spirituality in healthcare, and the spiritual dimension in nursing education.

Inclusion criteria for this literature search included articles from the early 1980s to present, full text articles available through online resources such as Sage Publications, CINAHL, Nursing and Allied Health, and ERIC databases, and the electronic catalog. These resources were accessed through the Sherrod Library at East Tennessee State University. Search terms used included spirituality, spiritual care, spiritual distress, spirituality and nursing education, spirituality and religion, spirituality in healthcare, patients spiritual-wellbeing, spirituality in nursing curricula, and spiritual dimension in healthcare. Early articles were used to demonstrate the history of nursing and spirituality.

Spirituality as a Concept

According to Delgado (2005), spirituality is a broad concept that encompasses religious and cultural boundaries and beyond. Delgado (2005) also shared a list of assumptions that were made by many nurses related to spirituality:

- a) spirituality is an inherently human quality;
- b) spirituality may manifest itself in varying degrees as it is influenced by the person's social and cultural environment;
- c) spirituality often involves faith, a search for meaning and purpose in life, a sense

of connection with others, as well as a transcendence of the self, resulting in a sense of inner peace and well-being; d) spirituality and the spiritual connection may assist when coping with a disability, and improve one's sense of satisfaction with their lives; and, e) spirituality can be a powerful resource for holistic care.

Using a method of concept analysis by Walker and Avant (1995), McBrien (2006), set out to clarify the concept of spirituality. According to Walker and Avant (1995), concept analysis can assist in clarifying and defining a concept, help to provide new tools for research and development, and ultimately, improve clinical nursing practice. Following the model by Walker and Avant (1995), McBrien (2006) conducted a literature review and then proposed attributes, antecedents, and consequences of spirituality (p. 44). Attributes included:

- *Belief and faith*; this entails believing in a higher power or God, significant relationships, self-chosen values/goals or believing in the world without acknowledging God.
- *Inner strength and peace*: this is achieved when the individual accepts his situation and a state of congruency exists
- *Connectedness*: relationships with self, others God/higher power, and the environment, which ultimately leads to a deeper meaning in life (Fawcett & Noble, 2004 as cited in McBrien, 2006).

Antecedents included:

- *Pivotal life events* such as illness, that may provide the impetus for spiritual awareness and growth (Meraviglia, 1999, as cited in McBrien, 2006)

- *Search for meaning*: this involves the need to understand the threatening event and its impact on life before spiritual wellbeing is attained.

Consequences included:

- *Sense of hope*: hope helps the individual transcend self-absorption, not only looking beyond themselves, but also offering a basis for courage to look within themselves (JoUey & Brykczynska, 1992 as cited in McBrien, 2006). Hope is considered essential to a life worth living and its loss is equated to the loss of life (Flemming, 1997, as cited in McBrien, 2006)
- *Self-transcendence*: regardless of the life event, the individual can move beyond it and aspire to a meaningful existence.
- *Other consequences* may include guilt and inner conflict about one's values and beliefs (Carson, 1988, as cited in McBrien, 2006).

McBrien (2006) stated that although nurses aim to provide holistic care, the spiritual dimension remains subjective. Sometimes the patient's perception and experience with spirituality is very different from the nurse's; however, Narayanasamy (2006) suggested that in the absence of a common set of defining characteristics, nurses are still charged with effectively attending to this aspect of holistic care. Hopefully, the identification of the attributes, antecedents, and consequences of the concept of spirituality can assist the nurse in holistically managing and contributing to the patient's spiritual wellbeing.

Another way to overcome barriers that hinder the provision of spiritual care is for the nurse to provide a therapeutic relationship of mutual trust and respect. Researchers have demonstrated that maintaining a caring relationship can be transcending, fulfilling, and spiritually rewarding to the patient and the nurse (Narayanasamy, 2006).

McBrien (2006) indicated that he hoped his concept analysis would be used as a foundation towards developing a comprehensive theory of spirituality. This concept analysis showed that spirituality involves a search for meaning and purpose and is transcendent and distinct from religion. “The nature of nursing practice places nurses in pivotal positions to foster peaceful resolutions in patients' lives, by assisting them with their spiritual needs.” (Narayanasamy, 2006, p. 47).

Professional Mandates for Spiritual Care

A variety of agencies, including accrediting bodies, address the provision of holistic, culturally competent care that includes spiritual care. The National Council of State Boards of Nursing (NCSBN), under Psychosocial Integrity, includes religious and spiritual influences on health as part of the licensing test plan (NCSBN-RN Test Plan, 2013).

The Accrediting Commission for Education in Nursing (ACEN, 2013) includes in the curriculum standard 4.5 that the “curriculum include cultural, ethnic, and socially diverse concepts” (p. 4). Although the standard does not mention spirituality explicitly, it is believed that the spiritual dimension is often part of cultural, ethnic, and socially diverse populations (Narayanasamy, 2006).

The Commission on Collegiate Nursing Education (CCNE) is an accrediting body who requires baccalaureate nursing programs to use the American Association of Colleges of Nursing's (AACN, 2008) document, *Essentials of Baccalaureate Education for Professional Nursing Practice* in curricular development. In the CCNE accreditation manual, Essential VI is *Clinical Prevention and Population Health*. Within that essential standard it is expected that “the nursing student will learn to collaborate with other

healthcare professionals and patients to provide spiritually and culturally appropriate health promotion and disease and injury prevention interventions” (p. 5). Other standards speak to the nurse’s ability to perform a spiritual assessment and appropriate referral as needed. Also suggested is the inclusion of cultural, psychological, and spiritual implications of clinical prevention and population health.

The Joint Commission on Accreditation of Healthcare Organizations (JCAHO) acknowledges that patients have the right to receive nursing care that respects and supports cultural, psychosocial, and spiritual values (Lantz, 2007). The mandates from these organizations show that spiritual care is essential in nursing care and curricula. Hodge (2006) points out that the JCAHO mandates not only include hospitals, but home care organizations, long-term care facilities, and behavioral health settings that treat addiction. JCAHO lists general content areas of discuss which includes identifying the importance of spirituality and religion to the patient as it may affect care, and to follow-up with a more comprehensive assessment as needed (Lantz, 2007).

Spirituality in Patients with Different Disease Processes

The need for spirituality in patients with different disease processes has been demonstrated in several studies. The studies considered in this section include the importance of spirituality as a coping tool for patients with heart failure (Black, Davis, Heathcotte, Mitchell, & Sanderson, 2006), gynecologic oncology (Gioiella, Berkman, & Robinson, 1998; Lopez, McCaffrey, Griffin, & Fitzpatrick, 2009), and home hospice patients (Dobratz, 2005). Other patient populations considered include those with HIV (Vance, Struzick, & Raper, 2009), sickle cell disease (Adegbola, 2011; Jenerette & Lauderdale, 2008), adult survivors of childhood sexual abuse (Gail, 2004), and older

adults with anxiety and depression (Phillips, Paulkert, Stanley, & Kunik, 2009).

Dobratz (2005) conducted a comparative study of home hospice patients. Using secondary analysis, two groups of patients were compared, those who expressed spirituality (n=44) and those who did not express spirituality (n=53). Those who did not express spirituality reported higher pain levels than those who did report a spiritual connection. T-tests were used to compare the expressed versus non-expressed spirituality groups on measures of psychological well-being and adaptation, physical function, social support, and pain. A significance level of $p < .05$ was established. There were no significant differences for all the measures except for pain. Significant differences were found on the *McGill-Melzack Pain Questionnaire (MPQ)* (Melzack, 1975). On average the expressed spirituality group reported lower total scores on the *MPQ* and used fewer words to describe their pain. The expressed group had a lower score on the affective dimension of the test. Also, in the group of non-expressed patients some of the dimensions of pain were significantly higher than those who expressed spirituality (Dobratz, 2005).

Similarly, in a study of women diagnosed with gynecologic cancer, Gioiella, et al., (1998) found the inclusion of the spiritual dimension when patients are assessed leads to appropriate interventions. These interventions helped to raise the patient's spiritual awareness and therefore assisted the patient to acceptance and comfort as they coped with their particular disease process. Tools that assessed *the Functional Living Index: Cancer (FLIC)* and the *Spiritual Well-being Scale (SWB)* were administered to 18 patients who were diagnosed with some type of gynecologic cancer. Descriptive statistics and *t* tests were used to compare means and analyses of variance

were used to examine the relationships in the data.

No significant relationship was found between overall *SWB* and *FLIC*, but there were significant differences when comparing subgroups. Older patients and those who were married expressed a better perceived quality of life. A significant relationship was found between patients who are affiliated with a religion and their functional living index. Patients educational level did not make a difference in the data and patients diagnosed with cancer besides ovarian scored higher on the *FLIC* and *SWB* Scale.

Gioiella, et al., (1998) and Dobratz (2005) agreed that the inclusion of spiritual assessment and intervention was vital in assisting with pain control and increased quality of life. Gioiella and colleagues (1998) also emphasized the need for including spiritual education when training healthcare professionals.

In a review of the literature by Vance and associates (2009), the difficulties of aging with HIV and how spirituality can be used to assist with successful aging were examined. With the advent of protease inhibiting drugs many individuals with HIV are living longer, more productive, and healthy lives, hence there is a growing population of this demographic. The National Institute of Mental Health (NIMH) defines those who are 50 years old or above to be older and The Centers for Disease Control and Prevention (2014) reported in 2011, that people aged 50-54 represented 47% (3,951) of the estimated 8,440 HIV diagnoses among people aged 50 and older in the United States.

Vance, et al., (2009) cited several studies that indicate the positive role of spirituality in functioning adults with HIV. Ironson et al. (2002 as cited in Vance, et al., 2009) found that spirituality and religiosity was significant in that there were larger social supports, greater hope, less distress, more positive health behaviors and,

ultimately long-term survival. These studies emphasized the importance of spirituality in everyday function and the improvement of quality of life for adults with HIV. As previously stated, Vance and associates (2009) encourage nurses to assess the spiritual well-being of patients and intervene in a holistic manner.

Black and colleagues (2006) studied the relationship between spirituality and compliance in patients with heart failure (HF). Using Pearson's correlation coefficient it was suggested that there was not a correlation between aspects of spirituality and compliance with the treatment regimen in patients with HF. What was significant was that patients who were followed in an outpatient clinic scored higher on compliance with the prescribed program. The authors cautioned nurses to discard any biases they have about whether or not spirituality plays a role in compliance but to continue to recognize the importance of spirituality in patient care, as it is a critical component in holistic nursing care.

Exploring the role of spirituality and religiosity in domestic violence survivors with culturally diverse backgrounds, Yick (2008) synthesized several qualitative studies (Giesbrecht & Sevcik, 2000; Hassouneh & Phillips, 2001a, 2001b, 2003; Kwon, 2005; Nash, 2006; Senter & Caldwell, 2002; Taylor, 2004) using a metasynthesis outline offered by Noblit and Hare (1998). Some of the themes that emerged were: a) strength and resilience, b) reconstruction, c) recouping spirit and self, d) forgiveness as healing, and e) giving back.

In each theme the victims of domestic violence described how spirituality and religiosity assisted them in various situations as they were recovering or restructuring their lives. Strength and resilience was derived from the women's spiritual or religious

beliefs. The beliefs helped them to cope with their abuse and violence by acknowledging or relying on a “higher power or force” (Yick, 2008; p. 1301) to help them move forward in their lives. Reconstruction was discussed as a spiritual journey toward renewing and rebuilding their lives. Recouping their spirit and recovering their sense of self is also part of the spiritual journey as the women had not taken time for themselves during the abuse. The renewing might include attending counseling or support groups, reading books, and religious literature, all of which helped the women to look to the future (Yick, 2008).

Forgiveness as healing incorporated forgiving themselves and in most cases the abuser. Some talked about praying for their abuser and that the offering of forgiveness somehow allowed them closure and to experience forgiveness for themselves. The forgiveness described in the study did not include forgetting or excluding the accountability of the abuser (Yick, 2008).

The last theme to be discussed is giving back through social activism. As part of the women's spiritual awakening and recouping of themselves they have been empowered for the greater good. Practitioners are encouraged to search for the spiritual or religious connection for each victim and to assist them as they heal, renew, and become active in the community (Yick, 2008).

