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# Spiritual Perspective, Mindfulness, and Spiritual Care Practices of Hospice and Palliative Care Nurses

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SPIRITUAL PERSPECTIVE, MINDFULNESS, AND SPIRITUAL CARE PRACTICES OF  
HOSPICE AND PALLIATIVE CARE NURSES


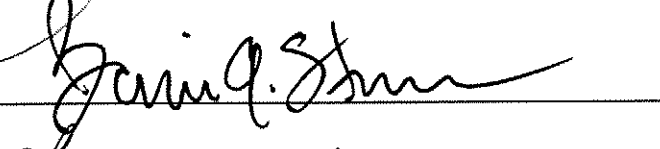

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Date 2/25/15

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Submitted in partial fulfillment of the  
Requirements for the Degree of Doctor of Philosophy in Nursing  
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## DEDICATION

This work is dedicated to my family. All that I have been able to achieve is due to the love and support I have received throughout my life. To my parents, who were my first teachers about how to love and care for others; to my grandmothers who showered me with love and affection; to my sister for her support and always being willing to listen; to my son Matthew who tolerated a mother who always seemed to be doing school work; and to my husband Joseph who has been patient and understanding, and kept our house a home during my PhD journey.

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## ABSTRACT

Spiritual care is an ethical obligation of the nursing profession and an essential component of palliative care, but is often misunderstood. Lack of conceptual clarity is problematic, for each nurse will provide spiritual care based on his or her understanding of what this care should include.

Regardless of how a nurse defines spiritual care, an important element of spiritual care is what nurses bring of themselves to the patient encounter. Findings from several studies have shown a positive relationship between a nurse's spiritual perspective and spiritual care practices. Spiritual perspective has increased as a result of participating in programs designed to develop mindfulness, "being attentive to and aware of what is taking place in the present" (Brown & Ryan, 2003, p. 822). Being present is an essential skill for spiritual care practice, and a nurse's ability to be fully present may be facilitated by his or her degree of mindfulness.

The relationships between and among spiritual perspective, mindfulness, and spiritual care practices were evaluated using a descriptive correlational design and a convenience sample of nurses from the Hospice and Palliative Nurses Association. Data were collected online via SurveyMonkey® using the Spiritual Perspective Scale (SPS), Mindful Attention Awareness Scale (MAAS), and the Nurse Spiritual Care Therapeutics Scale (NSCTS).

There was a positive correlation between mindfulness and spiritual care practices ( $r = .212, p = .05$ ). A linear regression analysis indicated that mindfulness

explained 4.5% of the variance in spiritual care practices. No statistically significant relationship was found between spiritual perspective and mindfulness or spiritual perspective and spiritual care practices in this sample of nurses engaged in hospice and palliative care nursing.

Identifying mindfulness as a factor that may influence spiritual care practices has implications for nursing education, research, and practice.

## Chapter I

### INTRODUCTION

A nurse's spiritual perspective has been recognized as an influencing factor in spiritual care practice (Nagai-Jacobson & Burkhardt, 1989; HPNA, 2010) with findings from several studies showing spiritual perspectives have increased as a result of participating in programs designed to develop mindfulness (Carmody, Reed, Kristeller, & Merriam, 2008; Shapiro, Schwartz, & Bonner, 1998). Mindfulness is defined as "being attentive to and aware of what is taking place in the present" (Brown & Ryan, 2003, p. 822). Mindfulness facilitates being present which has been identified as an essential skill for spiritual care practice (Baird, 2010; Carson, 2008; Taylor, 2002).

Spiritual care is an essential component of hospice and palliative care nursing (Baird, 2010; Coyle, 2010; Hospice and Palliative Nurses Association [HPNA], 2010) and an ethical obligation of the nursing profession (American Nurses Association [ANA], 2001; Burkhardt & Nagai-Jacobson, 2009; International Council of Nurses [ICN], 2012; Pettigrew, 1990; Wright, 1998) but has been described as "the most mysterious and often misunderstood part of palliative care" (Baird, 2010, p. 663). No consensus exists on a single definition for spiritual care and multiple interpretations can be found in the literature (Daaleman, Usher, Williams, Rawlings, & Hanson, 2008; Gijsberts et al., 2011; Narayanasamy & Owens, 2001). Sawatzky and Pesut (2005) described spiritual care as "an intuitive, interpersonal, altruistic, and

integrative expression that is contingent on the nurse's awareness of the transcendent dimension of life but that reflects the patient's reality" (p. 23). Taylor (2002) defined spiritual care as "the activities and ways of being that bring spiritual quality of life, well-being, and function-all of which are dimensions of health-to clients" (p. 24). Ferrell & Baird (2012) explained "Spiritual care addresses the thoughts, feelings, and experiences of being human" (p. 258). Baird (2010) simplified the definition by stating spiritual care is "allowing our humanity to touch another's by providing presence, deep listening, and compassion" (p. 663).

HPNA (2010) defines spiritual care as assessing, monitoring, and responding to the spiritual and religious issues that concern patients and families requiring both appreciation of the significance of presence and a willingness to be fully present. Effective spiritual care necessitates listening reflectively with a compassionate presence, creating therapeutic and healing spaces for spiritual expression, demonstrating empathy, and journeying with others in their suffering (HPNA, 2010).

### **Nursing's Role in Spiritual Care Practice**

Research findings, as well as professional guidelines, indicate integrated care by an interdisciplinary team consisting of nurses, physicians, and allied health personnel is necessary in order to effectively address spiritual needs in patients facing life-limiting illness (Hirai, Morita & Kashiwagi, 2003; Holloway, Adamson, McSherry, & Swinton, 2010; National Consensus Project [NCP], 2013; National Hospice and Palliative Care Organization, 2009). Nurses, as part of an interdisciplinary team, are expected to recognize spiritual distress and attend to the

spiritual needs of patients and families within their scope of practice (Puchalski et al., 2009; NCP, 2013). However, if the patient is in crisis or the spiritual history indicates a complex spiritual issue, nurses would be expected to refer to a spiritual care professional for an in-depth, on-going spiritual assessment (Puchalski & Ferrell, 2010).

Using the nursing process, nurses will assess and then identify problems or needs in order to plan care. Spiritual assessment may be viewed as a process consisting of a spiritual screening that quickly assesses for spiritual distress/crisis and an in-depth history to gain understanding of a patient's spiritual needs and resources (Fitchett, 2012; Puchalski et al., 2009; Taylor, 2010).

Although assessment tools have been developed to facilitate spiritual screening and history-taking (Anadarajah & Hight, 2001; Fitchett, 2012; Hermann, 2006; Hodge, 2006; Larocca-Pitts, 2008; Lo, Quill, & Tulsky, 1999; Puchalski & Romer, 2000), research has shown spiritual assessment is not performed consistently by hospice nurses (Belcher & Griffiths, 2005). Spiritual assessment should be considered an ongoing process because patients may not divulge sensitive information until rapport and trust are established (McSherry, 2006; Taylor, 2010). By being present and witnessing what the patient considers sacred, the process of assessment can also be considered a spiritual care intervention (Taylor, 2010).

The foundation of spiritual care is allowing an individual's humanity to touch the humanity of another (Baird, 2010). This can be accomplished through such interventions as compassionate presence, deep listening, bearing witness, and

compassion in action (Baird, 2010; Ferrell & Baird, 2012; Ferrell & Munevar, 2012; Taylor, 2002). Other interventions may include referral to clergy or a chaplain and facilitating religious practices, but various interventions of a non-religious nature have been identified in the nursing literature such as: conveying a benevolent attitude, instilling hope, touching, talking about spiritual topics, and exploring meaning in a situation (Amenta, 1986; Como, 2007; Emblen & Halstead, 1993; Grant, 2004; Hubbell, Woodard, Barksdale, & Parker, 2006; Mamier, 2009; Sellers & Haag, 1998; Taylor, 2002, 2005, 2008; Taylor, Amenta, & Highfield, 1995; Taylor, Highfield, & Amenta, 1999; Taylor & Mamier, 2005; Tuck, Wallace, & Pullen, 2001).

### **Importance of Spiritual Care Practice in Hospice and Palliative Care**

Palliative care has historically been associated with hospice or end of life care (Autor, Storey, & Ziemba-Davis, 2013). Palliative care can be instituted at the time of diagnosis of a serious or life-threatening illness and continue throughout the disease trajectory, including care of the dying and bereavement care for the family and significant others (Coyle, 2010; NCP, 2013; Puchalski et al., 2009). The World Health Organization defines palliative care as:

an approach that improves the quality of life of patients and their families facing the problem associated with life-threatening illness, through the prevention and relief of suffering by means of early identification and impeccable assessment and treatment of pain and other problems, physical, psychosocial and spiritual (nd)

Palliative care can be provided along with curative therapies across all health care settings including: acute care and rehabilitation hospitals, long term care, ambulatory care, home health care, and hospices (NCP, 2013). Hospice care can be

considered palliative care that is intensified as an individual moves closer to death (Coyle, 2010).

The ability to experience and to integrate meaning and purpose in life may become compromised in patients who are facing a life-threatening illness or dying, therefore spiritual care becomes an important component in maintaining quality of life (Ferrell & Munevar, 2012; HPNA, 2010; McSherry, 2006; Puchalski, Lunsford, Harris, & Miller, 2006; Taylor, 2002). Researchers have found that spiritual well-being is associated with overall quality of life in lung cancer survivors (Frost et al., 2013), decreased symptom distress in women with breast cancer (Manning-Walsh, 2005), and less depression in heart failure patients (Bekelman et al., 2007). In addition, spiritual well-being has been shown to help patients cope more effectively with terminal illness (Lin & Bauer-Wu, 2003) and was found to be negatively correlated with helplessness-hopelessness and anxious preoccupation in oncology patients (Whitford, Olver, & Peterson, 2008).

Spiritual care can be provided by nurses to assist individuals with their spiritual needs by supporting their world view and creating opportunities for expression of fears, doubts and anxiety, which can assist in a search for meaning and may prevent a spiritual need from evolving into spiritual distress (Grant et al, 2004). The North American Nursing Diagnosis Association International (NANDA-I) has defined spiritual distress as the “impaired ability to experience and integrate meaning and purpose in life through connectedness with self, others, art, music, literature, nature, and/or a power greater than oneself” (Herdman, 2012, p. 410). Spiritual

distress could result in physical pain, depression or anxiety, and social isolation (Chochinov & Cann, 2005; Puchalski & Ferrell, 2010). Existing physical or emotional symptoms may worsen as a result of spiritual distress, resulting in increased utilization of health services (Grant et al., 2004).

### **Factors Influencing Spiritual Care Practice**

An essential element of spiritual care provision is what nurses bring of themselves to the patient encounter (Puchalski et al., 2006). Being aware of and understanding personal spiritual perspective assists an individual to be cognizant of how his or her worldview impacts relationships and professional practice (Burkhardt & Nagai-Jacobson, 2002; McSherry, 2006; Narayanasamy, 1999). In order to provide spiritual care, the nurses must possess the ability to be present (Puchalski et al., 2006). Sitzman and Watson (2014) refer to mindfulness as “simply *being* fully present in each moment of life” (p. 25). In this study, nurses’ spiritual perspective and mindfulness was examined in relation to spiritual care practices.

**Nurses’ spiritual perspective.** Spiritual perspective is an indicator of the awareness of an individual’s inner self and a sense of connection to a higher being, nature, others, or to some dimension or purpose greater than oneself, which is manifested in beliefs and actions (Reed & Rousseau, 2007; Reed 1986a). Positive correlations have been found between nurses’ spiritual perspective and spiritual care practices (Mamier, 2009; Ronaldson, Hayes, Aggar, Green, & Carey, 2012; Stranahan, 2001; Vance, 2001). In order to provide effective spiritual care, it is important for the nurse to understand his or her own spiritual perspective (Miner-



Williams, 2006) so as to become more attuned to and respectful of another's spirituality (Jacik, 2008; Narayanasamy, 1999). By acknowledging self as a spiritual being and experiencing, reflecting, and exploring the meaning of his or her own spirituality, the nurse acquires skills necessary to deliver spiritual care (Nagai-Jacobson & Burkhardt, 1989).

**Mindfulness.** Mindfulness has been defined as “being attentive to and aware of what is taking place in the present” (Brown & Ryan, 2003, p. 822). The ability to be present is essential for spiritual care practice (Baird, 2010; Carson, 2008; Taylor, 2002). If an individual is intentional and deliberately aware of a situation, the experience changes, and he or she can connect more fully with the present (Segal, Williams, & Teasdale, 2002). Awareness of the present moment influences interactions with patients, which creates a connection and intimacy and can deepen caring (Sitzman, 2002).

Just as awareness of the present moment can influence interactions, being unaware can also impact relationships (Kabat-Zinn, 2013). Lack of awareness can be referred to as being on automatic pilot or “behaving mechanically, without really being aware of what is going on” (Segal et al., 2002, p. 99). This lack of awareness or being on automatic pilot can dominate the mind in any moment, and therefore “we may be only partially aware of what is actually occurring in the present” (Kabat-Zinn, 2013, p. 8), which may lead to a decreased sense of connection to oneself, others, nature, or the transcendent. It is possible that a nurse who is not fully aware of what is

taking place in the present moment may not be able to be authentically present, and this may affect his or her ability to provide spiritual care.

Programs designed to increase mindfulness have not only demonstrated increases in mindfulness, but also developed qualities that are necessary for spiritual care practice in health care providers. Researchers have found that mindfulness training increased health care providers' mindfulness (Cohen-Katz, Wiley, Capuano, Baker, & Shapiro, 2005a) and also developed skills such as being fully present (Beckman et al., 2012; Cohen-Katz et al., 2005b; Rushton et al., 2009) and listening (Beckman et al., 2012, Cohen-Katz et al., 2005a, 2005b). Spiritual perspective was also enhanced as a result of participation in mindfulness courses (Carmody et al., 2008; Cohen-Katz et al., 2005b; Geary & Rosenthal, 2011; Shapiro et al., 1998).

### **Problem**

Given the impact of spiritual distress and the potential benefits of spiritual well-being for patients, it is essential that hospice and palliative care nurses provide spiritual care. Yet, spiritual care practice is the most misunderstood component of palliative care (Baird, 2010) and lacks a universally accepted definition to guide nursing practice. Nurses' spiritual perspective has been shown to affect spiritual care practices (Mamier, 2009; Ronaldson et al., 2012; Stranahan, 2001, Vance, 2001). As a result of participation in courses designed to increase mindfulness, not only have spiritual perspectives increased (Carmody et al., 2008; Cohen-Katz et al., 2005b; Geary & Rosenthal, 2011; Shapiro et al., 1998), but skills necessary for spiritual care practice were also developed in health care practitioners (Beckman et al., 2012,

Cohen-Katz et al., 2005a, 2005b; Rushton et al., 2009). To date, empirical studies have not investigated the relationships between and among nurses' spiritual perspective, nurses' mindfulness, and nurses' spiritual care practices.

### **Purpose**

The purpose of this study is to examine the relationships between and among nurses' spiritual perspective, nurses' mindfulness, and spiritual care practices by hospice and palliative care nurses. Empirically evaluating relationships that can affect spiritual care practice may provide information that can have an impact on nursing practice and offer new areas of inquiry for research in hospice and palliative care nursing.

### **Overarching Research Question**

What are the relationships between and among spiritual perspective, mindfulness, and spiritual care practices of hospice and palliative care nurses?