In a study by Gall (2006), the use of spiritual coping during stress in life was explored with adult survivors of child sexual abuse (CSA). Both positive and negative forms of spiritual coping were discussed. Positive spiritual coping included spiritual support and congregational support, and also fostered a strong sense of God, personal reframing, and meaning in life. Negative coping referred to less security with God and

spiritual discontent. This was manifested in anger, discontent, and doubt. Pargament et al., (1998) found that anger with God was a very strong predictor of poorer mental health. The authors of this study encouraged practitioners to assess and offer support for spiritual coping in victims of CSA.

Good and Willoughby (2006) investigated the interaction between religiosity (church attendance) and spirituality (belief in God or higher power) in adolescent psychosocial adjustment. Adolescents were divided into groups that included church attendance, belief in a higher power, non-church attendance, and non-belief in a higher power. The church attending groups consistently reported more positive levels of psychosocial adjustment and parental relationships. Although there were many limitations within the study, the findings were sufficient enough to encourage adolescents and their families to attend church or other social groups that promote positive outcomes (Good & Willoughby, 2006).

Spirituality in Nursing Curricula

In a study by Lovanio and Wallace (2007) nursing students (n=10) were assigned an education project designed to improve their knowledge and attitudes about spiritual care. Using a pre- and posttest design, students' knowledge and attitudes about the spiritual care project were compared. After the pretest was administered, the students attended a presentation given by an expert and author of publications related to spirituality in nursing, Sister Mary Elizabeth O'Brien. The students also attended clinical conferences for 10 weeks, kept a journal, and completed a care plan using the nursing diagnoses related to spirituality and health. Significant differences were seen between student total pretest and posttest scores. The findings were very important because the

use of spiritual teaching strategies as a tool to enhance student nurses comfort and effectiveness in providing spiritual care was documented. This study was conducted in a faith-based setting; therefore, it was expected that students would report a higher level of knowledge and understanding at the completion of the project. The findings have limited generalizability due to the small sample size and the setting.

At a small, private church-affiliated university, Hoffert, et al., (2007), “explored the effectiveness of an intervention program designed and implemented to enhance nursing students’ comfort level with and ability to perform, a spiritual assessment by addressing identified barriers” (p. 66). Using Jean Watson’s (1999) theory of caring as a theoretical foundation, a seminar about the nurse’s role in assessing and providing spiritual care was conducted. The participants (n=38) were asked to complete a spiritual self-assessment and demonstrate acquired skills using a researcher-developed (Client Spiritual Assessment Tool – CSAT), (Hoffert, et al., 2007). It was determined that students’ comfort and confidence came not only with knowledge but also with experience (Hoffert, et al., 2007).

Wallace et al. (2008) explored integrating spirituality into the undergraduate nursing curricula and measured student (n=33 junior students, n=34 senior students) outcomes related to spiritual knowledge and attitudes. Faculty participated in a spirituality education program and then integrated spiritual content into individual nursing courses. Pre- and post-tests were administered to students to evaluate effectiveness of the program and the differences between the junior and senior students (Wallace et al., 2008). Paired *t*-tests were used to compare the student scores. Significant differences ($p < .05$) were found between the scores for the senior level

students. Their responses showed that the curriculum integration had expanded their thoughts about nurses' ability to provide spiritual care by spending time with the patient, helping them to find meaning and purpose in his or her illness, and listening and allowing patients to discuss and explore their fears and anxieties (Wallace et al., 2008)

Baldacchino (2008) introduced a study unit entitled "The Spiritual Dimension in Care" to a diploma nursing curriculum at the University of Malta. The aim of the unit was to increase students' (n=65) awareness of spirituality in nursing care. The study unit was based on the *ASSET* model presented by Narayanasamy (1999). *ASSET* is a model for "actioning" (inspiring action), spirituality, and spiritual care education and training in nursing. Traditional teaching methods, e.g., lecture and seminar, as well as self-reflection exercises, case-studies, and small group discussions were used to enhance learning. The students reported that they were Christians, which is consistent with the culture in Malta, but would limit the generalizability of the results. Each student reported his or her individual values were improved after the study unit. Results also showed the students broadened their definition of spirituality and spiritual care while clarifying their understanding of holistic care (Baldacchino, 2008).

In a dissertation by Barber (2008) entitled, *Nursing Students' Perception of Spiritual Awareness After Participating in a Spirituality Project*, the phenomenon of nursing students' (n=11 from a small private college) abilities to address the spiritual needs of patients after participating in a spirituality project were explored. Watson's (1999) theory was used as the conceptual framework. Research questions that guided the study were: How did nursing students perceive the experience of listening to individuals tell their life story? How did patients perceive the experience of telling

someone their life story? In what ways did the spirituality workshops and oral history project impact nursing students? In what ways did participating in spirituality workshops and the oral history projects impact the care students provide? The participants verbalized personal, professional, and spiritual growth after participating in the spirituality workshop and oral history project. Overwhelmingly they reported that the experience impacted their professional skills and improved how they deliver nursing care.

Mahon-Graham (2008), in her dissertation entitled, *Nursing Students' Perception of How Prepared They are to Assess Patients' Spiritual Needs*, used a mixed method design to examine nursing students' perceptions of competence in assessing patient's needs. Students' recognition of spiritual needs was scored after participation in a 4-hour spirituality seminar. Pre- and posttest data were collected from senior nursing students (n=24 from a small Midwestern Christian College) using the *Spiritual Assessment Scale* (SAS). The qualitative portion of the study used a phenomenological interview approach to assess students' perceptions (Mahon-Graham, 2008). Five themes emerged from the data analysis that described the students' experience assessing and providing spiritual care to their patients after participating in a spirituality seminar: (a) students personal spiritual beliefs, (b) spiritual interventions, (c) assessing patients' spiritual needs, (d) personal beliefs impacting nursing care, and (e) spirituality in nursing education.

Lemmer (2002) explored how the spiritual dimension of nursing care was being taught in baccalaureate nursing programs in the United States. Representatives from both public and private nursing programs were asked to report how the spiritual

dimension of care was incorporated within the curriculum. The majority of schools included the spiritual dimension, 71% in their philosophy and 96% in the curriculum. Respondents agreed that holistic nursing care, including the spiritual dimension, is important and that the content is teachable. Nursing faculty's willingness to teach and participate in the teaching of the spiritual dimension reflects some of the findings in other studies, lack of time, and faculty's uncertainty in their understanding and knowledge of the spiritual dimension (Lemmer, 2002).

In most cases, authors found that spiritual content in nursing curriculums take the form of an elective class or seminar added to a standing curriculum. Small numbers of students in faith-based institutions are the primary participants in the classes and studies being conducted (Baldacchino, 2007; Barber, 2008; Hoffert, et al., 2007; Lovanio & Wallace, 2007; Mahon-Graham, 2008; Wallace et al., 2008).

There is no significant research in public community colleges leaving a gap in the literature. These discoveries along with the professional mandates to include spirituality in nursing curriculum are the bases for the proposed study of nursing programs in public community colleges in the southeast United States.

CHAPTER 3

METHODOLOGY

The purpose of this study was to determine associate degree nursing faculty's perception of their ability to teach nursing students about the spiritual dimension in the delivery of nursing care. The study also explored whether faculty have received training related to spiritual care, how and where nursing programs integrate spirituality education into the curriculum, nursing faculty's understanding of the terms spirituality and spiritual care, and faculty members perception of whether they receive sufficient support and guidance in teaching related to spirituality and spiritual care. This chapter describes the methodology and research design used to conduct this study. The design, population, measures, and procedures are also described.

Design

The design used for this study is descriptive. According to Polit and Beck (2008) descriptive research is used to describe and document a particular phenomenon. The incorporation of the spiritual dimension into associate degree nursing curriculum is the phenomenon in this case. Since the researcher is seeking to identify faculty perceptions of their ability to teach the spiritual dimension of nursing care a descriptive design is appropriate for this study. The research aims and questions will be used to discover how associate's degree nursing programs incorporate the spiritual dimension in the curriculum and faculty's perceptions of teaching spirituality.

The specific aims and questions are as follows:

Aims:

- Discover and explore faculty members' understanding of and attitudes towards the concepts of spirituality and spiritual care.
- Identify whether the spiritual needs of patients are recognized by faculty members in the delivery of nursing care.
- Establish whether faculty members feel that they are providing sufficient education and training to enable students to effectively meet patients' spiritual needs.
- Explore the associations that may exist between religious belief and faculty members' understanding of spirituality and the provision of spiritual care.

Questions:

- What are nursing faculties' understanding of the terms spirituality and spiritual care?
- How does nursing faculty perceive their ability to teach spirituality to nursing students?
- How does nursing faculty integrate spirituality education in the nursing curriculum?
- Do faculty members feel that they receive sufficient support and guidance in teaching related to spirituality and spiritual care?

Sample

A convenience sample of faculty members teaching in publically funded Accrediting Commission on Education in Nursing (ACEN) accredited associate degree nursing programs were used. The sample was chosen from associate degree nursing programs in the southeastern United States (TRIPmedia, 2010). A total of 204 publically

funded schools offering an associate's degree in nursing were identified in this specified region. The states included are Alabama, Arkansas, Florida, Georgia, Kentucky, Louisiana, Mississippi, North Carolina, South Carolina, Tennessee, Virginia, and West Virginia (TRIPmedia, 2010).

A National Statistical Series Calculator was used to determine acceptable sample size and power analysis. Using a confidence level of 0.95 and a power of 0.80 and a target population of approximately 2000 faculty members, a minimum sample of 323 participants would be needed to reach statistical significance (National Statistical Series Calculator, 2015).

Inclusion and Exclusion Criteria

Inclusion criteria were identified as faculty teaching in publically funded, associate degree, ACEN accredited nursing programs. The faculty included in the study must teach full-time in the designated southeastern United States.

Exclusion criteria were identified, as faculty teaching primarily in other levels of nursing education such as licensed practical nurse, baccalaureate, masters', and doctoral education. Also excluded were faculty classified as adjunct and those who taught in programs not identified as public, as well as those whose primary teaching assignment was outside the identified southeastern United States.

The potential benefit to participants was the opportunity for the faulty member to lend their experience and their voice in the development of nursing knowledge by completing the survey. The knowledge gained by the survey will help to facilitate and/or enhance the inclusion of the spiritual dimension in nursing care throughout nursing curricula.

Setting

The survey for this study was administered electronically. Participants were able to complete the survey anonymously in a convenient location.

Instrumentation

The survey instrument that was used, included a combination of tools developed by McSherry, Draper, and Kendrick (2002) incorporating the *Spirituality and Spiritual Care Rating Scale (SSCRS)*, and an investigator-designed tool by Lemmer (2002). Both authors gave permission for the use of their tool (see permission letters in Appendix B). The combination of the tools was accomplished by merging the demographic sections so there is not duplication in the questions. Setting up the questions in different parts allows both tools to be used in an efficient manner. Part A was the demographic section. Part B was the *Spirituality and Spiritual Care Rating Scale* (McSherry & Jamieson, 2011) used to measure faculty perception of spiritual care. Part C had questions about the participant's particular nursing program. Part D included questions for faculty to rank the degree certain content related to the spiritual dimension is included in their nursing curriculum and for attitudes that might have influenced the teaching of the spiritual dimension. Part E further explored faculty's perception of providing spiritual care, how prepared they are to provide spiritual care, and who they perceive is responsible for providing education about spiritual care. Finally, Part F finished the survey with two questions about possible religious affiliation (see Appendix C).

McSherry and Jamieson (2011) surveyed nurses from the Royal College of Nursing in the United Kingdom. McSherry's tool included the *Spirituality and Spiritual Care Rating Scale (SSCRS)*, (McSherry, Draper, & Kendrick, 2002), questions about

nursing practice, demographic information, and several open-ended questions for comments. The second tool designed by Lemmer (2002) was used to survey baccalaureate nursing programs in the United States, related to their inclusion of the spiritual dimension of nursing care. Lemmer's tool includes some demographic, as well as Likert-type questions.