### **Research Questions**

1. What is the relationship between hospice and palliative care nurses' spiritual perspective and mindfulness?
2. What is the relationship between hospice and palliative care nurses' spiritual perspective and spiritual care practices?
3. What is the relationship between hospice and palliative care nurses' mindfulness and spiritual care practices?
4. What is impact of hospice and palliative care nurses' spiritual perspective and mindfulness on spiritual care practices?

**Definitions**

**Hospice nurse:** A hospice nurse is conceptually defined as a licensed registered nurse or an advanced practice nurse with one year or more experience providing direct patient care in hospice settings and will be operationally determined by response on demographic questionnaire.

**Palliative care nurse:** A palliative care nurse is conceptually defined as a licensed registered nurse or an advanced practice nurse with one year or more experience providing direct patient care in palliative care settings and will be operationally determined by response on demographic questionnaire.

**Spiritual Perspective:** Spiritual perspective is conceptually defined as an individual's perspective on the extent to which he or she holds certain spiritual views and engages in spiritually-related interactions (Reed, 1987). Spiritual perspective is operationally defined as the average of the summed score on the Spiritual Perspective Scale (SPS) (Reed, 1986a).

**Mindfulness:** Mindfulness is conceptually defined as "being attentive to and aware of what is taking place in the present" (Brown & Ryan, 2003, p. 822). Mindfulness is operationally defined as the average of the summed score on the trait Mindful Attention Awareness Scale (MAAS) (Brown & Ryan, 2003).

**Spiritual Care Practice:** Spiritual care practice is conceptually defined as actions or ways of being employed by the nurse to promote the integration of spirituality into all aspects of life for the patient (Taylor, 2002). Spiritual care practice

is operationally defined as the summed score on the Nurse Spiritual Care Therapeutics Scale (NSCTS) (Mamier & Taylor, 2014).

### **Inclusion/Exclusion Criteria**

Licensed registered nurses and advanced practice nurses with one or more years of experience providing direct patient care in hospice or palliative care settings who report providing at least 36 hours of direct patient care in the two weeks prior to survey completion were included in the study. Licensed registered nurses and advanced practice nurses who have had less than one year experience providing direct patient care in a hospice or palliative care setting were excluded. Nurses with less than a year experience would be considered novices, and therefore need time and experience to develop necessary skills (Benner, 1984).

### **Theoretical Framework**

The theoretical framework for this study is Watson's theory of human caring (Watson, 2008). Although not specific to spiritual care practice, the theory acknowledges spiritual dimensions of caring and healing, "Consistent with timeless nursing and our Nightingale roots, we acknowledge that nursing is ultimately a spiritual practice" (Watson, 2002, p. 17). The theory of human caring has evolved over the last 30 years and can be viewed as an ethic, philosophy, paradigm, or world view (Watson, 1996). The original work published in 1979 arose from Watson's pursuit to bring new meaning and dignity to the profession of nursing and patient care and provided the basis and structure for the theory, which included ten carative factors (Watson, 1997). Carative factors are fundamental practices that distinguish

nursing as a caring profession, distinct from the curative focus of medicine. In her later work, Watson redefined the curative factors as *caritas* processes. The word *caritas* in Latin means to cherish, to appreciate, and to give special attention to and is used to describe the connection between caring and love which creates an opening for inner healing for self and others (Watson, 2008). In order to practice in a model of caring-healing, the nurse needs “to be fully present in the moment, more open and available to self and situation” (Watson, 2008, p. 54).

In the theory of human caring, a main concept is the transpersonal caring relationship (Watson, 2012). In order to build a relationship, the nurse must understand self and cultivate his or her own spiritual growth in order to be sensitive to self and other (Watson, 2008). Building an authentic caring relationship is cultivated by presence, authentic listening and being present for another in the moment (Watson, 2008). “Genuine presence and simple attentiveness to self and other in the moment facilitate trust and allow for helping and healing to take place” (Sitzman & Watson, 2014, p. 75). This type of relationship has been identified as facilitating spiritual care (Baird, 2010; Burkhardt & Nagai-Jacobson, 2002; Ferrell & Baird, 2012; HPNA, 2010; McSherry, 2006; Puchalski et al., 2006; Taylor, 2002).

The theory of human caring is based on a value system that has high regard for the wonders and mysteries of life and acknowledges the spiritual dimension of life (Watson, 2012). The subjective-internal life of both the patient and nurse is valued, as well as their perceptions and experiences of the health-illness condition, and the search for meaning that goes beyond the condition. Regardless of the health

condition, the nurse assists the person to gain more knowledge, control, care and inner healing of self and is regarded as a co-participant in the healing-caring process. If disharmony exists among the mind-body-spirit, or amid a person and his or her nature and connection to the universe, then there is a division and incongruence between the self as perceived and actual experience. Incongruence can also occur between the person and nature. This incongruence can lead to issues such as anxiety, feeling threatened, inner turmoil, existential despair, dread, and illness, and if prolonged can contribute to disease. Furthermore, incongruence can lead to lack of union with others or cause one to feel disengaged and isolated in the pursuit of “being-in-right relation” and growth. Each individual searches for harmony, integrity, and unity, not only with self in relation to others, but also in relation to the community, environment, nature, the universe and the “source”.

### **Significance of the Study**

Hospice and palliative care nurses listen and remain present in the face of great suffering and distress with patients and families throughout the illness trajectory (Coyle, 2010). Nurses are the healthcare professionals that spend the most time with patients and family members; therefore, it is imperative for nurses to be knowledgeable and competent in spiritual care provision because spiritual issues may arise at any time (Baird, 2010; Taylor, 2002). Empirically evaluating relationships that can affect spiritual care may impact nursing research, practice, and education.

**Significance for nursing research.** Although spiritual care is a core domain of palliative care, there is a lack of consensus regarding a definition which hinders

practice and research efforts (Gijsberts et al., 2011; Martsof & Mickley, 1998; Puchalski, 2007). This lack of conceptual clarity is also problematic clinically, because each nurse will provide spiritual care based on his or her understanding of what this care should include (Sawatzky & Pesut, 2005). Empirically evaluating spiritual care has been challenging. Not only is there a lack of consensus on the definition of spiritual care, but also a paucity of valid and reliable instruments that measure spiritual care practices. This study used the Nurse Spiritual Care Therapeutics Scale (NSCTS), an instrument that is theoretically based and has been validated in 554 RNs in a faith-based tertiary health care system (Mamier & Taylor, 2014). The study can establish further reliability of the NSCTS for use in hospice and palliative care settings.

**Significance for nursing practice and education.** The ultimate goal of nursing research is to advance nursing knowledge that will lead to improvements in patient care (Ferrell, Grant, & Sun, 2010). Identifying factors such as nurses' spiritual perspective and mindfulness that may influence spiritual care and empirically testing the relationships, may provide evidence for practice. The results of the study may also provide evidence to change and enhance nursing curriculum focused on spiritual care practice.



## Chapter II

### REVIEW OF THE LITERATURE

This chapter provides an overview of Watson's theory of human caring (2008) and discusses how the theory provides a theoretical framework for the current study investigating spiritual perspective, mindfulness, and spiritual care practices. This literature review will provide an overview and critique of the research pertaining to the study variables.

A literature search was performed to examine the research variables: spiritual perspective, mindfulness, and spiritual care practices. The databases searched included: Cumulated Index for Nursing and Allied Health (CINAHL), ProQuest, Medline, ALTA Religion Database, Cochrane Database of Systematic Reviews, and Science Direct. The following search terms were included in the search: spirituality, spiritual care, palliative care, hospice, end of life, spiritual perspective, Spiritual Perspective Scale, mindfulness, and nursing. Manual search of reference lists of retrieved studies was also performed to identify additional research. The search was limited to research published in English.

#### **Theoretical Framework**

Watson's theory has continued to evolve since the publishing of *Nursing: The Philosophy and Science of Caring* (1979). The original work provided the foundation and structure for the theory, specifying ten carative factors. The work was derived from her personal values, beliefs, observations, and experiences and was influenced

by the works of Carl Rogers, Yalom, Peplau, Kierkegaard, Whitehead, de Chardin, and Sartre (Watson, 1997, 2008). In her second book, *Nursing: Human Science and Human Care, A Theory of Nursing* (1985), the philosophical and transpersonal aspects of a caring moment as a core framework were further developed, along with an explicit acknowledgement of the spiritual dimensions of caring and healing (Watson, 2008). In *Postmodern Nursing and Beyond* (Watson, 1999), there was further development regarding the personal evolution of the nurse, caring consciousness, intentionality, and human presence occurring “within the emerging postmodern cosmology of healing, wholeness, and oneness that is an honoring of the unity of all” (Watson, 2008, p. 7). The next work, *Caring Science as Sacred Science* (2005), brought a sacred component to caring and made it more explicit that human beings dwell in “mystery and the infinity of Cosmic Love as the source and depth of all of life” (Watson, 2008, p. 9). In 2008, in a revised edition of the original work, the carative factors evolved into the caritas processes creating new connections between caring and love (Watson, 2008).

Throughout the thirty year evolution of the theory, nurses have used the theory of human caring as a framework for research. The first research conducted in 1988 by Cronin and Harrison identified nurse caring behaviors in patients after a myocardial infarction. Since that initial investigation, numerous researchers have used the theory to conduct studies in the United States and internationally (Fawcett, 2005; Nelson & Watson, 2012; Smith, 2004), and instruments to measure caring based on the theory have been developed (Watson, 2009). In March of 2014, a search

of CINAHL revealed over 85 studies using Watson's theory as a theoretical framework.

The main concepts in the theory of human caring are: transpersonal caring relationship, caring moment/caring occasion, caring (healing) consciousness, and the 10 caritas processes. According to Watson, the nurse and patient come together in a caring occasion. "The transpersonal dimensions of a caring occasion are affected by the nurse's consciousness in the caring moment, which in turn affects the field dynamic of the transaction" (Watson, 1996, p. 158). In a transpersonal caring relationship, there is a connection with another in which the whole person and his or her "being-in-the-world" is honored (Watson, 2012, p. 75). The relationship has the potential for not only affecting the patient but the nurse as well (Watson, 1985). This transpersonal relationship allows space for the patient to access his or her own inner healing resources and to unite with a universal source for healing, which may allow for miracles (Watson, 2012). Caring-healing is guided by the 10 caritas processes (Watson, 2008).

### **Spiritual Perspective**

Spirituality is an inherent quality of all individuals but what varies between individuals is spiritual perspective, the awareness of his or her own spirituality and its qualities (Haase, Britt, Coward, Leidy & Penn, 1992). Spirituality can be defined as, "Awareness of one's inner self and a sense of connection to a higher being, nature, others, or to some dimension or purpose greater than oneself" (Reed, 1986a, p.1). Spiritual perspective represents a way of expanding personal boundaries through

practices which may include “prayer, forgiveness, meditation, and a belief in a transcendent dimension or being” (Reed, 1991, p. 122).

By acknowledging self as a spiritual being that experiences, reflects on, and explores the meaning of his or her own spirituality, the nurse acquires skills necessary to deliver spiritual care (Nagai-Jacobson & Burkhardt, 1989). Bryson (2004) asserts that there is subjective growth and the ability to identify with another’s search for meaning and transcendence when an individual acknowledges their spiritual perspective. Clinical practice guidelines (NCP, 2013) and the HPNA Position Statement on Spiritual Care (HPNA, 2010) state health care professionals should acknowledge and explore their own spiritual perspective.

**Spiritual perspective and the theory of human caring.** Watson acknowledges the importance of a nurses’ spiritual perspective in the second and third caritas processes. The second caritas process, *Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other*, “honors the belief system of the nurse, inviting the practitioner to connect with that which sustains him or her when in need of faith and hope...” (Watson, 2008, p. 62). The third caritas process, *Cultivation of One’s Own Spiritual Practices and Transpersonal Self*, is described as a lifelong journey. Without this process, an individual can become hardened and lose compassion and caring for self and other. The nurse needs to attend to and cultivate his or her own spiritual growth, insight, mindfulness, and spiritual dimension of life, in order to be able to be sensitive to self and other (Watson, 2008). Watson makes explicit that a

professional commitment to caring-healing cannot be complete or fully developed without focusing on this aspect of personal and professional growth (Watson, 2008). Watson not only invites the nurse to connect with his or her own source of faith and hope, but addresses the necessity to attend to and cultivate spiritual growth in order to be able to care, connect, or have compassion. This connection, attention to and cultivation of spiritual growth is manifested in an individual's spiritual perspective.

**Measuring nurses' spiritual perspective.** Spiritual perspective is an indicator of an individual's awareness of inner self and the sense of connection to a higher being, nature, others, or to some purpose greater than the self; spiritual perspective is manifested through beliefs and actions (Reed, 1987; Reed & Rousseau, 2007). Spiritual perspective and spirituality are used interchangeably in the healthcare literature (Haase et al., 1992; Meraviglia, 1999). For this study, instruments that evaluate self-awareness of personal experience regarding aspects of spirituality will be considered to be a measure of spiritual perspective. It is beyond the scope of this literature review to address all instruments that assess spiritual perspective, therefore only instruments that have evaluated nurses' spiritual perspective are included in this literature review.

The Spiritual Perspective Scale (SPS) (Reed, 1987) assesses the saliency of an individual's spiritual perspective. The SPS contains 10 items and uses a 6-point Likert-type scale to assess frequency of spiritual behaviors and importance of spiritual beliefs. The SPS is based on a conceptualization of spirituality as "Awareness of one's inner self and a sense of connection to a higher being, nature,

others, or to some dimension or purpose greater than oneself' (Reed, 1986a, p. 1). The SPS was initially validated in a sample of 300 adults: healthy ( $n = 100$ ), hospitalized non-terminally ill ( $n = 100$ ), and hospitalized terminally ill ( $n = 100$ ). Cronbach's alpha ranged from .93 to .95 in those adults (Reed, 1987). Construct validity was supported; women and those with a self-reported religious background scored higher on the SPS than men and those without a religious background, as was found in previous research (Reed 1986a, 1986b, 1987). The SPS has been used to measure spiritual perspectives in nursing faculty (Gray, Garner, Snow, & Wright, 2004), advanced practice nurses (Stranahan, 2001), and nurses in specialties such as: parish (Tuck et al., 2001), acute care (Ronaldson et al., 2012), palliative care (Ronaldson et al., 2012), maternal-infant (Dunn, Handley, & Dunkin, 2009), and mental health (Pullen, Tuck, & Mix, 1996).

The Spiritual Involvement and Beliefs Scale (SIBS) (Hatch, Burg, Naberhaus, & Hellmich, 1998) measures spiritual activity and beliefs with terms that avoid cultural or religious bias. The 26 item scale has established reliability with Cronbach's alpha reported as .92 in patients from a rural family practice and family practice professionals. Since 1998, the scale has been revised and both versions have been used in over 25 studies with adults and adolescents (R. Hatch, personal communication, June 4, 2014). The SIBS was used by Vance (2001) to evaluate acute care nurses' spiritual perspectives.

The Spiritual Well-Being Scale (SWBS) (Ellison, 1983) is the most widely used scale (Cohen, Holley, Wengel, & Katzman, 2012) and measures spiritual well-

being. The SWBS contains two subscales: Religious Well-Being (RWB) and Existential Well-Being (EWB). The scale contains 20 items with reliabilities reported for the total scale ( $\alpha = .89$ ) and for each subscale: RWB ( $\alpha = .87$ ) and EWB ( $\alpha = .78$ ). The RWB items assess an individual's relationship to God and the EWB items assess an individual's experience of purpose, meaning, and satisfaction in life. The RWB items contain references to God and may create issues for those who do not believe in God (VandeCreek & Smith, 1992). The SWBS has been used to examine spiritual perspectives in acute care nurses (Vance, 2001), parish nurses (Tuck et al., 2001), and maternal-infant nurses (Dunn et al., 2009).