McSherry, Draper, and Kendrick (2002) conducted a survey to determine construct validity of the *SSCRS* as well as to identify associations between items on the scale. A 17-item instrument with four factor-based subscales including: Spirituality, Spiritual Care, Religiosity, and Personalized Care were the result. The *SSCRS* has been used in 42 different studies and internationally. The scale was determined to have a reasonable level of internal consistency and reliability with a Cronbach's alpha coefficient of 0.64. A Cronbach's alpha coefficient of 0.66 was determined for the current study.

Lemmer's instrument was researcher developed and reviewed by content experts in order to establish content validity. The instrument, the *Spiritual Care Content Scale* (SCCS; 2002), included two questions that asked for program definitions of spirituality and spiritual care along with a 25-item Likert scale of content used in teaching spiritual care. A 13-item checklist of instructional methods and a 14-item Likert scale of attitudes that influence the teaching of the spiritual dimension were also incorporated in the instrument. The last section of the instrument had two open-ended questions to elicit further information (Lemmer, 2002). The resulting combination tool that was used for this study has been evaluated for content validity and usefulness by several content experts.

The use of these two instruments allowed nursing faculty to express their perceptions of the spiritual dimension and teaching, and the depth to which the spiritual dimension is incorporated into their current nursing curricula. Demographics in the instruments include age, gender, years in nursing education, highest earned nursing degree, status of employment (full-time, part-time, adjunct), and area of teaching responsibility.

Procedure

Data collection for this study was conducted using survey research. According to Polit and Beck (2014), the focus of survey research is on “what people do and how they feel” (p. 324). Survey research is used to collect data from a large sample of participants in a short period of time.

Participants were solicited from the Accrediting Commission for Education in Nursing (ACEN) accredited public funded associate degree nursing programs in the southeastern region of the United States. Contact information for the Dean’s and Directors of programs within the states selected for inclusion was also obtained from the ACEN list of accredited programs.

An email including an explanation of the study, a survey link, and a request that the survey be forwarded to full-time nursing faculty was sent to the Dean’s and Directors of the included nursing programs. A follow-up reminder email was sent approximately 2 weeks after the initial contact. The survey was designed to take approximately 20 minutes to complete.

Informed consent information was included at the beginning of the survey. Participants were able to continue with the survey or choose not to participate. The

submission of a completed survey was considered consent to participate in the study. Surveys were anonymous and did not include participant's names or place of employment. Surveys were submitted through an online survey site housed at East Tennessee State University and accessible through the College of Nursing Research Center. Collection of the data occurred during the summer/fall semester, 2015.

Analysis

Surveys received were reviewed for completeness and to determine if they met inclusion criteria. Responses were imported and analysis completed using SPSS (2015). Descriptive statistics were used to highlight the characteristics of those who responded. According to Polit and Beck (2014) descriptive statistics are used to describe and summarize data. The demographic information included age, gender, highest earned degree in nursing, years in nursing education, and primary area of teaching responsibility. The status of employment (full-time, part-time) were also collected to confirm inclusionary status.

Other statistical tests that were used included frequencies and percentages. This data is illustrated in tables and charts to highlight the most important findings. Polit and Beck (2014) define "frequency distribution as a systematic distribution that brings order to the data, making it easier to see values from high to low, how many times each value occurred, and how they may cluster by using counts and percentages" (p.215).

For the first research question, faculty was asked to describe their understanding of the terms spirituality and spiritual care. The second question, sought faculty perception of their ability to teach spirituality to nursing students. The third question asked how faculty integrates spirituality education in the nursing curriculum, and the

final question 4 asked faculty members if they feel that they receive sufficient support and guidance in teaching related to spirituality and spiritual care. Each of the responses were analyzed using descriptive statistics. The responses were summed and divided by the number of surveys received and reported as percentages.

Human Subjects

The study was approved by the East Tennessee State University (ETSU) institutional review board as an exempt study. The IRB process was used to assure the protection of human subjects. According to the Collaborative Institutional Training Initiative (CITI, 2014) some of the most challenging tasks of the IRB are identifying and evaluating risks associated with participation in research. Risks associated with social and behavioral research can include invasion of privacy, breach of confidentiality, and in the actual study procedures.

Invasion of privacy can occur if personal information is accessed or collected without the subject's knowledge (CITI, 2014). In this study participants completed a survey anonymously, and no identifying information was collected other than possibly the state in which their school resides. Breach of confidentiality occurs when an unauthorized release of data could have a negative effect on the participant's psychological, social economic status (CITI, 2014). Participants in this study were not personally identified and there were no identifying factors to release. Study procedures themselves can place a participant at risk, especially if the study involves interviews about sensitive materials such as gang activity, sexual orientation, or domestic violence (CITI, 2014). This study involved an online survey and posed minimal risk to the participant.

When assessing risk there were several factors: probability and magnitude of harm, situation and time, and subject population. As researchers it is very easy to underestimate risks when the activities are familiar, and overestimate the benefit of the activities when it is something important to the researcher (CITI, 2014). Federal regulations require that potential risks be reasonable as they relate to the benefits (CITI, 2014). Within this study the potential risks were minimal and the potential benefit to participants was the opportunity for the faulty member to lend their experience and their voice in the development of nursing knowledge by completing the survey. The knowledge gained by the survey will hopefully help to facilitate and/or enhance the inclusion of the spiritual dimension in nursing care throughout nursing curricula.

The Belmont Report (1979), addressed the disparities of early research in the United States. A group of researchers met and ultimately published "*Ethical Principles and Guidelines for the Protection of Human Subjects of Research.*" Autonomy of the participants was considered one of the most important principles. Participants must be empowered to make decisions related to their health and well-being. They must be given the choice to participate in the research. It is important that the participant realizes that participation is voluntary and that they may withdraw at any time. Informed consent is part of respecting the participants, educating them about the study and the potential risks and benefits is part of informed consent. Other ethical principles include beneficences (to do no harm) and justice to insure that all participants are treated in an equitable fashion and to protect those most vulnerable.

Summary

The information sought by the researcher was intended to assist administrators of nursing programs and nursing faculty to integrate the spiritual dimension of nursing care into the nursing curricula with greater depth. This descriptive research study was designed to seek information from associate degree nursing educators in the southern region of the United States. After the research questions were identified a sample size, along with inclusion and exclusion criteria were also identified. The limitations and benefits of the study were determined and addressed. The instruments for data collection were selected for usefulness, reliability, and validity. Data analysis techniques were identified and discussed. The Institutional Review Board at East Tennessee State University reviewed and approved the exempt study. Information gained from this study will provide insight and strategies for associate degree nurse educators for inclusion of the spiritual dimension into the nursing curricula.

CHAPTER 4

RESULTS

The purpose of this study was to determine associate degree nursing faculty's perception of their ability to teach nursing students about the spiritual dimension of nursing care. Other considerations were related to integration of spirituality education into the curriculum, whether faculty have received training related to spiritual care and their perception of whether they receive adequate support in teaching spiritual care, and to determine their understanding of the terms spirituality and spiritual care.

The power analysis for this study recommended a total of 328 surveys to reach statistical significance based on an estimated sample of 2000 faculty. This number was not obtained.

Using survey research, data collection for the study occurred during the summer and fall semesters of 2015. Responses to the survey relied on individual self-report. Surveys were sent to 204 associate degree programs with instructions to include all full-time faculty members. Initially, 214 surveys were returned and after a review of the data 206 surveys were included in the data analysis. Those not considered failed in meeting the inclusion criteria for the study. Five respondents indicated that they worked part-time and three of the surveys were incomplete. The return rate was 65% with 62% of the surveys being usable.

Demographics

Participants for this study were solicited from the Accrediting Commission for Education in Nursing's (ACEN) accredited, publically funded associate degree nursing

programs in the southeastern region of the United States (n=12 states). Contact information for the Dean's and Directors of programs within the states selected for inclusion were also obtained from the ACEN list of accredited programs. Returned surveys were representative of all of the states except Virginia with approximately 50% of the sample coming from Alabama, Florida, and Tennessee (51.5%, n=95)

(Table 1).

Table 1. *Demographics*

Variables	Frequencies (%)
Age	
– 21-29	2 (1%)
– 30-39	31 (15%)
– 40-49	50 (24.3)
– 50-59	80 (38.8%)
– 60 or above	43 (20.9%)
Gender	
– Male	5 (2.4%)
– Female	200 (97.1%)
Years as Registered Nurse	
– Less than 1 year	1 (.5%)
– 1-5 years	2 (1%)
– 6-10 years	26 (12.9%)
– 11-25 years	72 (35.8%)
– 25+ years	100 (49.8%)
Years as Nurse Educator	
– Less than 1 year	6 (2.9%)
– 1-5 years	58 (28.3%)
– 6-10 years	57 (27.8%)
– 11-25 years	62 (30.2%)
– 25+ years	22 (10.7%)
Primary Teaching Responsibility	
– Classroom	186 (90.7%)
– Clinical	19 (9.3%)
Faculty Rank	
– Instructor	95 (46.3%)
– Assistant Professor	39 (19%)
– Associate Professor	31 (15.1%)
– Professor	31 (15.1%)
– Other	10 (4.5%)
Where did you receive your training?	
Community College	48 (27.7%)
Diploma	9 (4.4%)
University	116 (67.1%)

Table 1. (continued).

During the course of your nurse training did you receive content covering spiritual care?	
Yes	93 (53.8%)
No	80 (46.2%)
Since qualifying as a nurse have you been to any training courses that covered spiritual care?	
Yes	55 (32.4%)
No	115 (67.6%)
Do you feel nurses receive sufficient training related to spiritual care?	
Yes	26 (15.1%)
No	146 (84.9%)
Do you have a religion/denomination?	
Yes	156 (89.1%)
No	19 (10.9%)
Are you practicing your religion?	
Yes	146 (85.9%)
No	26 (15.1%)
In what state is your program located?	
– Alabama	25 (13.1%)
– Arkansas	7 (3.8%)
– Florida	37 (20.3%)
– Georgia	23 (12.6%)
– Kentucky	4 (2.2%)
– Louisiana	7 (3.8%)
– Mississippi	13 (7.1%)
– North Carolina	13 (7.1%)
– South Carolina	11 (6%)
– Tennessee	33 (18.1%)
– Virginia	0 (0.0%)
– West Virginia	5 (2.7%)

Of those who responded, 97.1% (n=200) were female and 2.4% (n=5) were male. The ages of the participants ranged from 21-60+ years, with almost 60% aged 50 years or above. Almost half of the participants had been registered nurses for 26 or more years (n=100, 49.8%), but the number of years as a nurse educator varied. Sixty-two participants had been a nurse educator for 11-25 years (30.2%), 58 participants for 1-5 years (28.3%), and 57 participants for 6-10 years (27.8%). The overwhelming majority of participants taught in the classroom (90.7%, n=186) and the greatest number of participants were at the instructor rank (46.3%, n=95).

When asked where the faculty's initial training occurred 67.1% (n=116) said at a university, 27.7% (n=48) at a community college, and 4.4% (n=9) at a diploma nursing program. The respondents (n=102) also listed the colleges they attended, with the largest portion being in the southeast (78%, n=80). Other regions represented include, north central (5%, n=6), northeast (5%, n=6) and the southwest (2.9%, n=3) United States. Five (4.9%) individuals did not list the name of their college.

Respondents indicated whether they received spiritual care training while in their initial program with 53.8% (n=93) saying yes and 46.2% (n=80) saying no. Of those who responded to the question about receiving additional training or attending a seminar related to providing spiritual care, only 32.4% (n=55) responded yes, with 67.6% (n=115) indicating they had no further training in spiritual care past their initial training.

When answering the questions do you have a religion/denomination and do you practice your religion, the majority responded yes (89.1%, n=156 and 85.9%, n=146 respectively). Of those who specified their religions 97.3% (n=109) were Protestant, 14.2% (n=19) were Catholic, 1.5% (n=2) were Jehovah's Witnesses, 1.5% (n=2) were Latter Day Saints, and .07% (n=1) stated none.