The Daily Spiritual Experiences Scale (DSES) assesses "ordinary experiences of connection with the transcendent in daily life" (Underwood, 2011, p. 29). Since the scale measures experiences rather than behavior or beliefs, it was intended to transcend religious boundaries (Underwood & Teresi, 2002). The 16 item scale has excellent reliability with Cronbach's alpha coefficients ranging from .94 to .95. Scoring the DSES can be confusing because more frequent daily experiences are represented by a lower score. Some researchers have reported results incorrectly (Underwood, 2011). Scores have also been reported inconsistently; some researchers report total scores, while others report mean scores (Underwood, 2011). The DSES has been used with nurses from various practice settings (Mamier, 2009; Taylor, Mamier, Bahjri, Anton, & Peterson, 2009).

Cohen et al. (2012) recommend nurse researchers be aware of the numerous definitions for spiritual perspective and consider the foundation of earlier work when

selecting instruments. The SPS measures the saliency of an individual's spiritual perspective, which is congruent with Watson's theory that acknowledges the need for nurses to cultivate their own spiritual growth (Watson, 2008). Although the SIBS measures spiritual activities and beliefs, it has only been used once to measure spiritual perspectives in nurses (Vance, 2001). Ten of the 20 items in the SWBS reference God, which may create issues for those who do not believe in God or a higher power. The DSES assesses spiritual perspective in relation to an individual's daily experiences transcending religious and cultural boundaries, but scoring of results may be misinterpreted. The current study utilized the SPS to assess spiritual perspective because it has established reliability and validity, is congruent with Watson's theory, and has been the most frequently used instrument to measure spiritual perspective in nurses.

**Nurses' spiritual perspective.** Nurses' spiritual perspectives have been evaluated in the empirical literature with three primary objectives. Researchers have examined nurses' spiritual perspectives in order to describe perspectives (Cavendish et al., 2004; Gray et al., 2004; Pullen et al., 1996; Tuck et al., 2001), to explore the relationship to spiritual care (Mamier, 2009; Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001), and to assess effects on spiritual perspective after interventions (Geary & Rosenthal, 2011; Taylor et al., 2009).

**Description of nurses' spiritual perspective.** Pullen et al. (1996) used a convenience sample of 50 registered nurses from a public mental health facility to describe spiritual perspectives of mental health nurses using the Spiritual Perspective



Scale (SPS). The nurses were mostly female (86%), Christian (96%), White (92%), and age 40 or older (90%). Only 24% of the nurses had some type of exposure to spiritual care education programs. Scores for the SPS can range from 1 to 6 with higher scores indicating a greater spiritual perspective (Reed, 1987). The mean SPS score for this group of mental health nurses was 5.33 ( $SD = .56$ ) indicating a high spiritual perspective in these nurses. No statistically significant differences were found between demographic variables and SPS scores.

Tuck et al. (2001) surveyed parish nurses to assess spiritual perspectives. Using a randomized stratified selection process, surveys were mailed to 305 parish nurses throughout the United States with a 45% response rate. The sample ( $N = 119$ ) was primarily female (97.5%), Caucasian (94.6%), Christian (99%) with mean age of 50.8 (range 30-74 years). Spiritual perspectives were measured with the Spiritual Perspective Scale (SPS) and the Spiritual Well-Being Scale (SWBS) with higher scores representing greater spiritual perspective or spiritual well-being (Ellison, 1983; Reed, 1987). Scores for the SPS and SWBS were positively correlated ( $r = .358, p < .01$ ). SWBS scores can range from 20 to 120. The parish nurses' mean SPS score was 5.65 ( $SD = .43$ ) and mean SWBS score was 108.58 ( $SD = 11.96$ ). The scores indicate a high spiritual perspective and greater spiritual well-being for these parish nurses. In evaluating demographic variables and SPS and SWBS mean scores, the only statistically significant finding was the mean score of the SWBS by age group ( $F = 3.642, p = .01$ ),  $df$  not reported. Nurses 50 years or older had higher scores on the SWBS compared to nurses under age 50.

Cavendish et al. (2004) sought to capture a comprehensive and contextual description of nurses' spiritual perspectives using the SPS (Reed, 1987) and content analysis of the question, "Do you have any views about the importance or meaning of spirituality in your life that have not been addressed by the previous questions?" Questionnaires were mailed to a national random sample of 1,000 Sigma Theta Tau International (STTI) members with a 55% ( $N = 545$ ) response rate. The sample was predominately female ( $n = 533$ ) with ages ranging from 21 to 61 years (mean not reported). Almost all of the nurses reported a religious affiliation (99%) with the majority being Christian (77%). The majority of the participants was White (91%), married (73%), and had children (63.6%). Practice settings were not reported. The mean participant SPS score was 4.92 ( $SD = .99$ ). Statistically significant differences were present between demographic variables and SPS scores. Married nurses vs. single/living with significant other had higher scores ( $F(5.539) = 2.558, p = .027$ ). Younger ( $< 40$  years) and older ( $> 41$  years) nurses with a religious affiliation had higher SPS scores than their counterparts who did not have a religious affiliation ( $F(5.535) = 17.689, p = .001$ ). One hundred and sixty-five nurses (30.2%) responded to the research question regarding the importance or meaning of spirituality in their life. The spiritual perspectives were categorized into six themes: strength for acceptance, belief system, guidance, connectedness, promotes health, and supports practice.

Gray et al. (2004) surveyed baccalaureate nursing faculty from a public ( $n = 36$ ) and a Christian private ( $n = 22$ ) university to describe spiritual perspectives and to

ascertain if there are differences between the two groups using the SPS. The majority of the sample was female (98%), between the ages of 40-59 (59%), and had a range of total work experience between 8 to 40 years ( $M = 22.2$ ,  $SD = 8.1$ ). The researchers did not report if there were statistically significant demographic differences between public and private faculty. The majority of nursing faculty identified a religious affiliation (86%) and 21% attended religious or spiritually oriented meetings weekly. Specific religious affiliations were not reported. Breakdown for the 10 items reveals the private nursing faculty had higher scores for all SPS items and the total SPS mean score for the private nursing faculty ( $M = 5.51$ ,  $SD = .53$ ) was significantly higher than public nursing faculty ( $M = 4.97$ ,  $SD = .82$ ):  $F(1, 57) = 8.10$ ,  $p = .006$ .

*Synthesis of description of nurses' spiritual perspective.* The four studies presented in this section assessed nurses' spiritual perspective mostly using the SPS. Only one study (Cavendish et al., 2004) used an open-ended question and one study also included the SWBS (Tuck et al., 2001). The high scores for the SPS and the SWBS in the diverse nursing specialties indicated a high spiritual perspective for nurses in the studies. There were statistically significant positive relationships between spiritual perspective and age (Tuck et al., 2001), having a religious affiliation (Cavendish et al., 2004), and marital status (Cavendish, et al., 2004). Although scores on the SPS were high in nursing faculty, faculty from a private Christian university scored higher. The nurses from these four studies were predominately White females with a Christian religious affiliation and age 40 or older limiting generalizability due to the homogenous samples.

**Nurses' spiritual perspective and spiritual care practices.** Quantitative studies evaluating nurses' spiritual perspective and spiritual care practices were performed with nurses from various practice settings. Three studies were conducted in the United States (Mamier, 2009; Stranahan, 2001; Vance, 2001), and one study was conducted in Australia (Ronaldson et al., 2012). Each study utilized different instruments to measure nurses' spiritual perspective and spiritual care limiting comparison among studies.

Stranahan (2001) examined the relationships between spiritual perspective and spiritual care practices in nurse practitioners using the Spiritual Perspective Scale (SPS) and a modified version of the Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS) (Taylor, Highfield, & Amenta, 1994), titled the Nurses Spiritual Care Perspective Scale (NSCPS). Reliability and validity were not established for the modified NSCPS. The NSCPS measured frequency of 12 spiritual interventions on a 4-point Likert-type scale (*Rarely to Always*). Questionnaires were mailed to all 269 nurse practitioners (NP) licensed by the state of Indiana with 102 returned (40% response rate). The sample contained 97 females and 5 males with a mean age of 50 years ( $SD = 11$ ). Practice settings were not reported, but the NPs had a mean of 7.8 ( $SD = 6.8$ ) years of experience working as a NP. Seventy-seven percent of the sample ( $n = 79$ ) received some type of spiritual care education, but only 39% ( $n = 36$ ) believed this education was somewhat adequate. The mean score for the SPS was 4.98 ( $SD = 1.1$ ) which indicated a high spiritual perspective. Statistically significant positive correlations were found with the SPS and 9 out of 12 listed spiritual care

practices. Correlations between the SPS and spiritual interventions ranged from .22 ( $p = .05$ ) to .595 ( $p = .001$ ). In this sample, only 18% ( $n = 18$ ) reported providing spiritual care at work every day, while 57% ( $n = 58$ ) indicated they rarely or never provide spiritual care.

Vance (2001) used a descriptive correlational design to determine how acute care RNs' spiritual perspective influenced spiritual care provision. Spiritual perspective was measured with the Spiritual Involvement and Beliefs Scale (SIBS) and the Spiritual Well-Being Scale (SWBS). Spiritual care practices were measured by the Spiritual Care Practice Questionnaire (SCPQ), which was developed by Vance for the study. Surveys were mailed to a random sample of 425 nurses in a Midwestern teaching hospital with a 40.7% response rate ( $n = 173$ ). The majority of respondents were female (89.6%), White (94.2%), Christian (88%), and 70% were between the ages of 30 and 49 (range 20 to 69,  $M$  not reported). In this sample, the majority of nurses were critical care and medical/surgical nurses (75.7%) with 61% having 11 or more years of experience. Scores for the SIBS can range from 24 to 130 and the nurses' mean score was 97.1. The nurses' mean score for the SWBS was 101.7; scores can range from 20 to 120. The high scores on the SIBS and the SWBS indicate a high spiritual perspective for these nurses. There was a positive correlation between the SIBS and the SWBS scores ( $r = .72, p < .05$ ). The SCPQ measures the frequency of spiritual assessment and spiritual care interventions on a five-point Likert-type scale (*Very seldom* to *Very often*) with scores ranging from 9 to 45. Vance established a score of 32 as an ideal mean. "The ideal mean of 32 represents nurses who are

involved in spiritual care activities somewhere between “occasionally” and “often” on the Likert scale” (Vance, 2001, p. 267). Sixty nurses (34.6%) scored 32 or above on the SCPQ. A significant positive correlation ( $r = .19, p < .05$ ) was found between nurses’ spiritual perspective and the delivery of spiritual care; higher spiritual perspective scores were associated with higher spiritual care practice scores.

Using Vance’s SCPQ, Ronaldson et al. (2012) conducted a cross-sectional study to identify and compare spiritual perspectives and spiritual care practices of palliative care RNs ( $n = 43$ ) and acute care RNs ( $n = 50$ ). Both groups of nurses were predominately female (85.7% and 78%), but the palliative care nurses were significantly older ( $p \leq .05$ ) with a mean age of 43 years versus 33.5 years for the acute care RNs. The results showed SPS scores for the palliative care RNs ( $M = 4.1, SD = 1$ ) were significantly higher ( $p \leq .05, t$  not reported) than acute care RNs ( $M = 3.7, SD = 1.3$ ). Scores on the SCPQ were also significantly higher for palliative care RNs ( $M = 31, SD = 5.8$ ) than acute care RNs ( $M = 25, SD = 6.7$ ) ( $p \leq .001, t$  not reported). Forty percent of palliative care RNs achieved a score of 32 or more on the SCPQ compared to 12% of acute care RNs. There was a statistically significant positive correlation between the SPS and SCPQ scores ( $r = .37, p = .02$ ) for palliative care RNs but not for the acute care RNs.

Mamier (2009) examined the relationship between nurses’ spiritual perspective and frequency of spiritual care practices using the Nurse Spiritual Care Therapeutics Questionnaire (NSCQ) via an online survey. RNs ( $N = 2311$ ) were recruited from a private faith-based health care system in the southwestern United

States with a 26.9% response rate. The sample ( $N = 554$ ) was predominately female (86.3%) with the following racial breakdown: White (47.1%), Hispanic/Latino (13.5%), Asian/Pacific Islander (32.5%), Black/African American (4.7%), and American Indian/Alaskan Native (0.4%). The majority of nurses reported a Christian religious affiliation (92%), and ages ranged from 21 to 67 ( $M = 39$ ,  $SD = 10.89$ ). RN experience ranged from less than 1 year to 45 years ( $M = 11$ ,  $SD = 10.4$ ). Spiritual perspective was measured using the Daily Spiritual Experiences Scale (DSES); potential mean scores on the DSES can range from 1 to 6. The results for the DSES ( $M = 2.07$ ,  $SD = 1.18$ ) indicate a highly spiritual sample, as lower scores indicate more daily spiritual experiences. The score for the NSCQ can range from 17 to 85. The mean score of 36.98 ( $SD = 12.01$ ) in this sample indicated the nurses engaged in the spiritual care activities listed on the NSCQ an average of 1-2 times in the past 72-80 hours at work. A statistically significant negative correlation was found between the NSCQ and the DSES which is reverse-coded ( $r = -.343$ ,  $p < .01$ ) indicating a positive correlation between spiritual perspective and spiritual care practices.

*Synthesis of spiritual perspectives and spiritual care practice.* As seen in prior research, the majority of participants in the studies evaluating spiritual perspectives and spiritual care practices were White, Christian females with mean ages ranging from 30s to 50. Spiritual perspectives were assessed with various instruments measuring religious and non-religious components of an individual's spiritual perspective. Spiritual care practices were evaluated with three different instruments which limits comparison among the studies.

Although two studies (Ronaldson et al., 2012; Vance 2001) utilized the Spiritual Care Practice Questionnaire (SCPQ) to measure spiritual care practices, spiritual perspectives were assessed with different instruments. Ronaldson et al. (2012) used the SPS, and Vance (2001) used the SIBS and SWBS to measure spiritual perspectives. Stranahan (2001) measured spiritual perspectives with the SPS, as did Ronaldson et al., but used the NSCPS to evaluate spiritual care practices. Mamier measured spiritual perspective with the DSES and spiritual care practices with the NSCQ. Instruments can assess varying aspects of spiritual perspectives making comparisons problematic. In addition, three different instruments were utilized to measure spiritual care practices which limited comparison among studies. Regardless of instrument or setting, results indicated that a higher spiritual perspective correlated with a higher provision of spiritual care.

**Effects of interventions on nurses' spiritual perspective.** Two studies evaluated nurses' spiritual perspective before and after two different types of interventions: self-study program on communication regarding spirituality (Taylor et al., 2009) and a Mindfulness-Based Stress Reduction (MBSR) course (Geary & Rosenthal, 2011).

Taylor et al. (2009) used the DSES to evaluate nurses' spiritual perspective before and after a self-study program designed to educate nurses in how to talk about spirituality with patients. The sample ( $N = 201$ ) consisting of RNs and student nurses was primarily female (94%), Euro-Americans (63%), and Christian (89%) with a mean age of 35 ( $SD = 12.6$ ). The DSES scores prior to the program were  $M = 40.8$



( $SD = 13.6$ ) and after program completion  $M = 37.6$  ( $SD = 12.8$ ); these differences were statistically significant ( $t(193) = -6.85, p < .0001$ ). Results of the participants' lower DSES scores indicate these participants had more daily spiritual experiences after course completion.

Geary and Rosenthal (2011) conducted an interventional study with nursing and non-nursing employees of an academic medical center and evaluated the effect of a MBSR course on spiritual perspective using the DSES. The DSES was administered before, immediately upon completion, and one year after the course. The MBSR group was primarily female (85%), White (75%), married (57%), with a mean age of 48 ( $SD = 9.6$ ). The control group was also predominately female (96%), White (55%), married (61%), with a mean age of 42 ( $SD = 8.7$ ). The only significant demographic difference was the percentage involved in patient care: MBSR group 50% and control group 100%. Pre-course scores on the DSES were similar between the groups: MBSR ( $M = 50.48, SD = 17.5$ ) and control ( $M = 49.6, SD = 18$ ). However, per the researchers, the DSES scores were "significantly different" ( $t$  test and  $p$  values not reported) at 8 weeks and 1 year for the MBSR group ( $M = 44.04, SD = 19.2; M = 42.26, SD = 18.7$  respectively) compared to the pre-course MBSR and control group DSES scores. The control group DSES scores at 8 weeks and 1 year indicated little variability over time ( $M = 50.45, SD = 19.2; M = 50.6, SD = 19$ , respectively).

*Synthesis of effects of interventions on nurses' spiritual perspective.* Two studies demonstrated that spiritual perspective can increase after varying

interventions. The intervention by Taylor et al. (2009) focused on improving the nurse's ability to communicate with patients, while Geary and Rosenthal (2011) used an intervention designed to impact the individual nurse or employee. The samples were similar because they contained primarily White or Euro-American females with mean ages mid- 30s to 40s. Geary and Rosenthal (2011) demonstrated that changes were sustained one year after intervention.

**Synthesis of spiritual perspective.** Spiritual perspective and spirituality have been used interchangeably in the healthcare literature (Haase et al., 1992; Meraviglia, 1999). Spiritual perspective is an indicator of an individual's awareness of inner self and sense of connection to a higher being, nature, others, or to some purpose greater than oneself which is manifested through beliefs and actions (Reed, 1987; Reed & Rousseau, 2007). Although researchers have evaluated spiritual perspectives in advanced practice nurses and registered nurses from diverse settings, the samples mainly consisted of White females with a Christian religious affiliation.

Several instruments have been used to measure spiritual perspective in nurses with the Spiritual Perspective Scale being used the most. Instruments assess beliefs and actions or assess personal experiences. Overall, the nurses surveyed had high spiritual perspectives regardless of instrument utilized in the study.

Correlations were found between nurses' spiritual perspective and certain demographics and spiritual care practices. Positive correlations were found between nurses' spiritual perspective and characteristics such as: age (Tuck et al., 2001), having a religious affiliation (Cavendish et al., 2004), and being married (Cavendish

et al., 2004). In spite of measuring nurses' spiritual perspective and spiritual care practices with varying instruments, positive correlations were found between nurses' spiritual perspective and spiritual care practices in each study sample with the exception of Ronaldson et al. (2012); no correlation was found with acute care RNs' Spiritual Perspective Scale and Spiritual Care Practice Questionnaire scores.

Nurses' spiritual perspectives were shown to increase after interventions. A self-study communication program regarding spirituality and a mindfulness based stress reduction program were found to increase spiritual perspectives as measured by the Daily Spiritual Experience Scale in nurses. Findings from these studies indicate that nurses' spiritual perspectives are amenable to change.

Gaps have been identified in the studies concerning nurses' spiritual perspective. Male nurses and nurses with diverse religious and racial backgrounds are underrepresented in studies examining nurses' spiritual perspective. Positive correlations have been identified with certain demographics. Yet, researchers have not explored if other characteristics that can be developed, such as mindfulness, are correlated with nurses' spiritual perspective.

### **Mindfulness**

In the healthcare literature, the term mindfulness can be used in several ways. Mindfulness can refer to an individual characteristic or trait describing how mindful the individual is in general, or a state indicating how mindful a person happens to be at a given time (Young, 2013). It also can denote practices, such as meditation, designed to increase an individual's level of awareness or attention (Young, 2013).

Being mindful is an inherent human capacity (Kabat-Zinn, 2003). Individuals vary on their degree of mindfulness, but it can be enhanced through regular disciplined practice (Nhât, 2009; Sitzman & Watson, 2014). Mindfulness practices can cultivate being present in the moment (Burkhardt & Nagai-Jacobson, 2002; Epstein, 2001; Kabat-Zinn, 2013), compassion (Condon, Desbordes, Miller, & DeSteno, 2013; Gunaratana, 2011; Kabat-Zinn, 2013), and may enable an individual to respond to situations more reflectively and not just out of a habitual pattern (Bishop et al., 2004). In clinical practice, reacting habitually may be perceived by patients as a clinician who is unaware, unfeeling, or distracted (Connelly, 2005), but carefully listening to a patient helps them to feel heard, cared for, and understood (Connelly, 1999).

Epstein (1999) stated in his seminal article that the goals of mindful practice are “to become more aware of one’s mental processes, listen more attentively, become flexible, and recognize bias and judgments, and thereby act with principles and compassion” (p. 83). Clinicians who practice mindfully can develop qualities that are considered prerequisites to compassionate care: being present in the moment, the ability to remain ostensibly undistracted, listening before expressing an opinion, and the ability to be calm even if performing several tasks at once (Epstein, 2003). Compassionate care is a component of spiritual care (Ferrell & Baird, 2012; Ferrell & Munevar, 2012; Taylor & Walker, 2012).

Mindfulness has been incorporated into care models found in the healthcare literature. The COMFORT framework for communication in palliative nursing

includes mindfulness as a component. In this model, the principle of mindfulness is used to avoid predetermined scripts so as to be in the moment, to avoid prejudging how interactions should proceed, to avoid judgment about patient and families, and to adapt to dynamic changes in interactions (Wittenberg-Lyles, Goldsmith, & Ragan, 2010). The ATTEND (Attunement-Trust-Touch-Egalitarianism-Nuance-Death Education) model is an interdisciplinary mindfulness-based bereavement care model in which attunement in patient care is attained through mindfulness, responsiveness, empathy, and self-awareness (Cacciatore & Flint, 2012).

In a concept analysis of mindfulness, White (2014) stated that there are indications that mindfulness can serve as a practical approach for nurses to develop presence, empathy, patience, awareness of self and other, and compassion. Mindfulness in nursing was conceptualized as a transformative process in the experience of being present, which is sustained and cultivated by awareness, acceptance, and attention (White, 2014). The consequences of mindfulness include improvements in physical and mental health, personal and professional relationships, self-care practices, and new or increased engagement with spirituality (White, 2014).

**Mindfulness and the theory of human caring.** Watson states one of the first requirements for nurses practicing within a caring-healing model is to be fully present in the moment in order to be more open and accessible to oneself and the situation (Watson, 2008). In the first caritas process, *Cultivating the Practice of Loving-Kindness and Equanimity Toward Self and Other*, Watson introduces an overview of mindfulness meditation as a means for personal and profession preparation.

This form of meditation is recommended not only because I have experienced it and continue to practice it but because it is directly relevant to professionals preparing themselves to be present and mindful in caring-healing work. It is closely related to learning to live the Theory to Be/Become the *Caritas Consciousness* we wish to be (Watson, 2008, p. 56)

Mindfulness practice is intended to assist the mind, body, heart, and spirit to be present with what is happening in the moment, and in doing so, one can be fully available for another (Sitzman & Watson, 2014).

**Measuring mindfulness.** Brown and Ryan (2004) describe mindfulness as a “deceptively simple concept that is difficult to characterize accurately” (p. 242). Over 10 self-report instruments to assess mindfulness can be found in the literature, yet there is no accepted “gold standard” (Grossman, 2008; Park, Reilly-Spong, & Gross, 2013). The instruments are based on varying conceptualizations and assess different dimensions of mindfulness (Haigh, Moore, Kashdan, & Fresco, 2011). The majority of instruments assess mindfulness as a “trait” indicating how mindful a person is in general (Young, 2013). Instruments have also been developed to assess the “state” of mindfulness or how mindful a person may be at a given time (Young, 2013). The current study examined mindfulness as a trait, thus only instruments that measure trait mindfulness are discussed.

The current study utilized the Mindful Attention Awareness Scale (MAAS), trait version (Brown & Ryan, 2003). The MAAS evaluates a core characteristic of mindfulness, “a receptive state of mind in which attention, informed by a sensitive awareness of what is occurring in the present, simply observes what is taking place” (Brown, nd, p. 2). This definition is congruent with Watson’s theory, for in describing

mindfulness, she states it is a “noninterference with what is rising up and falling away in your inner and outer awareness” (Watson, 2008, p. 53). The MAAS was the first widely disseminated instrument to measure mindfulness (Park et al., 2013), and one of the instruments most used (Sauer et al., 2013). The scale contains 15 items which describe attributes uncharacteristic of mindfulness and asks respondents to indicate how frequently these occur in their everyday experience using a 6-point Likert-type scale (*Almost always* to *Almost never*). Exploratory factor analysis revealed a single factor structure which accounted for 95% of the variance. Confirmatory factor analysis was also performed and found all 15 items significantly related to the latent factor ( $ps < .001$ ). Cronbach’s alphas ranging from 0.80 to 0.87 in college, adult, and cancer patient populations have been reported (Brown & Ryan, 2003; Carlson & Brown, 2005). The MAAS has also been used in adults with major depression (Chiesa, Mandelli, & Serreti, 2012), chronic pain (McCracken, Gauntlett-Gilbert, & Vowles, 2007), and in health care providers (Beach et al., 2013; Cohen-Katz et al., 2005a; McGarrigle & Walsh, 2011; Shapiro, Brown, & Biegel, 2007).

The Freiburg Mindfulness Inventory (FMI) (Buchheld, Grossman, & Walach, 2001) was the first insight meditation (also known as mindfulness meditation) inspired measure of mindfulness published (Park et al., 2013). This 30 item instrument was designed to operationalize the Buddhist concept of mindfulness for use in individuals with prior exposure to the practice of mindfulness meditation. Cronbach’s alphas were reported to range from 0.80 to 0.94 (Buchheld et al., 2001; Leigh, Bowen, & Marlatt, 2005). A modified shorter version of the FMI (14 items)

was developed by Walach, Buchheld, Büttenmüller, Kleinknecht, and Schmidt (2006) for use with individuals without previous meditation experience. The shortened version has a Cronbach's alpha of 0.86 and is correlated with the 30 item version ( $r = .95$ ) in community and clinical participants. The majority of studies utilizing the FMI-short version have been conducted in Germany (Belzer et al., 2013; Kohls, Sauer, & Walach, 2009; Sauer, Walach, & Kohls, 2011).

The Philadelphia Mindfulness Scale (PHLMS) (Cardaciotto, Herbert, Forman, Moitra, & Farrow, 2008) measures present moment awareness of internal and external stimuli and acceptance of experiences without judgments based on Bishop's et al. (2004) definition. The 20 item instrument has two subscales: awareness and acceptance. Each subscale contains 10 questions with Cronbach's alphas ranging for the awareness subscale 0.75 to 0.86 and the acceptance subscale 0.75 to 0.91. The subscales were not correlated, therefore a total score for the PHLMS is not recommended. This scale was validated in clinical and non-clinical student populations and has been used with undergraduates (Bergen-Cieo, Possemato, & Cheon, 2013), clinical and community adults (Ruocco & Direkglu, 2013), and adults with post-traumatic brain injuries (Bedard et al., 2013).

The Southampton Mindfulness Questionnaire (SMQ) (Chadwick, Hember, Peters, Kuipers, & Dagnan, 2008) contains 16 items evaluating mindful awareness of distressing thoughts and images. The items relate to four aspects of mindfulness: awareness of cognitions as mental events in a wider context, allowing attention to remain with difficult cognitions, non-judgment, and letting go of cognitions without



reaction. Cronbach's alpha for the SMQ ranged from 0.85 to 0.89 in clinical and adult community samples (Chadwick et al., 2008). The SMQ has been used in adults with chronic depression (Strauss, Hayward, & Chadwick, 2012), hallucinations (Perona-Garcelán et al., 2014), and adults with psychotic disorders (van der Valk, van de Waerdt, Meijer, van den Hout, & de Haan, 2013).

The Cognitive and Affective Mindfulness Scale-Revised (CAMS-R) (Feldman, Hayes, Kumar, Greeson, & Laurenceau, 2007) is a refinement of the Cognitive and Affective Mindfulness Scale (CAMS). Psychometric issues related to the CAMS (low alpha coefficient of 0.64 and inability to replicate factor loadings across samples) led to the development of the CAMS-R. The CAMS-R measures four aspects of mindfulness: ability to regulate attention, orientation to present experience, awareness of experience, and an attitude of acceptance/non-judgment toward experience. The 12 item CAMS-R had improved reliability coefficients (0.77 to 0.81) in university students (Feldman et al., 2007). The CAMS-R has also been used in undergraduates in the US (Moore, 2013; Schmertz, Anderson, & Robins, 2009), community dwelling adults and undergraduates in Turkey (Catak, 2012), and community dwelling adults in Poland (Janowski & Lucjan, 2012).

The Kentucky Inventory of Mindfulness Skills (KIMS) (Baer, Smith, & Allen, 2004) is an instrument that assesses the propensity to be mindful in daily life. The 39 item instrument uses a 5-point Likert-type scale (*Never or very rarely to Almost always or always true*) to evaluate four mindful skills: observation of present moment experiences, describing observed phenomena, acting with awareness, and accepting

present moment experiences without judging. These skills are based on mindfulness as taught in dialectical behavior therapy (DBT). The KIMS was validated in undergraduate students and adults with borderline personality disorders. The Cronbach's alpha for the four subscales ranged from 0.76 to 0.91. The KIMS has also been used in adults with attention deficit hyperactivity disorder (Smalley et al., 2009) and borderline personality disorders (Perroud, Nicastro, Jermann, & Huguelet, 2012).

The Five Facet Mindfulness Questionnaire (FFMQ) (Baer, Smith, Hopkins, Krietemeyer, & Toney, 2006) is a composite of the following instruments: FMI, MAAS, CAMS-R, SMQ, and the KIMS. The FFMQ contains 39 items and is scored using the same 5- point Likert-type scale as the KIMS. All of the subscales from the KIMS are included with the addition of non-reactivity to inner experience subscale. The FFMQ was validated in undergraduate students, and the Cronbach's alphas for the subscales ranged from 0.75- 0.91. Although the FFMQ has been used in various studies with community and clinical populations (Garland, Roberts-Lewis, Kelley, Tronier, & Hanley, 2014; Paul, Stanton, Greeson, Smosky, & Wang, 2013), to date, the FFMQ has been rarely used with healthcare providers (Asuero et al., 2014).

*Summary of measuring mindfulness.* There are a number of instruments available to evaluate trait mindfulness, yet two scales have been predominately used: KIMS and the MAAS (Sauer et al., 2013). The KIMS has mainly been used in clinical samples but has not been used with health care providers. The MAAS has been used in a variety of populations as well as health care providers. Several instruments, such as the FMI-short, CAMS-R, and the PHLMS, have not been widely

used. Certain instruments, such as the FMI designed to be used in meditators, and the SMQ designed to evaluate mindful awareness of distressing thoughts and images, are not appropriate for all populations. Given that the MAAS is a valid and reliable instrument that is widely used and is congruent with Watson's definition of mindfulness, the MAAS is the appropriate choice for use in the current study.