Sixty individuals responded to the open-ended question about how they practice their religion/spirituality. Most of the respondents listed weekly services, prayer, bible study/reading, participating in mission work, and singing in the choir as ways they practice their religion. Two listed that they are Faith Community Nurses in their church. One stated that regular communion with nature and conversations with those who have transitioned to the spirit world and practicing touch therapy with patients was how they practiced their beliefs. One individual questioned this request stating that it was

impinging on their personal right to practice their faith. The suggestion was to change the question to “please describe how you practice your faith or demonstrate spirituality.”

Results of Research Questions

Understanding of Spirituality and Spiritual Care

The first research question was asked to determine nursing faculties’ understanding of the terms spirituality and spiritual care. This question was answered using the tool adapted from McSherry and Jamieson (2011), the *Spirituality and Spiritual Care Rating Scale (SSCRS)*. Frequencies for each of the 17 items were analyzed and are displayed in Table 2. Respondents answered strongly disagree to strongly agree on a 5 point scale. Cronbach’s alpha for the tool was 0.66.

Table 2. *Spirituality and Spiritual Care Rating Scale (SSCRS)* (McSherry & Jamieson, 2011).

Item (percentile/frequency)	SD	D	U	A	SA
I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient’s own religious leader if requested.	1.9 (4)	1.5 (3)	2.4 (5)	31.1 (64)	63.1 (130)
I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care.	1.0 (2)	1.0 (2)	3.9 (8)	16.7 (34)	77.5 (158)
I believe spirituality is concerned with a need to forgive and a need to be forgiven.	2.4 (5)	10.2 (21)	22.0 (45)	32.7 (67)	32.7 (67)
I believe spirituality involves only going to Church/Place of Worship.	63.1 (130)	31.6 (65)	1.9 (4)	1.5 (3)	1.9 (4)
I believe spirituality is not concerned with a belief and faith in a God or Supreme Being.	43.7 (90)	24.5 (50)	11.3 (23)	11.8 (24)	8.3 (17)
I believe spirituality is about finding meaning in the good and bad events of life.	5.9 (12)	9.8 (20)	23.5 (48)	37.5 (76)	23.5 (48)

Table 2. (continued).

I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need.	1.5 (3)	1.0 (2)	1.0 (2)	35.9 (74)	60.7 (125)
I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness.	2.9 (6)	7.3 (15)	15 (31)	37.4 (77)	37.4 (77)
I believe spirituality is about having a sense of hope in life.	1.5 (3)	2.4 (5)	8.3 (17)	37.1 (76)	50.7 (104)
I believe spirituality is to do with the way one conducts one's life here and now.	2.9 (6)	8.8 (18)	15.7 (32)	35.8 (73)	36.8 (75)
I believe nurses can provide spiritual care by listening to and allowing patient's time to discuss and explore their fears, anxieties and troubles.	.5 (1)	.5 (1)	3.4 (7)	32.7 (67)	62.9 (129)
I believe spirituality is a unifying force which enables one to be at peace with oneself and the world.	3.9 (8)	3.9 (8)	8.7 (18)	32 (66)	51.5 (106)
I believe spirituality does not include areas such as art, creativity and self-expression.	38.5 (78)	39.5 (81)	10.7 (22)	8.3 (17)	2.9 (6)
I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient.	1.0 (2)	1.5 (3)	1.5 (3)	20.4 (42)	75.7 (156)
I believe spirituality involves personal friendships, relationships.	1.0 (2)	5.4 (11)	16.6 (34)	38 (78)	39 (80)
I believe spirituality does not apply to Atheists or Agnostics.	41.3 (85)	30.1 (62)	19.4 (40)	4.4 (9)	4.9 (10)
I believe spirituality includes people's morals.	1.5 (3)	5.3 (11)	12.1 (25)	40.8 (84)	40.3 (83)

Of those who responded to the first item 94.2% (n=194) agreed or strongly agreed that nurses could provide spiritual care by arranging a visit by a religious leader, however, 94.7 (n=95) disagreed or strongly disagreed that attendance at church or a worship space is the sole means to meet spiritual needs. Respondents agreed or strongly agreed that some of the ways that nurses can provide spiritual care are giving

reassurance and support when needed (96.6%, n=199), having respect for the patient's cultural beliefs, dignity, privacy, and religious beliefs (96.1%, n=198), by taking time to listen to and allow patient's an opportunity to explore their anxieties, fears, and troubles (95.6%, n=196), by showing cheerfulness, concern and kindness (94.2%, n=192), and by assisting the patient to identify meaning and purpose after diagnosis of their illness (74.8%, n=154). Respondents also agreed or strongly agreed that spirituality (a) is about having hope (87.8, n=180), (b) allows one to find peace (83.5%, n=172), includes morals (81.1%, n=167), (d) involves friendships and other relationships (77.0%, n=158), and (e) is concerned with forgiveness (64.4%, n=134).

Respondents disagreed or strongly disagreed that spirituality does not (a) involve art and creativity (78.0%, n=159), (b) apply to agnostics and atheists (71.4%, n=147), and (c) involve a Supreme Being or God (68%, n=140). Finally, 76 respondents (37.5%) agreed that spirituality can involve finding relevance in the good and bad that happens in life. Forty-eight respondents (23.5%) strongly agreed and the same number was uncertain about this item.

Teaching Spirituality to Nursing Students

The second research question ascertained nursing faculty's perception of their ability to teach spirituality to nursing students. The *Spiritual Care Content Scale* (SCCS; Lemmer, 2002), a 25-item Likert scale of content used in teaching spiritual care was used to determine content included in the nursing curricula at the respondents schools. Respondents answered on a 4 point scale: not covered, covered briefly, covered moderately, and covered in depth (see Table 3).

Nursing faculty responded that spirituality as the search for meaning and purpose in life and as the search for hope for the future was covered briefly or moderately (73.8%, n=147 and 75.1%, n=142 respectively). Also covered briefly or moderately was spirituality as the dimension of the person concerned with: (a) when and how to make

Table 3. *Spiritual Care Content Scale (SCCS)*,(Lemmer, 2002)

Item (percentile/frequency)	Not taught	Covered Briefly	Covered Moderately	Covered in Depth
1. Spirituality as the search for meaning and purpose in life	15(31)	45.9(94)	27.9(53)	6.3(12)
2. Spirituality as the search for hope for the future	20.6(39)	49.2(93)	25.9(49)	4.2(8)
3. Spirituality as the dimension of the person concerned with the person's relationships with self and others, including the need for forgiveness	18.9(36)	39.5(75)	36.8(70)	4.7(9)
4. Spirituality as the person's relationship with a Higher Power, however the individual defines that (e.g., God, Allah, Buddha)	15.3(29)	38.4(73)	37.4(71)	8.9(17)
5. Assessment of spiritual needs (i.e., how to identify spiritual needs of patients and families)	5.9(11)	22.9(43)	43.6(82)	27.7(52)
6. Sensitivity to cues that may indicate spiritual needs (e.g., presence of religious articles, verbalization about God)	5.3(10)	26.6(50)	46.8(88)	21.3(40)
7. Use of a formal spiritual assessment tool (e.g., JAREL, Spiritual Well-being)	52.1(99)	35.3(67)	8.9(17)	3.7(7)
8. NANDA diagnoses related to spiritual distress or spiritual well-being	6.3(12)	36(68)	41.3(78)	16,4(31)
9. Review of beliefs/health practices of major religions (e.g., birth and death/dying rituals, dietary requests)	3.2(6)	27.9(53)	45.3(86)	16.4(31)
10. Review of influence of cultural beliefs/values on spiritual care	2.6(5)	19.5(37)	52.1(99)	25.8(49)

Table 3. (continued).

11. When/how to make referrals to pastoral care or the client's minister	7.4(14)	43.7(83)	35.3(67)	13.7(26)
12. Spiritual needs of atheists and agnostics	43.9(83)	43.4(82)	10.6(20)	2.1(4)
13. When/how to pray with patients and/or families	34.6(65)	42(79)	17.6(33)	5.9(11)
14. Use of scripture	66.1(125)	23.3(44)	10.1(19)	.5(1)
15. Active listening as a spiritual care intervention	6.9(13)	27(51)	37.6(71)	28.6(54)
16. "Being with"/"presence to" as a spiritual care intervention	16.9(32)	31.7(60)	29.6(56)	21.7(41)
17. Use of touch as a spiritual care intervention	10.6(20)	33.3(63)	36(68)	20.1(38)
18. Factors related to the appropriateness of sharing the nurse's spiritual beliefs with the client	20.1(38)	41.3(78)	29.6(56)	9(17)
19. Spiritual needs of the dying and their significant others	1.6(3)	22.22(42)	43.4(82)	32.8(62)
20. Crisis situations as triggers to spiritual questions/concerns	13.3(25)	30.3(57)	37.8(71)	18.6(35)
21. Importance of the nurse's self-knowledge when dealing with spiritual needs of clients	5.3(10)	31.7(60)	39.2(74)	23.8(45)
22. Provision of privacy for client's/family's need for solitude	2.6(5)	22.2(42)	43.4(82)	31.7(60)
23. Recognition of the client's definition of spirituality	6.3(12)	26.5(50)	46.6(88)	20.6(39)
24. The interrelationship of spiritual well-being with physical and emotional well-being	3.2(6)	30.3(57)	43.1(81)	23.4(44)
25. The nurse's role in support of religious practices (e.g., medicine man, sacraments).	6.3(13)	39.7(75)	33.9(64)	19.6(37)

appropriate referrals for pastoral care (79%, n=150), (b) NANDA nursing diagnoses related to spiritual distress or well-being (77.3%, n=146), (c) the person's relationships including the need for forgiveness (75.8%, n=145), (d) the persons relationship with a higher power (75.8%, n=144), (e) sensitivity to cues such as noticing the presence of

religious articles or verbalization about God (73.4%,n=138), (f) the interrelationship of spiritual well-being with physical and emotional well-being (73.4%, n=138), (g) review of beliefs and health practices of major religions (73.2%, n=139), (h) factors related to the appropriateness of sharing the nurse's spiritual beliefs with the client (70.9%, n=134), and (i) the use of touch as a spiritual care intervention (69.3%, n=131),

Some of the items covered moderately and in depth included (a) the influence of cultural beliefs on spiritual care (77.9%, n=148), (b) spiritual needs of the dying and their families (76.2%, n=144), (c) the assessment of spiritual needs (71.3%, n=134), and (d) active listening as a means of spiritual care (66.2%, n=125). Over half of the respondents stated that the influence of cultural values and beliefs on spiritual care was covered moderately (52.1%, N=99).

Items listed as not taught or covered briefly included (a) the use of scripture as a way to meet patients spiritual needs (89.4%, n=169), (b) use of a formal assessment tool (87.4%, n=166), (c) spiritual needs of atheists and agnostics (87.3%, n=165), (d) how and when to pray with patients (76.6%, n=144). Approximately two-thirds of the respondents did not teach the use of scripture (66.1%, n=125) and over 50% of the respondents said that a formal tool to measure spirituality was not used or taught (52.1%, n=99).

The *Program Attitude Scale* (PAS; Lemmer, 2002) was used to elicit program or faculty attitudes about teaching spiritual care (see Table 4). Respondents answered each of the 14 questions on a 5 point scale from strongly disagree to strongly agree. Several statements received a strong response by respondents. In response to the statements (a) holistic nursing care includes spiritual care 97.3%, (n=179), (b)

spiritual care is a significant part of nursing care 89.1% (n=164), (c) spiritual care can be taught, 84.6% (n=154) and, (d) religiosity is one aspect of spirituality 81.4% (n=149), faculty either agreed or strongly agreed.

Table 4. *Program Attitude Scale (PAS)*, (Lemmer, 2002).