**Descriptive study of mindfulness.** Bruce and Davies (2005) explored the experience of mindfulness with hospice caregivers who regularly engaged in mindfulness meditation. Caregivers from a hospice in which Western palliative care and Zen Buddhist philosophy are integrated were interviewed to ascertain the experience of mindful awareness and its effect on caregiving. Nine caregivers (6 male, 3 female) with an average age of 49 were interviewed. The mean average hospice experience was five years and mean years for meditation practice was 16 years. Four themes emerged that addressed "the experience of repeatedly bringing one's awareness partially or fully to the moment in end of life care" (Bruce & Davis, 2005, p.1335). *Hospice care as meditation in action* explained how caregivers practiced being in the moment by paying attention during routine activities of caregiving; practicing mindfulness was an approach to being present. The second theme is *abiding in liminal spaces*. Liminal spaces are those in which dichotomies such as self-other, work life-spiritual life, living-dying dissolve. In appreciating these liminal spaces, caregivers and residents are seen as inseparable, a concept which is integral to empathy and compassion. In the theme, *seeing differently*, perceptions shifted which caused caregivers to notice things for the first time. There was also a

vivid sense of appreciation, and an appreciation of beauty in the familiar. When caregivers cultivated an attitude that fostered being open to people or situations without predetermined expectations, they experienced kindness and availability with the patients and with each other. “This capacity to engage and be engaged without an agenda was described as ‘presence’ ” (Bruce & Davis, p. 1338). New possibilities for addressing patients’ needs arose from being fully present and trusting the authenticity of the caregivers intentions and skills. The final theme of *resting in groundlessness* encompassed several subthemes. It was described that letting go of the wish that things were different brought fear of what may be, but caregivers who were mindful of the hope/fear were open to what was happening in the moment. Mindfulness allowed caregivers to become intimate with fear, to be able to stay present in the space of mutual vulnerability, and to stay open when they did not know what to do.

**Development of mindfulness through training.** Cohen-Katz et al. (2005a, 2005b) explored the effects of a Mindfulness-Based Stress Reduction (MBSR) program on health care workers using quantitative and qualitative methodologies. A total of three cohorts, primarily consisting of nurses, completed the MBSR program. Trait mindfulness was measured immediately after the program and 3 months later. After completing the program, scores on the MAAS (trait mindfulness) had increased significantly from baseline ( $p = .004$ ), and those changes persisted at three months ( $p = .002$ ). The qualitative data analyzed came from interviews, evaluation forms, participant data sheets, unsolicited emails, and a focus group. As a result of the MBSR program, participants noted the following benefits: self-acceptance, self-

compassion, self-awareness, being in the moment, and enhanced spirituality.

Relationships were impacted by perceptions of improved communication, increased empathy, and being fully present without becoming reactive or defensive.

Beckman et al. (2012) randomly contacted physicians who had recently attended a mindful communication program in order to understand what aspects of the program contributed to improvements in well-being and patient centered-care. Subjects who agreed to participate were interviewed over the phone or in person using semi-structured interviews. Interviews were audio-taped and transcribed and saturation was reached after 20 interviews. A main theme that emerged was *acquiring skills of attentiveness, listening, honesty, and presence*. Participants conveyed that learning mindfulness skills enhanced their ability to listen attentively and respond effectively in their personal and professional lives. In addition, participants became more self-aware of personal reactions, and in turn, found this allowed them to become more accepting and responsive to the needs of others. Participants recognized that patients acknowledged when they were being present, listening, understanding, and empathic.

***Synthesis of development of mindfulness through training.*** Findings from these two studies indicate participants in mindfulness training programs have reported increased mindfulness and have developed qualities necessary for spiritual care practice. Researchers have found mindfulness training increased participants' mindfulness as measured by the MAAS (Cohen-Katz et al., 2005a). Qualitative findings reveal skills were developed as a result of mindfulness training such as:

becoming self-aware (Cohen-Katz et al., 2005a, 2005b; Beckman et al., 2012), being fully present (Beckman et al., 2012; Cohen-Katz et al., 2005b;), and listening (Beckman et al., 2012, Cohen-Katz et al., 2005a, 2005b).

**Mindfulness training and spiritual perspective.** Using a matched wait-list control design for medical and premedical students, Shapiro et al. (1998) assessed the effects of a seven week mindfulness program on spiritual perspectives. Premedical and medical students ( $N = 78$ ) were randomly assigned to the intervention or a wait-list control group and were matched for gender, race, and premedical versus medical student status. Spiritual perspectives were measured using the INSPIRIT, which assesses an individual's belief in God/higher power and an internalized relationship with God/higher power (Kass, Friedman, Leserman, Zuttermeister, & Benson, 1991). The INSPIRIT was administered to the intervention group and control group before the program and shortly after program completion. No significant differences were found between the intervention and control groups' pre-intervention scores ( $p > .05$ ), but there were significant differences in post-intervention scores ( $p < .05$ ). An analysis of variance (ANOVA) was performed and found the intervention group had an increase in INSPIRIT scores  $F(1, 69) = 5.62, p < .02$ .

Carmody et al. (2008) evaluated the effects of a MBSR course on mindfulness and spiritual perspectives in community dwellers ( $N = 44$ ). The participants in the MBSR course were self-referred or referred to the course by their health care provider (approximately 50%). The majority of the sample was female (75%) with a mean age of 47.8 years. Mindfulness was measured with the MAAS for trait mindfulness and

the Toronto Mindfulness Scale (TMS) (Lau et al., 2006) for state mindfulness. Spiritual perspective was measured using the Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale [FACIT-Sp] (Peterman, Fitchett, Brady, Hernandez, & Cella, 2002). The FACIT-Sp uses a 5-point Likert type scale (*Not at all* to *Very much*) to assess aspects of spirituality relating to meaning, peace, and faith. The authors stated there were no significant relationships with demographics and changes in mindfulness and spirituality. In order to make comparisons, scores for the MAAS, TMS, and FACIT-Sp were standardized to a 0-10 scale. Median percent change from baseline scores (post-MBSR- pre MBSR) were estimated based on standardized scores. The following median increases were reported: TMS (50%), MAAS (16.91%), and FACIT-Sp (22.65%). Increases in mindfulness on both the MAAS and TMS, predicted increases for FACIT-Sp scores. The estimated effect was greater for TMS ( $\beta = 0.40$ , 95% CI [0.22, 0.58],  $p = .001$ ) than MAAS ( $\beta = 0.28$ , 95% CI [0.09, 0.47],  $p = .005$ ).

*Synthesis of mindfulness training and spiritual perspective.* Only a few studies can be found in the literature examining spiritual perspectives and mindfulness. Only one study (Carmody et al., 2008) quantitatively examined changes in mindfulness (trait and state) and its effect on spiritual perspective scores. The Shapiro et al. (1998) study was conducted prior to 2003 when the first instrument to evaluate mindfulness was published. Participants in these studies were either self-referred or referred by their physician, and therefore motivation to participate may affect results. Participants in Shapiro's et al. (1998) study were students, and as with

all self-report instruments, the possibility exists to report socially desirable responses, which may have influenced results.

**Clinician mindfulness.** To date, researchers have not investigated the relationship between mindfulness and nursing care or spiritual care practices. In a related study, Beach et al. (2013) explored the relationship between clinician mindfulness and quality of patient care. Forty-five clinicians (physicians, nurse practitioners, physician assistants) from four HIV care sites (Baltimore, Detroit, New York, and Portland) and a convenience sample of their patients ( $n = 437$ ) participated in the study. Mean age of clinicians was 44.5 years. Fifty-six percent were female with the following ethnic breakdown: Caucasian (67%), Asian (24%), and other (9%). Encounters between clinicians and patients were audio recorded and then analyzed using the Roter Interaction Analysis System (RIAS). Patients completed a post-encounter interview answering demographic questions and evaluating care by rating overall satisfaction with medical care and communication behaviors. Clinicians completed the Mindful Attention Awareness Scale (MAAS) (Brown & Ryan, 2003) with scores ranging from 2.57 to 5.93 ( $M = 4.33$ ). Scores were not normally distributed, and so the variable was divided into low, medium, and high tertiles. When adjusting for site and demographics of clinicians and patients, patient encounters with high mindfulness clinicians versus low-mindfulness clinicians were more likely to have patient-centered patterns of communication (adjusted odds ratio = 4.14, 95% CI [1.58,10.86]). These encounters included more rapport building and addressing of psychosocial issues. In addition, high mindfulness clinicians versus low



mindfulness clinicians had more positive emotional tones with patients when adjusting for covariates of patient and clinician characteristics ( $\beta = 1.17$ , 95% CI [0.46, 1.9]). When adjusting for site and demographics of clinicians and patients, patients were more likely to assign high ratings for clinician communication (adjusted prevalence ratio (APR) = 1.48, 95% CI [1.17, 1.86]) and high overall satisfaction (APR = 1.45, 95% CI [1.15, 1.84]) to high mindfulness clinicians.

This was the first study that evaluated clinician mindfulness and quality of patient care, but limitations were noted by the authors. One limitation was potential changes in normal behavior due to the presence of a recorder. In addition, close relationships may already exist between providers and patients with a chronic serious illness which can affect patient-centered care regardless of clinician's degree of mindfulness.

**Synthesis of mindfulness empirical literature.** Researchers have examined mindfulness from different perspectives with qualitative and quantitative methodologies. Since 2003, numerous instruments have been developed to measure mindfulness. As a result of attending mindfulness training programs, participants had increases in mindfulness as measured by the MAAS (Beach et al., 2013; Cohen-Katz et al., 2005a; Carmody et al., 2008) and the TMS (Carmody et al., 2008) and spiritual perspectives as measured by the INSPIRIT (Shapiro et al., 1998) and the FACIT-SP (Carmody et al., 2008). Results from one study demonstrated that increases in mindfulness predicted increases in spiritual perspectives (Carmody et al., 2008). Participants in mindfulness training courses developed such skills as: attentiveness,

listening, being in the moment, self-awareness/acceptance, and recognizing need for self-care (Cohen-Katz et al., 2005b; Beckman et al., 2012). Hospice caregivers who regularly engaged in mindfulness meditation reported that this practice was a way of being present, integral to empathy and compassion, and they were open to the unexpected in the encounter (Bruce & Davies, 2005). Practitioners who were considered more mindful as measured by the MAAS were more likely to have patient-centered patterns of communication and were given higher scores for overall satisfaction by their patients (Beach et al., 2013).

Findings from these studies support using mindfulness as a variable for the current study which examined spiritual perspective, mindfulness, and spiritual care practices. Research has demonstrated a relationship between mindfulness and spiritual perspective both qualitatively and quantitatively. In addition, qualitative findings indicate that participants in mindfulness training have developed skills, such as, attentiveness, presence, and listening which are fundamental to spiritual care practice (Baird, 2010; Burkhardt & Nagai-Jacobson, 2009; Taylor, 2002).

### **Spiritual Care Practices**

**Spiritual care practices and the theory of human caring.** In this study, spiritual care is conceptually defined as actions or ways of being employed by the nurse to promote the integration of spirituality into all aspects of life for the patient (Taylor, 2002). The caritas processes can be used as a guide in providing spiritual care. Sawatzky and Pesut (2005) state compassion, hope, and love are components of the most basic and universal approach to spiritual care. The first and second caritas

processes, *Cultivating the Practice of Loving-Kindness and Equanimity Toward Self and Other* and *Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other*, address love, compassion, and hope. Authentic presence is described as a necessary component of spiritual care (Baird, 2010) and the second *caritas* process addresses the need for a certain level of authenticity required for human presence when assisting individuals in situations requiring hope and faith.

By being sensitive to our own presence and *Caritas Consciousness*, not only are we able to offer and enable another to access his or her own belief system of faith-hope for the person's healing, but we may be the one who makes the difference between hope and despair in a given moment (Watson, 2008, p. 62)

**Measuring spiritual care practices.** Measuring spiritual care practice is challenging because there is a paucity of valid and reliable instruments. Three instruments are described that have been used in research presented in this literature review: Nurse Spiritual Care Therapeutics Scale, Oncology Nurse Spiritual Care Perspective Survey, and Spiritual Care Practice Questionnaire.

The Nurse Spiritual Care Therapeutics Scale (NSCTS) (Mamier & Taylor, 2014), originally titled the Nurses Spiritual Care Therapeutics Questionnaire (NSCQ) (Mamier, 2009), is designed to measure the frequency of nursing spiritual care practices. The NSCTS contains 17 items and measures the frequency of nursing practices that support patient spirituality (Mamier & Taylor, 2014). The NSCTS has established reliability with a Cronbach's alpha coefficient of .93 and validity supported by a content validity index of .88 (Mamier & Taylor, 2014; Taylor, 2008).

Exploratory factor analysis was performed which resulted in a one factor solution which accounted for 49.5% of the variance (Mamier & Taylor, 2014).

The NSCTS is an appropriate instrument for this study which utilizes Watson's theory of human caring; items measuring spiritual care therapeutics are congruent with the caritas processes. Items assessing therapeutics include asking how the nurse could support the patient's spiritual or religious practices and informing the patient about spiritual resources. Both activities are congruent with the second and eighth caritas processes: *Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other* and *Creating a Healing Environment at All Levels*. Items also include listening and remaining present to show caring which are consistent with the fourth caritas process, *Developing and Sustaining a Helping-Trusting Caring Relationship*. Watson (2008) states presence, authentic listening, and being present for another is necessary to build authentic caring relationships. Items that address listening also pertain to the fifth caritas process, *Being Present to, and Supportive of, the Expression of Positive and Negative Feelings*. In addition, items that encourage patient dialogue are also consistent with the fifth caritas process.

The Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS) developed by Taylor, Amenta, and Highfield (1995) assesses frequency of specific spiritual care interventions. The ONSCPS was based on a review of the literature and clinical experience, and content validity supported by a panel of experts with only Hubbell et al. (2006) reporting on reliability (Cronbach's alpha of .77). The ONSCPS

has been modified for use with nurse practitioners (Hubbell et al., 2006; Stranahan, 2001).

The Spiritual Care Practice Questionnaire (SCPQ) was created by Vance (2001) to examine spiritual care practices. The instrument was developed based on a review of the literature and evidence for content validity was provided by a panel of experts. Reliability was established by a Cronbach's alpha of .87 and test-retest reliability was  $r = .80$  (time frame not given).

Of the three instruments discussed, only the Nurses Spiritual Care Therapeutics Questionnaire (Mamier & Taylor, 2014) has undergone instrument development with evidence of reliability and validity supported by an acceptable content validity index and factor analysis. The NSCTS is consistent with Watson's theory of human caring, because items measure practices consistent with the second, fourth, fifth, and eighth caritas processes.

**Spiritual care practices: Qualitative research.** Spiritual care practices of nurses have been evaluated qualitatively in various clinical settings including hospice and palliative care. The qualitative methodologies utilized included interviews and mailed surveys with open ended questions. Studies presented here include research that has been conducted in the United States (Belcher & Griffiths, 2005; Burkhart & Hogan, 2008; Daaleman et al., 2008; Dennis, 1991; Emblen & Halstead, 1993; Touhy Brown, & Smith, 2005; Tuck et al., 2001) and internationally in Australia (Harrington, 1995), Ireland (Bailey, Moran, & Graham, 2009), and the United Kingdom (Carroll, 2001).