Item (percentile/freq)	SD	D	U	A	SA
Spiritual care can be taught.	1.1 (2)	1.1 (2)	13.2 (24)	53.3 (97)	31.3 (57)
Religiosity is one aspect of spirituality.	2.2 (4)	6 (11)	10.4 (19)	52.5 (96)	29 (53)
Spiritual care is a significant part of nursing care.	.5 (1)	4.3 (8)	6 (11)	44 (81)	45.1 (83)
Holistic nursing care includes spiritual care.	.5 (1)	0 (0.0)	2.2 (4)	32.1 (59)	65.2 (120)
Nursing faculty have the necessary knowledge to teach about the spiritual dimension of nursing care.	4.3 (8)	13 (24)	32.1 (59)	31.5 (58)	19 (35)
Issues related to the separation of church and state affect our program's ability to teach about the spiritual dimension.	16.3 (30)	13 (24)	32.1 (59)	31.5 (58)	19 (35)
Providing care directed toward the spiritual dimension of the client and his/her family is not a nursing role.	57.9 (106)	28.4 (52)	6 (11)	3.8 (7)	3.8 (7)
Faculty are not comfortable teaching spiritual care content.	13.1 (24)	29.5 (54)	25.7 (47)	25.1 (46)	6.6 (12)
There is not enough time within the curriculum to address spiritual care.	17.4 (33)	26.6 (49)	20.1 (37)	24.5 (45)	11.4 (21)
There is confusion of religiosity with spirituality which makes teaching about the spiritual dimension of care difficult.	8.2(15)	27.2(50)	20.7(38)	35.3(65)	8.7(16)

Table 4. (continued).

There is a lack of clarity as to what are psychosocial and what spiritual needs are.	9.3 (17)	37.2 (68)	20.2 (37)	27.3 (50)	6 (11)
Religion and spirituality are one and the same.	38.3 (70)	44.8 (82)	8.7 (16)	6 (11)	2.2 (4)
Other content must take priority in the curriculum.	13.7 (25)	29.1 (53)	24.2 (44)	23.1 (42)	9.9 (18)
There is a lack of clarity as to what "spirituality" means.	10.9 (20)	32.2 (59)	15.8 (29)	30.6 (56)	10.4 (19)

When asked if nursing faculty have the necessary knowledge to teach about the spiritual dimension of nursing care about half either agreed or strongly agreed (50.5%, n=93) and about a third of those who responded were undecided (32.1%, n=59). When responding to the statement (a) religion and spirituality are one and the same, 83.1% (n=156), and (b) providing spiritual care is not a nursing role 86.3%, (n=158) either disagreed or strongly disagreed. When asked if issues related to the separation of church and state effected the faculty's ability to teach about the spiritual dimension 50.5% (n=93) agreed or strongly agreed and 32.1% (n=59) were undecided.

Six of the statements caused more of a division among the respondents with answers concentrated between disagree, undecided, and agree. The statements are (a) faculty are not comfortable teaching spiritual care content (29.5%, n=54; 25.7%, n=47; 25.1%, N=46), (b) there is not enough time within the curriculum (26.6%, n=49; 20.1%, n=37; 24.5%, n=45), (c) there is confusion of religiosity with spirituality (27.2%, n=50; 20.7%, n=38; 35.3%, n=65), (d) there is lack of clarity about spiritual needs (37.2%, n=68; 20.2%, n=37; 27.3%, n=50), (e) other content must take priority in the curriculum

(29.1%, n=53; 24.2%, n=44; 23.1%, n=42) and, there is lack of clarity as to what spirituality means (32.2%, n=59; 15.8%, n=29; 30.6%, n=56).

Spirituality Education in the Nursing Curriculum

The third research question was asked to determine how nursing faculty integrate spiritual care education in the nursing curriculum. Lemmer's (2002) checklist of possible methods was used to ascertain this information. Respondents could answer yes or no and in several areas could give details and/or examples. The responses to this checklist depicting methods used for teaching spiritual care are found in Table 5.

Table 5. *Method's Checklist*, (Lemmer, 2002).

Method (percentile/frequency)	Yes	No
Classroom lecture by faculty	87.4 (180)	12.6 (26)
Classroom group discussion	67 (138)	33 (68)
Clinical conferencing	51.5 (106)	48.5 (100)
Clinical assignment to care for dying patient	44.2 (91)	55.8 (115)
Discussion of case situations which include spiritual needs of clients	43.7 (90)	56.3 (116)
Required inclusion of nursing diagnoses related to spiritual needs in care plans or other client papers/presentations	29.6 (61)	70.4 (145)
Role modeling of spiritual assessment and intervention(s) by faculty in clinical setting	29.6 (61)	70.4 (145)
Student journaling about spiritual care experiences	26.7 (55)	73.3 (151)
Papers	15.5 (32)	84.5 (174)
Guest lectures by pastoral care or ministers	8.3 (17)	91.7 (189)
Clinical assignment in parish nursing	2.4 (5)	97.6 (201)
Field trips	2.4 (5)	97.6 (201)
Shadow experiences with pastoral care department	1.5 (3)	84.5 (174)
Guest Lectures by professors of Arts & Humanities	1 (2)	99 (204)

The methods used most often for teaching spiritual care were classroom lecture (87.4%, n=180), classroom discussions (67%, n=138), and clinical conferencing (51.5%,

n=106). These were followed by clinical assignments to care for a patient who is dying (44.2%, n=90) and case studies/situations at (43.7%, n=90).

Additional methods listed by 87 faculty included in an open ended question were (a) written work (papers, care plans, case studies) (24.1%, n=21), (b) simulations (20%, n=18), (c) lectures on cultural competence (11.4%, n=10), (d) death and dying and fetal death (9.1%, n=8), (e) presentations (6%, n=6), and (f) videos (5%, n=5). Only one respondent listed guest lectures by hospice nurses as a method.

Two nursing models were listed as helping with the content, Leininger's (2002) *Transcultural Nursing Care Model*, and the *Tanner Model of Self Reflection* (Tanner, 2006). *Quality and Safety in Nursing Education Competencies* (QSEN Institute, 2012) were also cited as a method used to teach about spiritual care. Fourteen faculty members (14.9%) stated that they used no other methods other than those listed in the methods table.

Another open-ended question elicited information about the inclusion of music, art and literature that was deemed helpful in teaching the spiritual care content. Of the 56 responses, (a) reading assignments (23.2%, n=13); (b) music (19.6%, n=10); (c) art (12.5%, n=7); (d) cultural competence assignments (11.4%, n=10); (e) religious writings/works, including the Bible (7%, n=4); and (f) videos, including YouTube clips (8.9%, n=5) were most often mentioned.

In addition, respondents mentioned articles by Brunner (2011) *Too Good for this World*, and Hoffert, et al., (2007) *Improving Student Perception of their Ability to Provide Spiritual Care*. A book by Fadiman (1997) *The Spirit Catches You and You Fall Down* was also listed as options to assist with teaching the spiritual dimension of nursing care.

Table 6 illustrates program specific questions related to program inclusion of definitions of spiritual care, where the content is included in the curriculum, and whether the spiritual dimension is included at the philosophy or mission level in the program. When asked if there was an agreed upon definition of spirituality, 88.8% (n=150) said no. The majority (61.3%, n=130) of respondents said that spiritual care concepts were integrated throughout their programs and 43.2% (n=89) said that it was a required unit in some courses.

Table 6. *Program Specific Questions*

Item (percentile/freq)	Yes	No
Does your nursing program's philosophy include a reference to the spiritual dimension of the human or person?	63.5 (115)	36.5 (66)
Is the spiritual dimension of nursing care taught in your curriculum?	82.8 (144)	17.2 (30)
Philosophy level	21.4 (44)	78.6 (162)
Mission level	9.7 (20)	90.3 (186)
Individual course on spirituality	3.4 (7)	96.6 (199)
Required unit in each course	4.4 (9)	95.7 (197)
Required unit in some courses	43.2 (89)	56.8 (117)
Required objective in each course	15.5 (32)	84.5 (174)
Does your program have an agreed upon conceptual definition of spirituality?	11.2 (19)	88.8 (150)
Does your program have an agreed upon definition of spiritual nursing care?	10.4 (17)	89.6 (147)
Spiritual care concepts are integrated throughout the curriculum	63.1 (130)	36.9 (76)
Spiritual care concepts are focused primarily in one course?	18 (37)	82 (169)

One respondent stated that spirituality is included in their Fundamentals of Nursing course outcomes, related to the use of the nursing process to meet individuals psychosocial and developmental needs of self-concept, sexuality, spirituality, and loss and grief. Only 21.4% (n=44) of the respondents said that spirituality is included in their philosophy and 9.7% (n=20) at the mission level of the program.

Faculty were asked to include phrases from their philosophy statement that refer to the spiritual dimension. Of the 52 responses the most prominent words reported in the philosophy statements were (a) spirituality/spiritual (65.3%, n=34), (b) holistic/holism (34.6%, n=18), (c) unique (23%, n=12) and (d) human flourishing (5.7%, n=3). The most complete statement listed was “Individuals are unique biological, psychosocial, and spiritual beings who strive to meet holistic needs.”

In addition to the program specific questions, participants were asked to give one or two examples of ways they had personally taught students about spirituality. There were 112 individual responses. Six respondents discussed how they role model spiritual care in front of their students by assessing patients at the bedside, praying with patients as requested, and using scripture for encouragement to patients and students. Other examples of how they teach their students are (a) lecture (35.7%, n=40), (b) case studies/care plans/written work/presentations (28.5%, n=32), (c) clinical/clinical conferencing (20.5%, n=23), (d) end of life discussions (17.8%, n=20), and (e) simulation (7.1%, n=8). Other words used to describe teaching were nurse’s role in spiritual assessment, NANDA nursing diagnosis, clinical decision making, cultural diversity and end of life content, holistic care, QSEN/patient centered care, use of exemplars throughout the lifespan in all aspects of illness, and role play. Two individuals said they had not taught this content.

Another aspect to be considered when teaching is who is responsible for providing spiritual care. Table 7 displays the responses to this question. The respondents replied yes to the following categories of caregivers: (a) the patient’s spiritual leader (52.9%, n=109), (b) combination of nurses and chaplain (50%, n=104),

(c) a combination of patients and family members (50%, n=103), (d) nurses (46.6%, n=96), (e) a combination of all (45.1%, n=93), (f) chaplain (43.7%, n=90), and (g) patients themselves (25.2%, n=52).

Further explanation was given in open ended responses from 10 individuals. Of those responses, three stated that the patient should take the lead or chose who is to assist with their needs. Other individual responses included all healthcare providers and

Table 7. *Who Should be Responsible for Providing Spiritual Care?*

Item (percentile/freq)	Yes	No
Who do you feel should be responsible for providing spiritual care?		
Nurses	46.6 (96)	53.4 (110)
Chaplain	43.7 (90)	56.3 (116)
Combination of Nurses/Chaplain	50.5 (104)	49.5 (102)
Patients	25.2 (52)	74.8 (154)
Patients family and friends	50 (103)	50 (103)
Nurses/Chaplain and patients themselves	45.1 (93)	54.9 (113)
Patient's own spiritual leader	52.9 (109)	47.1 (97)

ancillary staff, significant others, intradepartmental collaboration by those caring for the patient, social workers, therapists, and psychiatrists. Only one actually mentioned the nurse's responsibility to provide spiritual care and one said "I am not sure."

Respondents were asked about their own encounters with patients with spiritual needs. The majority, 96.6% (n=166) said they had encountered patients with spiritual

needs and 3.4% (n=6) said they had never encountered a patient with a spiritual need.

Table 8 lists the various ways the nurse became aware of the needs.

The patient was most often mentioned (65%, n=134) with listening to and observing the patient second (58.7%, n=121). When asked if they were usually able to meet the patient's spiritual needs 87.1%, (n=138) said yes.

Table 8. *Assisting with Spiritual Needs*

Item (percentile/freq)	Yes	No
In your clinical practice have you ever encountered a patient with spiritual needs?	96.5 (166)	3.5 (6)
How did you become aware of this need?		
– Patient himself/herself	65 (134)	35 (72)
– Patient's relatives/friends	21.8 (45)	78.2 (161)
– Nursing care plan	6.8 (14)	93.2 (192)
– Other nurses	14.1 (29)	85.7 (177)
– Chaplains/religious leaders	12.6 (26)	87.4 (180)
– Listening to and observing the patient	58.7 (121)	41.3 (85)
Do you feel you are usually able to meet your patient's spiritual needs?	86.8 (138)	13.2 (21)

Of those who answered yes, 100 responded to the open-ended question asking for further clarification of how the faculty help to meet patient's spiritual needs. The most common ways to meet the patient's needs were: (a) through referral to chaplain, spiritual guide, social worker, spiritual leader (31%, n=29); (b) through active listening (31%, n=29); and (c) through prayer (24%,n=26). Other ways mentioned were holding

the patient's hand, being present with the patients, and utilizing therapeutic communication skills. Those who responded to the open-ended question about not being able to meet patient's spiritual needs cited lack of time as the main reason, with personal discomfort and the uniqueness of the individual's needs playing a role in the situations.

Support for Teaching Spirituality and Spiritual Care

The fourth research question sought faculty member's perception of guidance and support in teaching content related to spirituality and spiritual care. When asked if they receive sufficient training on matters concerning spiritual care (see Table 1), the nursing faculty responded primarily that they did not (84.1%, n=146).

As noted earlier approximately half of the respondents indicated that they received spiritual care training while in their initial nursing program (53.8%, n=93). Of those who responded to the question about receiving additional training or attending a seminar related to providing spiritual care only 32.4% (n=55) responded yes, with 67.6% (n=115) indicating they had no further training in spiritual care past their initial training.

The respondents (n=42) were asked to give details of extra training they may have received to better equip them to provide spiritual care. Seven of the respondents said they were Faith Community Nurses; multiple others listed seminars, workshops, and continuing education as ways they have used to improve their knowledge, skills, and opportunities to provide spiritual care. Hospice and end-of-life care were also listed as resources for both nurses and patients. Another resource that was mentioned was the End-of-Life Education Consortium (ELNEC). The curriculum for this training course is offered through the American Association of Colleges of Nursing. When asked who

should be responsible for teaching nurses/students about spiritual care, the majority of the answers were nursing educators/schools (68.3%, n=80), the healthcare facilities who employ nurses (21.3%, n=25) and, chaplain/spiritual leader/expert (12.8%, n=15).

Summary

This study supported the current literature about the lack of perceived training for nurses related to the spiritual dimension and the need for an agreed upon definition of spirituality and spiritual care. It was gratifying to find that the participants were passionate about this topic in many ways, even though they still expressed feelings of inadequacy. Many commented that there needed to be a more concerted effort to include spirituality in the curriculum at their schools. The findings confirmed that many traditional methods were being used to teach the spiritual dimension, but some newer methods were mentioned like simulation. The respondents take responsibility for providing spiritual care and for teaching spiritual care, along with chaplains and other spiritual leaders.

CHAPTER 5

DISCUSSION AND IMPLICATIONS

The purpose of this study was to explore nursing faculty's perception of their education and preparedness related to teaching the spiritual dimension in the delivery of patient care. Associate degree nursing faculty were surveyed using multiple tools and open-ended questions, with the aim of determining their understanding of the terms spirituality and spiritual care, how spirituality education is integrated into the curriculum, and whether faculty members feel they receive sufficient support and guidance in teaching about spiritual issues. Two hundred and six surveys were included in the analysis for this study. This chapter will discuss the findings, limitations, theoretical implications, implications for nursing education, and implications for future research.

Discussion

Demographics

Respondents in this study were predominantly female with the greatest number falling into the 50-59 years of age category. McSherry and Jamieson's (2011) findings five years ago showed that nearly 75% of her respondents were ages 40-59, so there was similarity between the samples. These findings were also congruent with the report by the National Council of State Boards of Nursing (2013) who found that 55% of nurses are 50 years old or older.

Nearly one half of those who responded had been practicing as a registered nurse 25+ years. However, years as a nurse educator varied, with the 25+ year's category comprising only 10.7%. Over half of the nurse educators fell between the 1-10 year range of experience.

Of the southeast United States where the surveys were sent, only Virginia was not represented; the reasons were unknown. The majority of the surveys came from Alabama, Florida and Tennessee. Tennessee is the researcher's home state so familiarity could explain the increased number of responses. Why Alabama and Florida also responded in greater numbers was also unknown.

Two open-ended questions asked respondents if they had a religion and if they were practicing that religion. The majority of those who responded said yes and confirmed that they practice their religion. Of those who specified their religion, 97.3% were Protestant. Some of the practices included weekly services, prayer, bible study/reading, participating in missions, and other functions at the church like singing in the choir or teaching a class. Several responded that they were involved as Faith Community Nurses.

Understanding of Spirituality and Spiritual Care

The first research question sought to determine nursing faculty's understanding of the terms of spirituality and spiritual care. The SSCRS (McSherry & Jamieson, 2011) was used to address this question. The responses reinforce that many nurses agree with the fundamental areas related to spirituality that McSherry and Jamieson (2011) explored, such as hope, forgiveness, relationships, morality and values, a belief in a deity, and the search for meaning and purpose in life. In a concept analysis by Delgado (2005), a list of nurse's assumptions about spirituality was recorded. Nurses believe that spirituality often involves faith, a search for meaning and purpose in life, a sense of connection with others, as well as a transcendence of the self, that hopefully results in a sense of inner peace and well-being. Fawcett and Noble (2004) agree that relationships

with self, others, God/higher power, and the environment, which ultimately leads to a deeper meaning in life are components of spirituality.

The responses in this study also echoed McSherry and Jamieson's (2011) findings showing that nurses believe spirituality is individual and universal and is not strictly related to religion. They agreed or strongly agreed that having respect for the patient's cultural beliefs, dignity, privacy, and religious beliefs is central to providing spiritual care. These findings also agreed with Murray and Zentner (1989) who indicated that spirituality is universal, unique, and applies to all, even those without a religious affiliation. The findings also demonstrated that nurses recognize that spiritual care is multidisciplinary in that a variety of individuals including nurses, chaplain, patients, family/friends, and other members of the healthcare team can share responsibility for providing spiritual care.

Teaching Spirituality to Nursing Students

The second research question ascertained nursing faculty's perception of their ability to teach spirituality to nursing students. The *Spiritual Care Content Scale* (SCCS; Lemmer, 2002), was used to determine content included in the nursing curricula at the respondents schools. Respondents overwhelmingly agreed that: (a) holistic nursing care includes spiritual care, (b) spiritual care is a significant part of nursing care, (c) spiritual care can be taught, and, (d) religiosity is one aspect of spirituality. These findings echo the findings found in the study by Lemmer (2002). Murray and Zentner (1989) also agree that as nurses who strive to provide holistic care for individuals, it is important to include care for their physical, psychological, social, and spiritual needs. Other authors agree that spiritual care content in nursing curricula can help nurses learn to meet

patient's spiritual needs (Baldacchino, 2008; Hoffert, et al., 2007; Lovanio & Wallace, 2007; Narayanasamy, 2006; Wallace et al., 2008).

The items that were covered moderately or in-depth were assessment of spiritual needs, review of the influence of cultural beliefs and values related to spiritual care, active listening as a spiritual care intervention, spiritual needs of the dying, and the provision of privacy for patients/families need for solitude. The inclusion of these items was consistent with teaching in a publicly funded program, where issues of church and state are often considered (Lemmer, 2002). Not surprisingly, use of scripture, how to pray with patients, spiritual needs of agnostics and atheists, and use of a formal assessment tool were either not taught or covered briefly in the curriculum.

About half of the faculty who responded to a question about whether they have the necessary knowledge to teach about the spiritual dimension said they did have the knowledge needed, but were divided related to the statement that faculty are not comfortable teaching spiritual care content. The findings are in agreement with the nursing literature as it has been reported that nurses have stated that they have felt: (a) hesitancy or inadequately prepared to assess and promote spiritual health because of lack of knowledge and experience (Narayanasamy, 2006) or, (b) discomfort or confusion related to their own spirituality or the patients' belief system (Branch, 1995; Hoffert, et al., 2007; Narayanasamy, 2006).

The *Program Attitude Scale* (PAS; Lemmer, 2002) was used to elicit program/faculty attitudes about teaching spiritual care. Over three-fourths of the faculty reported that there was not an agreed upon definition of spirituality in their programs but, the majority of respondents said that spiritual care concepts were integrated throughout their

programs. These findings are congruent with Lemmer's (2002) study of BSN programs. There was some inclusion of the spiritual dimension as required objectives or units in their courses. Only a few respondents said that spirituality was included in their philosophy and even less at the mission level of the program.

Spirituality Education in the Nursing Curriculum

The third research question was asked to determine how nursing faculty integrate spiritual care education in the nursing curriculum. Lemmer's (2002) checklist of possible methods was used to ascertain this information. The findings of this study are similar to what Lemmer's (2002) reported. The methods used most often for teaching spiritual care were classroom activities including lecture, discussions, and clinical conferencing. This finding is somewhat disappointing because 14 years later methods and techniques have not changed. Other methods listed were clinical assignments to care for a patient who is dying, and written work (reflection papers, care plans, and case studies), simulations, along with cultural competence lectures, along with end-of-life content, presentations, and videos.

Only 18 respondents mentioned simulation as a technique to use when instructing students in the provision of spiritual care. There were studies that support simulation related to spiritual care and their effectiveness. One such study by Costello, Atinaja-Faller, and Hedberg (2012) piloted a study to determine the effectiveness of simulation as a viable method of teaching the spiritual dimension of patient care. The findings in this study demonstrated an increase in students spiritual care competencies, and a significant change in the student's attitudes about spiritual care. Hopefully, more programs will incorporate simulation as a method to teach spiritual care.

Faculty listed the use of established nursing models, articles, and books, the inclusion of music, art, and literature that was deemed helpful in teaching the spiritual care content. The use of models, articles, and books that consider the spiritual dimension offer faculty a pattern or a reference that would hopefully assist them in their efforts to include spiritual care into their curriculum. These findings are congruent with Fulton (1995) who stated that incorporating a model, like Neuman's Systems Model (1995), with the spiritual variable into the nursing curricula will help to organize course content which will meet the educational needs of nurses.

Respondents were asked about their own encounters with patients and how they identified spiritual needs. The respondents indicated that they became aware of spiritual needs from the patient and by listening to and observing the patient; and the majority felt that they were able to meet the patient's needs. The findings in this survey are similar to those in McSherry and Jamieson's (2011) online survey of nurse's perceptions of spirituality and spiritual care. The findings are confusing as in other aspects of the study discomfort or lack of preparation related to spiritual care was discussed.

Support for Teaching Spirituality and Spiritual Care

The fourth research question sought faculty member's perception of guidance and support in teaching content related to spirituality and spiritual care. The majority of faculty said that they do not have sufficient training related to matters concerning spiritual care. Only half of the respondents indicated that they received spiritual care training while in their initial nursing program. As to whether faculty have had additional training or attended a seminar related to providing spiritual care, the majority indicated that they had no further training. These findings were in agreement with Fulton (1995)

who lists lack of educational preparation as a contributing factor in not meeting the spiritual needs of patients, but states that nurses express a desire for education. Fulton (1995) says the first step is for nurses to be made aware of their own spiritual self before they can recognize and care for the spiritual needs of patients.

Training listed to better equip nurses to provide spiritual care included Faith Community Nursing education, seminars, workshops, and continuing education. Hospice and end-of-life care education were also listed as resources for both nurses and patients. Another resource that was mentioned was the End of Life Education Consortium (ELNEC). The curriculum for this training course is offered through the American Association of Colleges of Nursing. Since only about one-third of the nurses have had additional training related to spiritual care, it is speculated that offerings of spiritual care education may not be as readily available, and that the spiritual dimension of nursing care should be included as a part of other seminar topics.

When asked who should be responsible for teaching nurses/students about spiritual care the majority of the answers were nursing educators/schools. These findings are in line with Hoffert and colleagues (2007) who stated that if nursing is to provide holistic, individualized care, it is important for nursing faculty to incorporate spiritual care in the nursing curriculum. Lantz (2007) also states that with an increased focus on spirituality, nurse educators must teach the art and science of spiritual care. Healthcare facilities that employ nurses and chaplain or spiritual leaders were also listed as having a place in providing spiritual care education.

Limitations

A number of limitations exist within this study. First, the power analysis recommended a total of 328 surveys to reach statistical significance and there were only 211 surveys returned. There are several possibilities that may have contributed to the lower number of surveys returned. The time of the study was late summer and early fall and many faculty are off for the summer months. Director and faculty turnover (there were multiple undeliverable emails), possible overestimation of sample size, length of the survey, and survey fatigue could have been a factor in the return rate. In the case of undeliverable emails, the researcher sought viable emails from the campus websites with some success. In two cases, the schools requested additional IRB information, which was sent. One of the schools accepted the proposal and delivered the survey to the faculty via email.