Dennis (1991) used Watson's theory as a conceptual framework for her qualitative study to explore the question, "What are the components of spiritual nursing care as described by the nurses who provide such care?" Semi-structured interviews were conducted to elicit the lived experiences of 10 registered nurses (RNs) from various clinical settings who said they provided spiritual nursing care from a non-religious perspective. The sample was selected using the snowball technique. All but two of the participants were members of the American Holistic Nurses' Association, and all had been in nursing for 4 to 28 years ( $M = 16$ ). The sample consisted of all White females of Judeo-Christian background ranging in age from 35 to 50 ( $M = 41.1$ ). The following patterns emerged from data analysis.

Spiritual care pertains to all practice settings and is not a separate component of nursing care. The human spirit is the core of an individual's existence, and it is the power that heals. The goal of nursing is to call forth this inner power and help the individual to acknowledge his or her own spiritual needs and follow his or her inner guide which facilitates healing. This healing generates integration (ability to feel and express emotion), growth, transformation, and finding meaning. Nurses who provided spiritual care were committed and prepared; these nurses were willing to work on their own personal growth and development and considered the ability to remain centered important. The nurses reported spiritual care is a soul-to-soul connection which goes beyond the role of the nurse and patient. This does not happen with all patients; the patient must be ready and willing. Nurses can assist the patient to be ready by the nurse's presence, reassurance, and caring intent.

Emblen and Halstead (1993) explored what nurses identify as spiritual interventions in order to address patients' spiritual needs. The nurses who were interviewed (11 females, 1 male) were from surgical units with an average of 10.25 years of experience; ages were not reported. Six nurses were Catholic and six were Protestant. The spiritual interventions identified were categorized into the following groups: religious, relationships, communication, and other. Interventions included: praying, establishing trust, sensitivity to needs, listening, facilitating coping, and referral to chaplain/others.

Harrington (1995) interviewed 10 hospice and 10 acute care nurses to ascertain what spiritual care means and adequacy of nursing education to provide this care. There were 18 female and two male nurses who had an average of 16 years nursing experience. Ages ranged from 24 to 54 ( $M = 28$ ) for the participants who reported age ( $n = 14$ ). Religious affiliations included 10 Christians, two agnostics, and eight without a strong church affiliation. Participants expressed that spiritual care is an important element of nursing care but can be difficult to define. It involves listening, exploring issues, and can include praying or referral to others. Spiritual care is affected by the practice setting and dependent on the nurse-patient relationship. Factors influencing spiritual care can also include the patient's value system and culture. Basic nursing education was found to be inadequate, and some nurses viewed their life experiences had influenced their ability to provide spiritual care.

Tuck et al. (2001) asked nurses to describe spiritual care practices in response to open-ended questions in a mailed survey to a national sample of parish nurses. The

nurses in this sample were primarily White females with Christian religious affiliations with a mean age of 50.8. Responses to the survey were placed into four different categories: religious, interactional, relational, and professional. The primary intervention consistently reported was prayer. In addition to praying, religious interventions also could include offering communion, discussing spirituality, and laying on of hands. Interactional interventions involved human-to-human interactions such as listening, comforting, accepting, and touching. Although closely related to interactional interventions, relational interventions pertain to activities that were intended to cultivate the nurse-client relationship (listening, discussing, encouraging, and visiting). Professional interventions related to counseling-focused nursing care or holistic interventions (meditation, guided imagery, and therapeutic touch).

Carroll (2001) utilized a phenomenological heuristic approach to explore spiritual care practices in hospice nurses. A convenience sample of 13 hospice nurses and two nursing assistants (14 females, 1 male) were interviewed. The majority of nurses ( $n = 9$ ) had between 5-10 years of experience. Twelve participants believed in God or a Universal force, and eight had attended a place of worship. Nurses found spiritual care involved presence, attendance to the patient's physical needs, and enabling the patient and family to find purpose in life, suffering, and death. A trusting nurse-patient relationship was necessary before a patient would share spiritual concerns. Spiritual care was easier to provide when the nurse and patient shared similar beliefs. Documenting spiritual needs was a challenge and many nurses wrote a



précis in the nursing notes. Spiritual care was viewed as a multifaceted phenomenon requiring an interdisciplinary approach.

Belcher and Griffiths (2005) conducted a descriptive study using qualitative techniques to determine how hospice nurses integrate spiritual care into nursing care. A survey consisting of demographic information and fifteen open ended questions was sent to 880 members of the Hospice and Palliative Nurses Association. To ensure the sample was representative, one state from each of nine geographic areas of the United States was selected. The response rate was 23% ( $N = 204$ ). Ninety-five percent ( $n = 194$ ) of the sample were Caucasian with females comprising 93% ( $n = 189$ ). Ages ranged from 29 to 70 ( $M = 50$ ). Religious affiliations were not reported, but 71% reported regularly participating in religious practices. Nurses provided spiritual care by: listening, expressing hope, showing respect to patients and families, using humor, and story-telling. Extending spiritual care to peers and coworkers was also a part of the professional role. Most nurses were comfortable providing spiritual care except when a patient did not have a religious preference or if the patient felt he or she was not forgiven by God. Participants developed their knowledge of spiritual care from work experience, support of pastoral care staff, and an awareness of their own spirituality. Assessment of spiritual needs was described as a professional responsibility, but not performed in a consistent manner due to lack of an assessment tool, expectation that other team members (i.e. chaplain) will perform, feelings of incompetence, and time constraints.

Touhy et al. (2005) used phenomenology to describe the experience of providing spiritual care to nursing home residents who were dying. Physicians, nurses, and certified nursing assistants ( $N = 25$ ) from four nursing homes in southern Florida were interviewed. The majority of participants were female ( $n = 21$ ) and ranging in age from 29 to 61 ( $M = 50.64$ ). Racial background was reported: White ( $n = 14$ ), Hispanic ( $n = 2$ ), Haitian ( $n = 3$ ), Black ( $n = 5$ ), and Indian ( $n = 1$ ). Five themes emerged from the data: *honoring the individual's dignity, intimate knowing, wishing we could do more, personal knowing of self as caregiver, and struggle with end of life treatment decisions*. In the theme, *wishing we could do more*, time and staffing constraints affected spiritual care provision. The theme of *personal knowing of self as caregiver*, represented coming to terms with personal spirituality and was an acknowledged part of spiritual care. Spiritual care was perceived as a holistic response which included providing physical and psychosocial care, and spiritual comfort measures. Spiritual comfort was described in terms of religious activities, discussing fears, validating importance of the individual's life, and reassurance they would be remembered after they died.

Burkhart and Hogan (2008) used grounded theory to generate a beginning theoretical framework for spiritual care in nursing practice. Staff nurses ( $n = 25$ ) from various pediatric and adult settings participated in focus groups. An additional focus group was conducted with nine nurse managers after data suggested administrators' perceptions may be relevant to the emerging theory. Participants were mostly Caucasian (88%) and Christian (88%) with an average of 18 years in nursing. Gender

was not reported, but the average age was 42.8 years. The theory that emerged contained seven categories: cue from patient, decision to engage/not to engage, spiritual care interventions, immediate emotional response, searching for meaning, formation of spiritual memory, and nurse spiritual well-being. Participants established that in order for spiritual care to occur, the nurse must be invited by the patient to provide spiritual care; the nurse then chooses to either engage or not engage in spiritual care. When a spiritual connection occurs, the nurse provides an opportunity to explore meaning at this time of crisis by three types of intervention: promoting patient self-reflection, promoting connectedness between patient and family, and promoting a connectedness with a Higher Power/God. The nurse has an immediate emotional response that can be either positive or negative. Nurses then search for meaning in the encounter by reflecting with self or supportive people or faith rituals. Spiritual memories will then be formed from negative or positive emotional responses and can result in spiritually distress-filled memories or spiritually growth filled memories. Finally, the process of providing spiritual care and discovering meaning can assist the nurse in his or her own spiritual well-being.

Daaleman et al. (2008) used semi-structured interviews to explore perspectives on spiritual care from healthcare providers and workers from a university health care system in the southeast United States. Twelve healthcare providers and one ancillary staff member had been identified by dying patients and family members as spiritual caregivers. There were six females and the average age of the spiritual caregivers was 44 years (range 27 to 60). The majority were White (*n*

= 9). There was a heterogeneous mix of faith traditions. The 12 participants were asked to describe two patient encounters with spiritual care as a core element, one in which they were confident in delivering spiritual care and another encounter in which the caregiver had difficulty. Three major themes were identified: *being present*, *opening eyes*, and *cocreating*. *Being present* was defined as encounters “marked by intentionality or the deliberate ideation and purposeful action of care that went beyond medical treatment, giving attention to emotional, social, and spiritual needs” (Daaleman et al., 2008, p. 408). *Opening eyes* was a process in which the caregivers discovered the patient’s perspective of their illness, the uniqueness of their life story allowing potential inner resources to be identified. This was a bidirectional process, as both the patient and caregiver acknowledged the unique human dimension of each other. *Cocreating* was a mutual activity which generated a holistic plan of care with the goal of maintaining the patient’s humanity and dignity at the end of life. Barriers to spiritual care were identified: lack of time, discordance (social, religious, cultural) between caregiver and patient, and institutional obstacles (lack of privacy and continuity of care). Facilitators of spiritual care included having ample time to foster relationships, effective communication, and the caregivers’ family experience with serious illness or death.

Bailey et al. (2009) conducted a qualitative study to describe Irish palliative care nurses’ experiences in providing spiritual care on a hospice unit. Using a purposive sample of 22 nurses, semi-structured interviews were conducted over an eight week period. No demographics were provided except the researchers noted

participants appeared to be predominately Roman Catholic and had at least 1 year of hospice experience. One overarching theme and five subthemes emerged from the data. The five subthemes (understanding spirituality, the art of nursing, education and learning, challenge of spiritual caring, dimensions of time) “created a rich and complex spiritual tapestry interweaving themes common to the participants involved in the study” (Bailey et al., 2009, p. 43). Spirituality was defined in various ways and the value of presence and listening in providing spiritual care was noted. Difficulty with documentation, assessing spiritual needs, and measuring outcomes was also noted. Nurses described therapeutic use of self in providing spiritual care, and spiritual self-awareness enhanced their delivery of spiritual care.

*Synthesis of spiritual care practices: Qualitative research.* Researchers explored spiritual care practice with nurses from a variety of settings. Spiritual care practice encompasses: presence (Bailey et al., 2009; Carroll, 2001; Daaleman et al., 2008; Dennis, 1991), building relationships (Dennis, 1991; Emblen & Halstead, 1993; Tuck et al., 2001), listening (Bailey et al., 2009; Belcher & Griffiths, 2005; Emblen & Halstead, 1993; Harrington, 1995; Tuck et al., 2001), and assisting individuals to find meaning and purpose (Carroll, 2001; Dennis, 1991; Burkhart & Hogan, 2008). Spiritual care practice also includes interventions that assist an individual with his or her religious practices, by referring to chaplains or clergy, and praying (Burkhart & Hogan, 2008; Dennis, 1991; Emblen & Halstead, 1993; Touhy et al., 2005, Tuck et al., 2001). A trusting nurse-patient relationship is an essential element of spiritual care practice (Carroll, 2001; Harrington, 1995). Findings indicate that nurses believe

spiritual care requires an interdisciplinary approach (Carroll, 2001) but is an important component of nursing care (Dennis, 1991; Harrington, 1995) which can be difficult to define (Harrington, 1995). Nurses found it difficult to assess spiritual needs (Bailey et al., 2009; Belcher & Griffiths, 2005) and document spiritual care practice (Bailey et al., 2009; Carroll, 2001). Barriers to spiritual care practice were also identified: time (Daaleman et al., 2008; Touhy et al., 2005), discordance between nurse and patient (Daaleman et al., 2008), and institutional barriers (Daaleman et al., 2008; Touhy et al., 2005). Although barriers were found, spiritual care practice was enhanced through spiritual self-awareness (Bailey et al., 2009; Touhy et al., 2005).

Each study provided a description of methods for data collection and analysis, and excerpts from data provided evidence of credibility and trustworthiness for the findings. Only two studies (Burkhart & Hogan, 2008; Daaleman et al., 2008) reported saturation was achieved, but Dennis (1991) acknowledged that since only one interview was conducted with each nurse, all facets of the complex phenomenon may not have been captured. In designs that used mailed surveys to collect data (Belcher & Griffiths, 2005; Tuck et al., 2001), researchers were not able to verify and clarify responses. Findings of these qualitative studies represent perspectives of nurses from samples that consisted primarily of White females with Judeo-Christian backgrounds, mean age of 40 to 50 years, and a mean of 10 years of experience.

**Spiritual care practices: Quantitative research.** Spiritual care practice was quantitatively evaluated in six studies using mailed and on-line surveys. Nurses from various settings reported on types and frequencies of spiritual care practices primarily

using instruments developed or modified for the purpose of the individual study. All quantitative research presented was conducted in the United States.

Taylor, Amenta and Highfield (1995) used a descriptive cross-sectional survey to ascertain spiritual care practices of oncology nurses. Seven hundred questionnaires were mailed to members of the Oncology Nursing Society (ONS) with a response rate of 26% ( $N = 181$ ). Ninety-five percent of the sample was female with ages ranging from 23-60 ( $M = 39.96$ ). The sample was predominately Caucasian 88% ( $n = 159$ ) with the majority being of Christian background. The questionnaire contained demographic data along with the Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS). Nurses rated their perceptions of how frequently they provided traditional spiritual care interventions. Sixty-six percent of the nurses reported praying privately for the patient often to very often/always. Thirty-seven percent of nurses encouraged a patient to pray often or very/often always. Referring to a religious leader or clergy was reported often to very often/always by 56% of nurses and 45% referred to hospital chaplain often to very often/always. Nurses sometimes or rarely/never (89.5%) included a plan to address spiritual needs in the care plan. In response to open-ended questions, the following themes of non-religious interventions emerged: conveying a benevolent attitude, touching the patient, serving as a therapeutic presence, attending to a patient's family, involving others in patient's care, listening, and helping to find meaning in circumstances. Using a Likert-type scale ( $1 = Never$  to  $5 = Every day$ ) respondents were asked how frequently they provide spiritual care each day at work. The researchers reported that

the mean of 2.88 ( $SD = 1.05$ ) suggested that many nurses did not provide spiritual care on a daily basis.

Taylor, Highfield, and Amenta (1999) used data from the 1995 study of oncology nurses (Taylor, Amenta, Highfield) and compared it with data from a survey of hospice nurses in 1994 to ascertain if there is a difference in perceived frequency, ability, and comfort regarding spiritual care between nurses in different specialties. The hospice nurse sample was obtained from members of the Hospice Nurse Association (HNA). All 1160 members were contacted with 638 returning completed surveys (55%). The sample from HNA was predominately White ( $n = 617$ ), with an average of 19 years in nursing, and mean age of 46. Although both groups were comprised primarily of White, married, female, Christian nurses, statistical differences existed between the ONS and HNA samples. The hospice nurses were older ( $t(255) = 9.01, p < .0001$ ), had more years of nursing experience ( $t(290.5) = 5.94, p < .0001$ ) and had higher levels of self-reported spirituality ( $t(225) = 2.68, p = .008$ ). The ONS participants were more ethnically diverse ( $\chi^2(1) = 9.23, p = .0024$ ), had more highly educated nurses ( $t(183) = -2.18, p = .03$ ), and higher levels of self-reported religiosity than the HNA participants. In comparing frequency for 12 spiritual care interventions, hospice nurses offered more of the interventions except for encouraging prayer and referring to a chaplain. Hospice nurses had greater perceived ability ( $t = 5.41, p < .0001$ ) and comfort ( $t = 4.70, p < .0001$ ) in providing spiritual care. Positive correlations were found between self-reported spirituality (measured on a scale of *Not at all* to *Very*) and perceived ability to provide spiritual



care ( $r = .47, p < .001$ ). Comfort with spiritual care giving was positively correlated with ability ( $r = .63, p < .001$ ). Lastly, frequency and ability to offer spiritual care were correlated ( $r = .58, p < .001$ ). Using multiple regression, self-reported spirituality explained 22 % of the variance ( $R^2 = .22, \beta = - 1.30, p = .05$ ) in the perceived ability of the nurse to provide spiritual care.

Sellers and Haag (1998) conducted a descriptive study to explore nursing interventions used to enhance the spirituality of clients and their families. A questionnaire containing a demographic section and a section for identification of interventions and frequency of use were mailed to 750 oncology, hospice and parish registered nurses in the Midwest. Content validity was established by a panel of nine nursing experts. The response rate was 29.86% with 208 completed questionnaires. The sample was homogenous with 99.5% Caucasian and 98% female with a mean age of 47 years. Nursing experience ranged from 1 to 52 years ( $M = 23.44$ ), and the majority (57%) were parish nurses. The most frequently implemented interventions included: actively listening, conducting a spiritual history and assessment, conveying acceptance, therapeutic communication, touch, presence, and prayer. Fifteen percent of respondents noted that nurses need to clarify and have a strong sense of personal spirituality in order to effectively provide spiritual care. Additional comments were provided: nursing education regarding spiritual care is lacking and nurses felt inadequate providing spiritual care. Barriers were identified: time, institutional factors, and lack of support from staff and administration.

Grant (2004) mailed a survey to all bedside registered nurses in a southwestern university hospital to provide descriptive data on efficacy and types of spiritual therapeutics used. Out of 597 nurses, 299 returned the surveys for a 50% response rate. The survey was developed by the researcher from a review of the literature to ensure content validity and contained a list of 24 spiritual practices. Percentages of nurses who have offered, suggested, or provided the following type of care were listed: holding a patient's hand (92%), listening (92%), laughter (92%), prayer (71%), and being present (62%). Nurses would offer, suggest, or provide spiritual care when the following were present: request for spiritual support (98%), about to die (96%), grieving (93%), and receiving bad news (93%).

Hubbell et al. (2006) surveyed nurse practitioners in federally designated nonmetropolitan areas (FDNMA) of North Carolina to see how they integrate spirituality into their practice. The survey contained a demographic sheet and the Nurse Practitioner Spiritual Care Perspective Survey (NPSCPS). The NPSCPS questionnaire was a modified version of the Oncology Nurse Spiritual Care Perspectives Survey (Taylor, Amenta, & Highfield, 1994) and measured frequencies of spiritual care activities. A sample size of 101 was obtained using systematic sampling of 507 eligible nurses. Sixty-five surveys out of the 101 mailed surveys were returned (65%). The sample consisted mainly of females (91%) and 98% were Caucasian. The three most frequently provided spiritual care interventions were: referring to clergy/religious leader (54%), encouraging patients to pray (46%), and talking with patients about a spiritual/religious topic (39%). Seventy-three percent of

nurse practitioners *rarely* or *occasionally* provided spiritual care practices listed in the survey.

Mamier (2009) used an online survey sent to 2,311 RNs who were employed in four southwestern faith-based tertiary care settings to evaluate nurses' spiritual care practices using the Nurse Spiritual Care Therapeutics Questionnaire (NSCQ). The NSCQ assesses the frequency of providing specific spiritual care interventions during the past 72 or 80 hours of providing patient care. The sample was predominately female (86.3%) with the following racial breakdown: White (47.1%), Hispanic/Latino (13.5%), Asian/Pacific Islander (32.5%), Black/African American (4.7%), and American Indian/Alaskan Native (0.4%). Nurses' ages ranged from 21 to 67 ( $M = 39$ ,  $SD = 10.89$ ), and the majority of the sample reported a Christian religious affiliation. Fifty percent of the nurses had a bachelor's degree in nursing, and 39.4% had an associate degree in nursing with 49.5% reporting having received spiritual care education in their undergraduate nursing program. RN experience ranged from less than 1 year to 45 years ( $M = 11$ ,  $SD = 10.4$ ). The summed responses for the NSCQ can range from 17-85. In this study, the  $M = 36.98$  ( $SD 12.01$ ) indicated the scores were relatively low with nurses engaging in the spiritual care activities given on the NSCQ an average of 1-2 times in the past 72-80 hours at work. The most frequent practices performed were: after completing a task, remained present just to show caring (93.5%), listened actively to a patient's story (84.5%), assessed a patient's spiritual or religious beliefs and/or practices that are pertinent to health (86%), and listened to a patient talk about spiritual concerns (85.5%). Fifty-three percent of

nurses never documented spiritual care. Answers to an open ended question revealed that if there was a difference between the nurse and patient's spiritual orientation, some nurses disengaged themselves from the spiritual concerns of patients and families.

*Synthesis of spiritual care practices: Quantitative research.* The six studies presented in this section quantitatively evaluated spiritual care practice by assessing types and frequencies of spiritual care interventions. Only the most recent study (Mamier, 2009) used online data collection; the remaining studies utilized mail surveys to collect data. As in qualitative studies, prayer, referral to chaplain/clergy, and listening were identified as spiritual care (Grant, 2004; Hubbell et al., 2006; Mamier, 2009; Sellers & Haag, 1998; Taylor et al., 1995; Taylor et al., 1999). In addition, presence or being present (Mamier, 2009; Sellers & Haag, 1998) and finding meaning (Taylor et al., 1995) were also identified as ways to provide spiritual care. Frequency of spiritual care provision was measured with different parameters, but results indicate nurses do not provide spiritual care on a consistent basis (Hubbell et al., 2006; Mamier, 2009; Taylor et al., 1995). Sellers and Haag (1998) found that a nurse's spiritual perspective was a factor in spiritual care provision.

The demographics of the samples in these studies were similar to samples in the qualitative studies. The samples were predominately White females with a mean age range in the 40s and mean years of nursing experience ranging from 11 to 23 years. Of the studies that reported religious backgrounds (Mamier, 2009; Taylor et al., 1995, Taylor et al., 1999), the majority had Christian backgrounds. Researchers

developed their own instruments or modified an existing instrument (Hubbell et al., 2006) indicating tools were valid and reliable based on content validity and adequate alpha reliability coefficients. Only the tool used by Mamier (2009), the NSCQ, had undergone further evaluation with an adequate content validity index. Difficulty exists in comparing results among studies because different parameters were used to measure frequency of spiritual care provision. As with all self-report instruments, perception may not reflect actual practice.

**Synthesis of spiritual care practices.** In the empirical literature, spiritual care practice has been explored using quantitative and qualitative measures. Available instruments have primarily been developed by researchers for the purpose of their own study, or modified without establishing adequate validity. The exception is the Nurse Spiritual Care Therapeutics Questionnaire (NSCQ). The NSCQ had evidence to support validity with an acceptable content validity index prior to use in Mamier's study (2009). Mamier performed a factor analysis to establish further validation for the NSCQ; psychometric data for the NSCQ, now titled the Nurse Spiritual Care Therapeutics Scale, was reported by Mamier and Taylor in 2014. Similar spiritual care practices have been identified in both the qualitative and quantitative studies and include prayer, referral, listening, presence, and acknowledge the importance of establishing a trusting nurse-patient relationship.

### **Conclusion**

The current research explored relationships between and among nurses' spiritual perspective, nurses' mindfulness, and spiritual care practices. Watson's

theory of human caring provides a natural framework for exploring these relationships. In explicating the second caritas process, *Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other*, Watson (2008) invites the nurses “to connect with that which sustains him or her when in need of faith and hope to draw upon” (p. 62). Watson (2008) refers to ongoing spiritual development as “the foundation for caring, compassion, and transpersonal human-to-human connections with another” (p. 68). The third caritas process, *Cultivation of One’s Own Spiritual Practices and Transpersonal Self*, is a life long journey. In order to practice within a caring-healing model, the nurse first needs to be fully present in the moment (mindful) in order to be more open and accessible to oneself and the situation (Sitzman & Watson, 2014; Watson, 2008). Nurses can provide spiritual care by using the caritas processes to guide actions or ways of being in order to promote the integration of spirituality into all aspects of the patient’s life.

The empirical literature presented in the review of the literature explored nurses’ spiritual perspective, mindfulness, and spiritual care practices both qualitatively and quantitatively. Nurses’ spiritual perspective has been evaluated with instruments that assess the religious, existential, and transcendent aspects of an individual’s spirituality. When these measures have been compared to instruments assessing spiritual care practice, studies found a positive correlation between spiritual perspectives and spiritual care practices (Mamier, 2009; Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001). Bailey et al. (2009) found spiritual self-awareness

enhanced delivery of spiritual care, and understanding one's own spirituality was a major component of one of the themes that emerged in the study by Touhy et al. (2005). As a result of attending mindfulness programs, participants had increases in mindfulness as measured by the Mindful Attention Awareness Scale (MAAS) and the Toronto Mindfulness Scale (TMS), and increases in spiritual perspectives as measured by the Index of Core Spiritual Experiences (INSPIRIT), Daily Spiritual Experiences Scale (DSES) and Functional Assessment of Chronic Illness Therapy-Spiritual Well-Being Scale (FACIT-SP). Results from one study (Carmody et al., 2008) demonstrated that increases in the MAAS and the TMS predicted increases in spiritual perspectives scores as measured by the FACIT-Sp. Findings from Beach et al. (2013) demonstrated that clinicians with high mindfulness scores engaged in more rapport building and addressed psychosocial issues more than clinicians with low mindfulness scores. Participants in intervention studies based on mindfulness practices reported developing skills such as: attentiveness, listening, being in the moment, self-awareness, self-acceptance, and recognizing need for self-care (Cohen-Katz et al., 2005b; Beckman et al., 2012). These skills have been identified as necessary for spiritual care practice (Puchalski et al., 2006).

Spiritual perspectives have been shown to impact spiritual care provision. Mindfulness training not only impacts spiritual perspectives but promotes the development of skills necessary for spiritual care practice. To date, empirical studies have not investigated these relationships.

## **Chapter III**

### **METHODS AND PROCEDURES**

#### **Introduction**

The purpose of this descriptive correlational study was to examine the relationships between and among spiritual perspective, mindfulness, and spiritual care practices of hospice and palliative care nurses. This chapter provides an overview of the research questions, design, population and sample, description of power analysis, sample size, and recruitment of participants. Instruments used are described and reliability and validity are addressed. Data collection procedures, data analysis, and ethical considerations are also addressed.

#### **Overarching Research Question**

What are the relationships between and among spiritual perspective, mindfulness, and spiritual care practices of hospice and palliative care nurses?

#### **Research Questions**

1. What is the relationship between hospice and palliative care nurses' spiritual perspective and mindfulness?
2. What is the relationship between hospice and palliative care nurses' spiritual perspective and spiritual care practices?
3. What is the relationship between hospice and palliative care nurses' mindfulness and spiritual care practices?



4. What is impact of hospice and palliative care nurses' spiritual perspective and mindfulness on spiritual care practices?

### **Design**

This study utilized a cross-sectional descriptive correlational design to evaluate the relationships between and among the variables. The purpose of descriptive correlational research is to describe relationships without suggesting a causal relationship (Polit & Beck, 2012). Researchers have examined the relationship between spiritual perspective and spiritual care as well as spiritual perspective and mindfulness training. To date, researchers have not evaluated the relationship among these three variables. This design was chosen to explore the relationships among the three variables and the impact of spiritual perspective and mindfulness on spiritual care practices of hospice and palliative care nurses.

### **Description of Population and Sample**

The population for this study included licensed registered nurses and advanced practice nurses who provide direct patient care in hospice and/or palliative care settings in the United States. A convenience sample was solicited from the Hospice and Palliative Nurses Association (HPNA) which currently has approximately 11,100 members (HPNA, 2013). An invitation to participate in the survey was included in two eNewsletters sent to all members of the HPNA. In addition, email invitations to participate were sent to members of the Research and Advanced Practice Nurse HPNA Special Interest Groups (SIG). Licensed registered nurses and advanced practice nurses with one or more years of experience providing

direct patient care in hospice and/or palliative care settings and who have provided at least 36 hours of direct patient care in the two weeks prior to taking the survey were eligible to participate. Exclusion criteria included licensed registered nurses or advanced practice nurses with less than one year experience working in hospice or palliative care settings, and those nurses who had not provided at least 36 hours of direct patient care in hospice and/or palliative care settings in the two weeks prior to taking the survey.

### **Sample Size and Statistical Power**

Power analysis was used to determine how large the sample needed to be in order to reduce the risk of a Type II error (Polit & Beck, 2012). In examining the relationships between spiritual perspective and spiritual care practices using various instruments, prior research has shown statistically significant correlations ( $r$ ) ranging from .19 to .595 (Mamier, 2009; Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001). In addition, prior research has shown participation in mindfulness based programs has increased spiritual perspectives, but no correlations between the two have been reported (Carmody et al., 2008; Geary & Rosenthal, 2011; Shapiro et al., 1998). Polit (2010) advises use of a small to medium effect size for power analysis in absence of pilot data or prior research. Since prior research has shown correlations between spiritual perspectives and spiritual care practices and a possible relationship between mindfulness and spiritual perspectives, a medium effective size (.30) was used to calculate sample size. Using G\*Power 3.1.7 (Faul, Erdfelder, Buchner, &

Lang, 2009) to calculate an a priori analysis for two-tailed, medium effect size of .30,  $p = .05$ , and power of .80, the sample size required was 80.

### **Setting**

This study was an online survey solicited from a national sample using SurveyMonkey®. Participants had access to the survey from any computer, and therefore the setting and the conditions under which participants chose to access and take the survey were based on individualized factors.

### **Recruitment of Research Participants**

Study participants were recruited through the Hospice and Palliative Nurses Association. A letter of support (Appendix A) was received from the HPNA Director of Research. Once approval for the study was obtained from Seton Hall University's Institutional Review Board (Appendix B), the proposal was submitted to the HPNA Board of Directors and the invitation for participation was approved for dissemination in the eNewsletter and via email to the Special Interest Groups (SIGs). Email invitations (Appendix C) were sent to members of the HPNA SIGs to offer an opportunity to participate in the survey; the Research SIG has approximately 372 members, and the Advanced Practice Nurse SIG has approximately 486 members. A link to the survey was also included in two bimonthly eNewsletters sent to all members of the HPNA (Appendices D, E). HPNA members include not only nurses but members of the interdisciplinary team; therefore, the invitation to participate was only extended to licensed registered nurses and advanced practice nurses who provide direct patient care in hospice and palliative care settings.

If participants chose to access the link provided in the eNewsletter or in the email invitation, a Letter of Solicitation (Appendix F) appeared first. This letter included an invitation for licensed registered nurses and advanced practice nurses who provide direct patient care in hospice and palliative care settings to participate in the survey. The letter also contained information for the potential participant to consider in order to make an informed decision regarding participation. If the respondent decided to enter the survey, two screening questions appeared requiring a yes or no response: 1. Are you a licensed registered nurse or advanced practice nurse with one or more years of experience providing direct patient care in hospice or palliative care settings? 2. In the past two weeks of working, have you provided at least 36 hours of direct patient care in hospice or palliative care settings? If respondents answered no to one or both questions, they were directed to a Disqualification Page via disqualification logic through a set function in SurveyMonkey®. This page thanked them for their interest in the study but informed them that they did not meet inclusion criteria for the study.