Another limitation was related to the actual participants themselves. The ones who were willing to respond may have been more comfortable with teaching the spiritual dimension of care. This study only considered nursing educators responses. Students, patients, and school administrators were not included.

There is potential bias in the sample because participants represent only one type of nursing program, associate degree, and programs that are publicly funded. Using this homogenous sample from one selected region of the United States may limit the generalizability of the results.

In the recruitment of subjects an additional bias may have occurred as subjects were solicited via email sent to the dean or director of the selected nursing programs. The study depended on cooperation from the nursing administrator in forwarding the

survey link to full-time nursing faculty. There was also a possibility that a select group of participants may be acquainted with the researcher through the nursing community. To avoid this bias, anonymous survey submission was used.

Regardless of these limitations the majority of nursing faculty agreed that spirituality and spiritual care can be taught and that spiritual care concepts were integrated throughout their programs. They also believed that spiritual care is a vital component in patient care and it is the role of the nurse to provide that care.

Theoretical Implications

The conceptual framework for this study was based on the work of Dr. Betty Neuman. The Neuman's Systems Model (1995) presented a comprehensive systems-based framework that represents individual patients within the systems (w)holistically and multidimensionally. Neuman (1995) has consistently posited that considering the spiritual variable is necessary for a truly "wholistic" perspective in caring for patients.

The model was originally designed as a method of teaching and could be incorporated in nursing curriculum. The model would also help nurses to consider the different aspects of spiritual care and the importance of providing that care as needed.

This model was very appropriate when considering the spiritual dimension of nursing care. Assessment of spiritual needs, appropriate interventions and assisting the patient in their spiritual distress or on to spiritual wellness fits very well with the beliefs and practices of the respondents in this survey.

Implications for Nursing Education

This study is congruent with other studies on this topic, such as Lemmer (2002), and McSherry and Jamieson (2011). Since there are many regulating bodies that

mandate spiritual care education and since spiritual care is a recognized part of patient care, nurse educators must include the spiritual dimension in a more comprehensive way. Not only for the students in their programs but also, as continuing education for graduates and other nurses in their area.

Although there are many definitions of spirituality that exist and there are various components of each one that are similar, confusion is still expressed, so it is felt that efforts must be made to find an agreed upon definition of spirituality and spiritual care. Nursing programs could utilize a model like Neuman's (1995) or others that emphasize the spiritual dimension to guide spiritual care education.

Accrediting bodies (ACEN, 2013; AACN, 2008) require that the spiritual dimension be addressed in the nursing curriculum but there are no clear guidelines or requirements for how the topic is to be covered. These agencies along with boards of nursing could be approached about adding some guidelines for spiritual care that could be disseminated to nursing faculty. One step in that direction has been taken by the National Council of State Boards of Nursing (NCSBN). The 2016 test plan includes an emphasis on religious and spiritual influences on health (NCSBN, 2016).

A partnership with Faith Community Nurses could also assist with educational offerings for faculty and provide hands on experience for nursing students. Incorporating guest speakers from different faith traditions could also be helpful as faculty become more adept in teaching about the spiritual dimension.

Future Research Considerations

Additional research is needed to explore faculty needs related to providing spiritual care education. Identifying the effectiveness of various methods for teaching

spiritual care and expanding the study to include students, patients, administrators, and faith community nurses or spiritual leaders would add to the knowledge base by providing a more balanced view of the topic.

Researchers could use various methods for study in this area. Qualitative and quantitative research would bring more depth to the topic. Nurses of every age and experience level could be interviewed and their stories used to assist others as they develop their own spirituality and spiritual care philosophy.

The need to expand to other regions of the United States would give a broader picture of the state of spiritual care education. Further research in this area would increase the options for generalizability of the study and allow for comparison of the regions.

Although Neuman's (1995) model lends itself to actual nursing education settings, a different theoretical framework may have helped to inform standards that would guide faculty education and the understanding of the spiritual dimension. There are several models that include spiritual variables as part of the holistic care of patients, such as Watson's (2015) Caring Science Theory.

Conclusion

In spite of increased attention to spirituality and spiritual care in the nursing literature, the findings in this study confirmed that there is still much work to be done to increase the comfort level of nursing faculty in teaching about the spiritual dimension of nursing care. Nursing faculty expressed agreement with the need to teach nursing students about the provision of spiritual care and offered methods that they have used in the education process. It was disappointing to find a lack of innovation in presenting

the spiritual content. This could be related to time allotted and the perceived need to concentrate on other topics.

Using the Neuman's System's Model (1995) as a theoretical framework was good as a guide for including the spiritual variable in the curriculum, because it outlines the spiritual variable and how beneficial the patient's spirituality is in illness, recovery, and wellness. Also, the levels of prevention in the theory give nurses options for intervening at any point and assist the patient to spiritual well-being. Perhaps another model would have better informed the needs of faculty as they teach about the spiritual dimension.

The study supports the current literature about the lack of perceived training for nurses related to the spiritual dimension and the need for an agreed upon definition of spirituality and spiritual care. Providing clear guidelines for the provision of spiritual care, providing support for nursing students as they develop a comfort level with providing spiritual care, and continuing with research in this area will help to increase understanding about the importance of spiritual care.

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APPENDICES

Appendix A

See Next Page for Neuman's Systems Model

Neuman's Systems Model (1995), Spiritual Variable (adapted from The Neuman's System's Model 3rd. ed. 1995).

Nursing Process

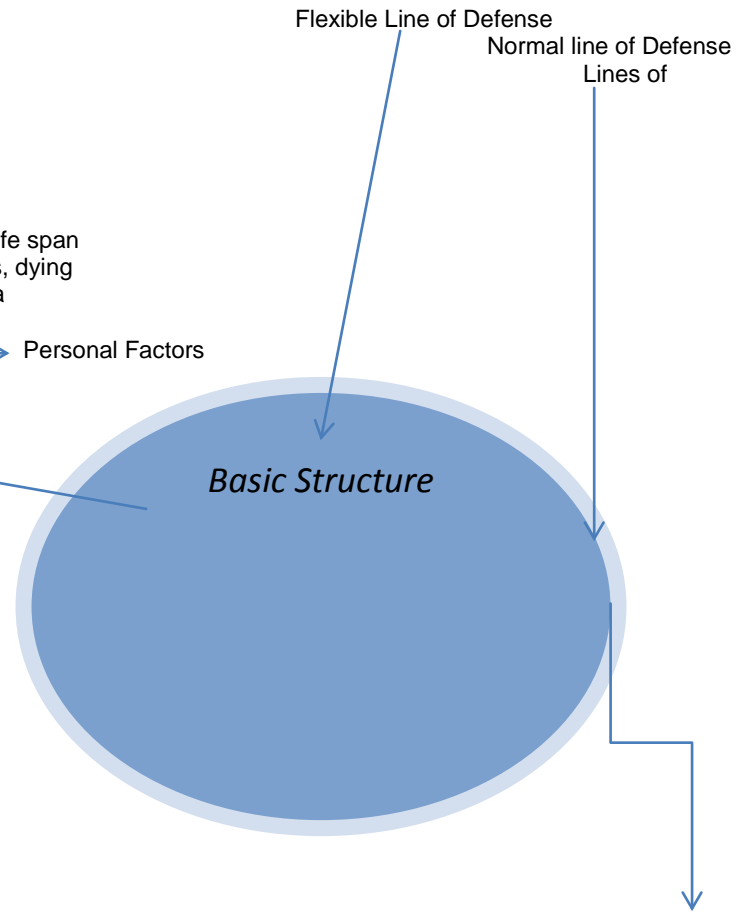
Assess with appropriate
"spiritual needs"
data base
Resistance

Love; trust/faith, Acceptance, Forgiveness, Hope,
Meaning and purpose in life
Meaningful relationships:

- ✚ Interpersonal
- ✚ God
- ✚ Deity, higher being

Stressors
Maturation-over life span
Situational-illness, dying
accidental trauma
Inter
Intra → Personal Factors
Extra

Provide Stability
Reconstitution



Based on data collection:
Determine where pt. is on continuum:

Spiritual Distress
Nursing Diagnosis

Spiritual Well-being

- Primary Prevention Interventions:
- ✚ Anticipatory
 - ✚ Strengthen
 - ✚ Educate
 - ✚ Nursing Goals-Spiritual Care

Secondary Prevention

Tertiary Prevention

Nursing outcomes
restore Spiritual well-being

- Inner peace
- Emotions:
- Listening
- Empathy
- Vulnerability
- Humility
- Commitment
- Prayer

<p>Spiritual Well-Being Evidence of: well being Meaning and Purpose in Life Relationships</p> <ul style="list-style-type: none"> ✚ God ✚ A Deity ✚ Force, Higher Being <p>Transcendence</p>	<p>Spiritual Distress—Express Concerns (illness): Meaning in life, illness, death Belief systems Values Manifested by: Depression; anxiety; fear; guilt Loneliness Hopelessness Powerlessness Diminished self-esteem</p>	<p>5 Variables considered simultaneously in each concentric circle:</p> <ol style="list-style-type: none"> 1. Physiological 2. Psychological 3. Sociocultural 4. Developmental 5. Spiritual
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Appendix B

Letters of Permission

**Faculty of Health Sciences
School of Nursing and Midwifery
Staffordshire University
Blackheath Lane
Stafford, ST18 0AD
Email: wilf.mcsherry@staffs.ac.uk
Direct line: 01785 353630
Fax: 01785 353731
6 May 2015**

Dear Nancy,

Re: SSCRS Permission – Nancy LaBine

Thank you for the interest you have shown in my research and the Spirituality and Spiritual Care Rating Scale (SSCRS). I hereby give you authorization and permission to reproduce or use the scale in your research. There is no fee for using the scale or the questionnaire; however I would appreciate if you could forward me a copy of your research findings and report when completed.

I enclose a copy of the questionnaire in which the SSCRS can be found. If you require any further information, please contact me.

The scale was developed as part of descriptive study. If you want to obtain a copy of my original thesis - you should be able to receive through Inter Library Loan the title is - A Descriptive Survey of Nurses' perceptions of Spirituality and Spiritual Care Unpublished Master of Philosophy Thesis, The University of Hull, England.

A summary of how the SSCRS was constructed was published in the International Journal of Nursing Studies 2002:

McSherry W., Draper P, Kendrick D (2002) Construct Validity of a Rating Scale
Designed to Assess Spirituality and Spiritual Care
International Journal of Nursing Studies 39 (7) 723 - 734

May I take this opportunity to wish you all the best with your studies. If I can be of any assistance in the future then do not hesitate to contact me again.

Yours sincerely,

**Professor Wilfred McSherry
Professor in Dignity of Care for Older People
Faculty of Health Sciences**

Corinne Lemmer clemmer@mtmc.edu

Ms. LaBine. I'm sorry it has taken me some time to get back to you. I have attached the research tool that I utilized and you have my permission to use it and amend it as fits your study. I wish you the best of luck on your research endeavors. Sister Corinne Lemmer, PhD, RN

-----Original Message-----

From: LaBine, Nancy [<mailto:nlabine@clevelandstateecc.edu>]

Sent: Friday, February 22, 2013 7:28 PM

To: Corinne Lemmer

Subject: Research Questions

Hello Dr. Lemmer,

I hope this finds you well and enjoying this spring semester! I am a graduate student at East Tennessee State University and I would like to ask you some questions.

I am in the dissertation process and up to this time, I have been doing most of my writing related to spiritual care. I enjoyed your article that surveyed BSN programs in the USA related to spirituality in their curricula. I would like to do a similar study of state schools in Tennessee, both AAS and BSN. Would you be willing to share the tools you used in your study? Do you have suggestions that would help me conduct a good (doable) study that would also contribute to the spiritual literature and nursing education?

I would appreciate any suggestions you may have along with your prayers for success!

Nancy LaBine

Appendix C

Copy of Tool

Teaching the Spiritual Dimension of Nursing Care: A Survey of Associate Degree Nursing Programs in the Southeast United States

This study is seeking to obtain information about how the faculty at public associate degree nursing programs in the Southeast United States perceive the spiritual dimension of nursing care and how they teach students to identify and meet the spiritual needs of clients and their families. In the items that follow, "your program" refers to that associate program in which you teach. Please answer the questions to the best of your knowledge. Feel free to consult with your colleagues, handbook, syllabi and any other document that may assist you in answering these questions (there are no right or wrong answers so please answer honestly).

Participation in this survey is voluntary and anonymous and completing the survey will be considered faculty consent to participate.

Although the Questionnaire looks quite lengthy it shouldn't take you long to complete. Thank you for your time, Investigator: Nancy LaBine nlabine@clevelandstateecc.edu, phone: 423-478-6227.

In appreciation for your time, there will be an opportunity for you to participate in a random drawing for one of 5, \$50 Amazon Gift Cards. At the end of the survey you will be asked to provide your email if you want to be considered for the drawing. This link will allow you to share your email but will not connect your email with your survey. Thanks again for your willingness to participate.

PLEASE ONLY COMPLETE THIS SECTION IF YOU HAVE CHOSEN NOT TO COMPLETE THE QUESTIONNAIRE.

If you have chosen not to complete the questionnaire, would you mind sharing your reasons with me?

I decided not to complete the questionnaire because

Part A – Demographics (Please mark the appropriate answer)

Gender

Male

Female

Age

21-29

30-39

40-49

50-59

60 or above

What is your present qualification/rank?

Nursing instructor

Assistant Professor

Associate Professor

Professor

Other:

Do you work?

Full Time

Part Time

How long have you been a registered nurse?

Less than 1 year

1 - 5 years

6 - 10 years

11 - 25 years

25+ years

How long have you been a nurse educator?

Less than 1 year

1 - 5 years

6-10 years

11-25 years

25+ years

What is your nursing specialty?

Med Surg

Mental Health

Pediatrics

Mother/Baby

Community Health

Other:

What is your primary teaching responsibility?

classroom

clinical

Back

Save And Exit

Next

Part B– Faculty Perception of Spiritual Care

SPIRITUALITY AND SPIRITUAL CARE RATING SCALE

For each question please check the ONE ANSWER which best reflects the extent to which YOU agree or disagree with each statement.

1 Strongly disagree 2 Disagree 3 Uncertain 4 Agree 5 Strongly agree

	1	2	3	4	5
1. I believe nurses can provide spiritual care by arranging a visit by the hospital Chaplain or the patient's own religious leader if requested	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. I believe nurses can provide spiritual care by showing kindness, concern and cheerfulness when giving care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. I believe spirituality is concerned with a need to forgive and a need to be forgiven.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. I believe spirituality involves only going to Church/Place of Worship.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. I believe spirituality is not concerned with a belief and faith in a God or Supreme Being	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

6. I believe spirituality is about finding meaning in the good and bad events of life
7. I believe nurses can provide spiritual care by spending time with a patient giving support and reassurance especially in time of need
8. I believe nurses can provide spiritual care by enabling a patient to find meaning and purpose in their illness
9. I believe spirituality is about having a sense of hope in life
10. I believe spirituality is to do with the way one conducts one's life here and now
11. I believe nurses can provide spiritual care by listening to and allowing patients time to discuss and explore their fears, anxieties and troubles
12. I believe spirituality is a unifying force which enables one to be at peace with oneself and the world
13. I believe spirituality does not include areas such as art, creativity and self-expression
14. I believe nurses can provide spiritual care by having respect for privacy, dignity and religious and cultural beliefs of a patient
15. I believe spirituality involves personal friendships, relationships
16. I believe spirituality does not apply to Atheists or Agnostics
17. I believe spirituality includes people's morals

Part C

The literature indicates that there is a variety of content that may be taught relating to the spiritual dimension of nursing care. Please circle the number that most closely indicates the degree to which the following items are addressed in your program's curriculum.

The following scale applies:

1 = not taught at all 2 = covered briefly 3 = covered to a moderate degree 4 = covered in depth

	1	2	3	4
1. Spirituality as the search for meaning and purpose in life	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
2. Spirituality as the search for hope for the future	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
3. Spirituality as the dimension of the person concerned with the person's relationships with self and others, including the need for forgiveness	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
4. Spirituality as the person's relationship with a Higher Power, however the individual defines that (e.g., God, Allah, Buddha)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
5. Assessment of spiritual needs (i.e., how to identify spiritual needs of patients and families)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
6. Sensitivity to cues that may indicate spiritual needs (e.g., presence of religious articles, verbalization about God)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
7. Use of a formal spiritual assessment tool (e.g., JAREL, Spiritual Well-being).	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
8. NANDA diagnoses related to spiritual distress or spiritual well-being	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
9. Review of beliefs/health practices of major religions (e.g., birth and death/dying rituals, dietary requests)	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
10. Review of influence of cultural beliefs/values on spiritual care	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
11. When/how to make referrals to pastoral care or the client's minister	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
12. Spiritual needs of atheists and agnostics	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
13. When/how to pray with patients and/or families	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
14. Use of scriptures	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
15. Active listening as a spiritual care intervention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
16. "Being with"/"presence to" as a spiritual care intervention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
17. Use of touch as a spiritual care intervention	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
18. Factors related to the appropriateness of sharing the nurse's spiritual beliefs with the client	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
19. Spiritual needs of the dying and their significant others	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
20. Crisis situations as triggers to spiritual questions/concerns	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
21. Importance of the nurse's self-knowledge when dealing with spiritual needs of clients	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

22. Provision of privacy for client's/family's need for solitude
23. Recognition of the client's definition of spirituality
24. The interrelationship of spiritual well-being with physical and emotional well-being
25. The nurse's role in support of religious practices (e.g., medicine man, sacraments).
26. What other content not listed above does your program include as spiritual care content?

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What instructional methods and student assignments does your program use for teaching spiritual care? Please check those that apply.

- classroom lecture by faculty
- guest lectures by pastoral care or ministers
- guest lectures by professors of arts and humanities
- classroom group discussion
- discussion of case situations which include spiritual needs of clients
- role modeling of spiritual assessment and intervention(s) by faculty in clinical setting
- clinical conferencing
- student journaling about spiritual care experiences
- required inclusion of nursing diagnoses related to spiritual needs in care plans or other client papers/presentations
- clinical assignment to care for dying patient
- clinical assignment with parish/faith community nurses
- papers
- shadow experiences with pastoral care department, field trips
- field trips

List what agencies/resources:

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Please describe other teaching methods/assignments used by your program to address spiritual care needs of clients and families.

Please list any music, art and/or literature that have been useful in teaching the spiritual care content in your curriculum.

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In the section below please circle the number that best reflects your program's attitudes regarding factors: that may influence the teaching of content related to the spiritual dimension.

The following scale applies:

1 Strongly disagree 2 Disagree 3 Undecided 4 Agree 5 Strongly agree

	1	2	3	4	5
Spiritual care can be taught.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Religiosity is one aspect of spirituality.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Spiritual care is a significant part of nursing care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Holistic nursing care includes spiritual care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Nursing faculty have the necessary knowledge to teach about the spiritual dimension of nursing care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Issues related to the separation of church and state affect our program's ability to teach about the spiritual dimension.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Providing care directed toward the spiritual dimension of the client and his/her family is not a nursing role.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
Faculty are not comfortable teaching spiritual care content.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is not enough time within the curriculum to address spiritual care.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is confusion of religiosity with spirituality which makes teaching about the spiritual dimension of care difficult.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
There is a lack of clarity as to what are psychosocial and what are spiritual needs.	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

Religion and spirituality are one and the same.

Other content must take priority in the curriculum.

There is a lack of clarity as to what "spirituality" means.

What further insights about teaching the spiritual dimension of nursing care would you care to share? Please comment.

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Part D – Your Program

1. In what state is your program located?

Select:

[] ▼

Does your nursing program's philosophy include reference to the spiritual dimension of the human or person?

No

Yes

please include the phrase or phrases that refer to the spiritual dimension.

Is the spiritual dimension of nursing care taught in your curriculum?

Yes

No

If Yes, Check all that apply.

philosophy level

mission level

Individual course on spirituality

required objectives in each course

required unit in each course

objective in each course

units in some courses

If No, why has the nursing program chosen not to address this content?

Does the curriculum of your nursing program have an agreed-upon conceptual definition of Spirituality?

- No
 Yes

If Yes, what is that definition?

Does the curriculum of your nursing program have an agreed-upon definition of spiritual nursing care?

- Yes
 No

If Yes, what is that definition?

In what semester is the spiritual dimension of nursing care first introduced?

- 1
 2
 3
 4
 Other:

Check all that apply: Spiritual care concepts are

- integrated throughout the curriculum
 focused primarily in one course, if so, which course?
 Other:

Give 1-2 examples of how you have taught spirituality to your nursing students.

Does your program teach an individual spiritual care course that is

- required

elective

Approximately how many actual contact hours (not credit hours) are allocated to the spiritual dimension of care in your program's curriculum?

0-5

6-10

11-15

16-20

Other:

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Part E

Who do you feel should be responsible for providing Spiritual Care? (Choose all that apply)

Nurses

Chaplain

Combination of Nurses/Chaplain

Patients

Combination of Patients Family & Friends

Nurses/Chaplain and Patients Themselves

Patients Own Spiritual leader

Other:

In your clinical practice have you ever encountered a patient(s) with a spiritual need(s)?

Yes

No

If yes, how did you become aware of this need(s)? (Choose all that apply)

Patient himself/herself

Patient's relatives/friends

Nursing care plan

Other Nurses

- Chaplains/religious leaders
- Listening to and observing the patient
- Other:

Do you feel that you are usually able to meet your patients Spiritual Needs?

- Yes
- No

If no, please give details:

During the course of your nurse training did you receive any lessons/lectures covering Spiritual Care?

- Yes
- No

If yes, please give details:

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During the course of your nurse training did you receive any lessons/lectures covering Spiritual Care?

- Yes
- No

If yes, please give details:

Where did you receive your nurses training?

- diploma
- community college
- university

Specify school if you are willing?

Since qualifying as a nurse have you been to any training courses which covered Spiritual Care?

- Yes
- No

If yes, please give details of training course - stating whether you feel this has enabled you to better meet your patient's spiritual needs

Do you feel nurses receive sufficient training on matters concerning Spiritual Care?

- Yes
- No

If Nurses are to receive instruction concerning Spiritual Care who do you feel should be responsible for this?

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As it is possible that connections may exist between religious affiliation and certain responses given, I would appreciate if you would answer the following two questions.

Do you have a religion/denomination?

- Yes
- No

If yes, please state which religious affiliation

Are you practicing your religion?

- Yes
- No

If yes, please briefly describe in what capacity you practice i.e. attend Services Weekly, Yearly, participate in study, regular prayer, work with missions, etc.

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Thanks you so much for taking the time to complete this questionnaire.

If you are interested in being entered in a random drawing for one of 5 – \$50 Amazon Gift Cards please share your email address. This link is not associated with your survey therefore your anonymity is

protected.

Click the links: <https://com.etsu.edu/esurvey/Survey.aspx?s=c98689b337344de7adb694f5400f0a07>

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Finish

Thank you for taking the survey.

VITA

NANCY LABINE

Education: PhD in Nursing
East Tennessee State University – December, 2015

Masters of Science in Nursing Education
University of Tennessee at Chattanooga – August, 1998

Bachelors of Science in Nursing
University of Tennessee at Chattanooga – May, 1984

Associates of Science in Nursing
Hillsborough Community College, Plant City, Florida – May, 1979

Experience: Registered Nurse

Dean of Health & Wellness/Director of Nursing
Cleveland State Community College – 2006 – present

Chief Nursing Officer
Bradley Memorial Hospital – 2003-2005

Associate Professor of Nursing
Cleveland State Community College – 1999-2003

Bradley Memorial Hospital – 1985-1999 (Cleveland, TN)

Cleveland Community Hospital – 1980-1985 (Cleveland, TN)

Tampa General Hospital – 1980 (6 months)

Community General Hospital – 1979-1980 (Dade City, FL)