### **Instruments**

For this study, three instruments were used to examine the relationships between and among the variables: Spiritual Perspective Scale (SPS), Mindful Attention Awareness Scale (MAAS), and Nurse Spiritual Care Therapeutics Scale (NSCTS). Permission for use of each instrument is contained in Appendices G, H, and I.

**Spiritual Perspective Survey (SPS).** The SPS was “based on a conceptualization of spirituality as a human experience that is relevant in everyday life, during health-related events, and times of increased awareness of mortality” (Reed, 1986a, p. 1). The SPS measures the individual’s perceptions of the extent to which he or she holds certain spiritual views and engages in spiritually-related interactions (Reed, 1987). The SPS contains 10 items and responses are selected from a 6-point Likert-type scale. Six questions pertain to views of spirituality, for example, “My spirituality is especially important to me because it answers many questions about the meaning of life” (Reed, 1987, p. 338). Responses can range from *Strongly disagree* to *Strongly agree*. Four questions address frequency of spiritual interactions such as, “In talking with your family or friends, how often do you mention spiritual matters?” (Reed, 1987, p. 337). Responses to these questions can range from *Not at all* to *About once a day*. The score for the SPS is obtained by calculating the arithmetic mean across all items. Scores can range from 1 to 6 with higher scores indicating a more salient spiritual perspective in the individual’s life (Reed, 1987).

Reliability has been established for the SPS. In the initial study, the SPS was administered to 3 adult groups: hospitalized terminally ill ( $n = 100$ ), non-terminally ill hospitalized ( $n = 100$ ), and healthy non-hospitalized ( $n = 100$ ). Groups were matched for age, gender, years of education, religious background, and each contained 55 females and 45 males. The sample was predominately White (81%), mean age range 60-61 years, mean years of education ranged from 12.55 to 13.09 years, and 92% reported a religious background. Cronbach’s alpha coefficient was reported for each

group and ranged from .93 to .95 (Reed, 1987). Since 1987, the SPS has demonstrated good reliability in various adult populations such as: homeless men  $\alpha = .89$  (Brush & McGee, 2000), pregnant African American women  $\alpha = .91$  (Dailey & Stewart, 2007), African American breast cancer survivors  $\alpha = .86$  (Leak, Hu, & King, 2008), sheltered battered women  $\alpha = .87$  (Humphreys, 2000), and pregnant Appalachian women  $\alpha = .91$  (Jesse & Reed, 2004). The SPS has also been used with nurses from a range of specialties with Cronbach's alpha ranging from .85 to .94 (Gray et al., 2004; Ronaldson et al., 2012; Tuck et al., 2001).

Initial evidence for construct validity for the SPS was provided by Reed (1987). Reed reported that evidence for construct validity was found as women and those reporting a religious background scored higher on the SPS as in previous research (Reed, 1986). Reed (1987) also reported that qualitative data collected from open ended questions supported validity. Inter-item correlations were above .40, with average inter-correlations ranging from .57 to .68.

Dailey and Stewart (2007) provided further evidence to support validity of the SPS. The researchers evaluated the psychometric properties of the SPS in pregnant African American females. The SPS was administered to a convenience sample ( $N = 102$ ) of pregnant females from two prenatal clinics in Northern California. Ages ranged from 18 to 39 ( $M = 25$ ,  $SD = 5.4$ ). Thirty-two percent of the women had graduated from high school, 37% had completed some college, and the majority reported a monthly income less than 3,000 dollars. Seventy-eight percent reported a religious affiliation, 60.8% perceived themselves *Very/fairly religious*, and

64.7 % perceived themselves as *Very/fairly spiritual*. The SPS was correlated with hypothesized relationships: self-reported spirituality ( $r = .71, p < .01$ ), self-reported religiosity ( $r = .61, p < .01$ ), and church attendance ( $r = .21, p < .05$ ). The corrected item-total correlations ranged from .54 to .85. Preliminary analyses were conducted to evaluate factorability of the scale. The Kaiser-Meyer-Olkin (KMO) test was .85 and Bartlett's test of sphericity was significant ( $p < .0001$ ). KMO values of .80 or greater and significance of Bartlett's test supports decision to perform factor analysis (Polit, 2010). Principal axis extraction was used in the factor analysis. Two factors were extracted. Factor 1 accounted for 58% of the variance and Factor 2 accounted for 14%. After Varimax rotation, Factor 1 and Factor 2 accounted for 36% and 30% of the variance. Factor 1 contained items pertaining to spiritual views with rotated loading values ranging from .68 to .90. Factor 2 contained items relating to spiritual interactions with rotated loading values ranging from .62 to .83. One item regarding forgiveness loaded on Factor 1 (.42) and Factor 2 (.50).

**Mindful Attention Awareness Scale (MAAS), trait version.** The MAAS (Appendix J) is a 15 item scale that measures the presence or absence of attention and awareness of what is occurring in the present moment (Brown & Ryan, 2003). Using a 6-point Likert-type scale (1 = *Almost always* to 6 = *Almost never*), respondents are asked how frequently they have the experience being described. Items were written to describe experiences inconsistent with mindfulness, for example, "I do jobs or tasks automatically, without being aware of what I'm doing." As Baer explained, "it is not useful to ask people explicitly to rate how mindful they are, because they are likely to

have idiosyncratic understandings (or no understanding) of what this term means” (Baer, 2011, p. 248). The score for the MAAS is obtained by calculating the arithmetic mean across all items. Scores can range from 1 to 6. Higher scores reflect higher levels of dispositional mindfulness.

Items were developed from the researchers’ personal experiences, knowledge of mindfulness and mindlessness, review of the literature, and scales which assessed various conscious states (Brown & Ryan, 2003). Items were constructed to capture the subjective experience of present attention and awareness. Items pertaining to attitudinal components (e.g., acceptance), motivational intent (e.g., why), and potential consequences (e.g., calmness) were excluded.

In the initial stage of development, nine experienced mindfulness practitioners rated the items based on exclusion criteria and a working definition of mindfulness (Brown & Ryan, 2003). Items were rated for adequacy on a 5-point Likert-type scale (*Very good, Good, Fair, Poor, Very Poor*). A content validity coefficient (*V* statistic) was used as the criterion for item retention (Aiken, 1985). Items that were rated highly and consistently across raters ( $p < .05$ ) were retained. The retained items were evaluated again using the *V* statistic with eight faculty and graduate students. Another team of six faculty and graduate students rated items and their feedback was used to further eliminate items. Fifty-five items remained and were used in pilot studies with undergraduate students. Items with skewed or kurtotic distributions, and those showing less than the full range of responses were eliminated.



To explore the factor structure of the remaining 24 items, 313 undergraduate students completed the MAAS (Brown & Ryan, 2003). Given the item pool was small and normally distributed, the maximum-likelihood method of parameter estimation was used. Kaiser measure of sampling adequacy was .89 indicating data were amenable to factor analysis (Polit, 2010). There was a significant gap between the first and second factor. The eigenvalue for Factor 1 was 7.85 and explained 95 % of the variance. Factor 2 eigenvalue was .66. Average factor loading was .52. Exploratory factor analysis was also used (principal-factors method) and resulted in a strong single factor solution. Only items that loaded on the first factor were retained resulting in a 15 item scale. In this 15 item scale, all but two items loaded above .30. All 15 items were retained because the researchers felt the items added substantive breadth to the scale. Confirmatory factor analysis was performed of the single factor model with data from 327 university students and 239 community adults. Results showed all 15 items were significantly related to the latent factor (all  $p_s < .001$ ).

Additional evidence of construct validity was reported (Brown & Ryan, 2003). There were positive correlations between the MAAS and the Mindfulness/Mindlessness Scale (Bodner & Langer, 2001) in two groups of university students ( $N = 187$ ,  $N = 145$ ) ( $r = .31$ ,  $p < .001$ ;  $r = .33$ ,  $p < .001$ , respectively). The MAAS was negatively correlated to the Rumination subscale of the Rumination-Reflection Questionnaire (Trapnell & Campbell, 1999) in three groups of undergraduate students tested ( $N = 327$ ,  $N = 187$ ,  $N = 145$ ):  $r = -.39$ ,  $r = -.29$ , and  $r = -.38$  (all  $p_s < .001$ ). The researchers theorized that mindfulness would facilitate several aspects of well-being

such as psychological health. The MAAS was negatively correlated with depression as measured by the Center for Epidemiological Studies-Depression (CES-D) (Radloff, 1977) scale in 327 university students:  $r = -.37, p < .0001$ . The MAAS was also negatively correlated with neuroticism measured by the NEO-Personality Inventory Neuroticism subscale (Costa & McCrae, 1992) in 313 undergraduates ( $r = -.56, p < .001$ ) and the NEO-Five Factor Inventory Neuroticism (Costa & McCrae, 1992) in two groups ( $n = 187, n = 145$ ) of university students ( $r = -.33, r = -.56, p_s < .001$ ). Known groups validity was assessed and found that Zen students ( $n = 50$ ), who cultivate mindfulness through meditative practices, had higher scores than a comparison group ( $n = 50$ ) of community adults:  $t(98) = 2.45, p < .05$  (Cohen's  $d = .50$ ) (Brown & Ryan, 2003).

Reliability for the MAAS was established (Brown & Ryan, 2003). Stability was evaluated with test-retest score agreement. In a sample of 60 students, mean scores at Time 1 (3.78) and Time 2 (3.77) for the MAAS over a 4 week period were not significantly different ( $t(59) = .11, ns$ ). Cronbach's alpha coefficients were reported as .82, .87, .86, and .87 respectively, for four groups ( $N = 327, N = 239, N = 74, N = 92$ ) during validation.

**Nurse Spiritual Care Therapeutics Scale (NSCTS).** The NSCTS (Mamier & Taylor, 2014; Taylor, 2008) (Appendix K) measures how often a nurse uses specific therapeutics with the intent of offering spiritual care. Therapeutics is defined as “ways of being or actions taken by a nurse with the intent to promote patient health

(or a good death) - in this case, spiritual health (best termed integration or the incorporation of spirituality into all aspects of life)” (Taylor, 2008, p. 155).

The NSCTS contains 17 items using a 5-point Likert-type scale. Participants are asked to rate how often in the past 72 or 80 hours (for those working 12 hour shifts or 8 hour shifts respectively) of providing patient care, did they provide a specific therapeutic such as “Encouraged a patient to talk about what gives his or her life meaning amidst illness” (Mamier & Taylor, 2014, p. 10). Respondents can choose the following options: *Never = 0 times, Rarely = about 1 to 2 times, Occasionally = about 3 to 6 times, Often = about 7 to 11 times, Very often = at least 12 times*. Scores are obtained by summing responses to items and can range from 17 to 85. Higher scores indicate more frequent use of spiritual care practices measured by the NSCTS (Mamier & Taylor, 2014). Instructions explicate that the term “patient” should be considered in a broad sense and may also include family members. In addition, some items used the term “illness”, but respondents are directed that this could include health challenge, loss, or any circumstances requiring nursing care. The therapeutics contained in the scale could be offered to any patient regardless of religiosity (Mamier & Taylor, 2014).

The NSCTS was piloted in a small groups of nurses ( $n = 53$ ) who volunteered to evaluate the instrument for clarity and feasibility (Mamier & Taylor, 2014). No demographics were provided for the sample. The Cronbach’s alpha coefficient for this sample was .89 for the entire scale, and the mean score was 50.56 ( $SD = 11.69$ ).

The NSCTS is newly developed and evidence was provided that support content validity (Taylor, 2008). Development of a new scale should include evidence that the scale and items are content valid (Polit, Beck, & Owens, 2007). The initial 29 items for the NSCTS were developed from an extensive review of the nursing literature. The items were then sent to nine doctorally prepared nurses who had published on the subject of spiritual care in order to determine the content validity for each item and the total scale. Each expert rated the items as: (1) *Not relevant*, (2) *Somewhat relevant*, (3) *Quite relevant*, and (4) *Highly relevant*. To calculate the item content validity index (I-CVI), the number of experts rating an item 3 or 4 were totaled and then divided by the number of experts. Experts also provided comments regarding appropriateness of some items. Only items with an I-CVI of .78 or greater were retained (Mamier & Taylor, 2014). In order for a scale to be considered to have excellent content validity, Polit, Beck and Owen (2007) recommend retaining items with I-CVI of .78 or greater. The scale CVI (S-CVI) was reported as .88 but did not indicate which method (universal agreement or averaging) was used to calculate the score (Mamier & Taylor, 2014). A criterion of .80 is often used by scale developers to establish the lower limit of acceptability for the S-CVI, but Polit, Beck and Owen (2007) recommend .90 or higher for an S-CVI using the averaging method.

Validation for the NSCTS was further examined in Mamier's (2009) study. The NSCTS (titled Nurses Spiritual Care Therapeutics Questionnaire [NSCQ] in 2009) was administered to a convenience sample of 554 RNs. Validity was supported by performing an exploratory factor analysis to examine construct validity. A one

dimensional solution was obtained using principal axis factor analysis for factor extraction. Factor loadings ranged between .407 and .836 and accounted for 49.5% of the variance. The item “After completing a task, remained present just to show caring”, received the lowest factor loading. However, if this item was omitted, the Cronbach’s alpha would have increased from .93 to .94, and the researchers elected to keep the item in the scale.

Correlations between items were examined (Mamier & Taylor, 2014). Inter-item correlations ranged from .15 to .81 with most ranging between .30 and .80. The range for corrected item-total correlations was .40 to .80.

In Mamier’s study (2009), the following psychometric information was reported. Reliability was established for the NSCTS with a Cronbach’s alpha coefficient of .93. In this sample, the mean total score was 37 ( $SD = 12$ ). Mean scores for each item were also reported (potential range 1 – 5). Item mean scores ranged from a low of 1.43 (Offered to read a spiritually nurturing passage) to a high of 3.37 (After completing a task, remained present just to show caring).

**Demographic Information.** The Demographic Questionnaire (Appendix L) included 19 questions. The questions gathered personal demographic information: age, gender, race/ethnicity, and region of US residing in. Information regarding professional employment and education was also sought. The following demographics may influence spiritual perspective: age, gender, and religious background (Reed, 1987), and therefore were included in the demographic

questionnaire. Information regarding race/ethnicity is important to evaluate because the majority of studies include participants that are predominately White.

### **Data Collection Procedures**

Data was collected electronically using Survey Monkey®. A link to the survey was included in two eNewsletters sent to all members of the HPNA and email invitations sent to members of two HPNA Special Interest Groups (SIG). Members chose to participate by accessing the link. Informed consent was implied if the survey was completed and submitted. Collected data were directly imported into IBM® SPSS® for Windows Version 22.

The link to the survey brought the respondent to the Letter of Solicitation. This letter invited licensed registered nurses and advanced practice nurses to participate in the study. If the respondent accepted the invitation and entered the survey, two screening questions appeared; a respondent would be ineligible to participate if he or she answered no to either question. An ineligible respondent was exited from the survey using the Disqualification Question Logic feature in SurveyMonkey®. The survey began with the instruments (SPS, MAAS, NSCTS) and finished with the demographic questions. Demographics were placed at the end of the survey, as is the general trend (Burns & Grove, 2009). Each page of the survey contained several items, and the participant was able to go back and forth between pages by selecting the “Previous” or “Next” navigation button at the bottom of the screen. Survey instructions included directions for the respondent indicating the “Exit Survey” navigation button to exit the survey may be selected at any time, but

responses would not be saved. If the survey was not submitted, the respondent could access the survey again to complete and submit it. When the survey was completed, the “Done” navigation button was selected to submit the survey, and the respondent was directed to a Thank You Page.

Researchers have the responsibility to ensure participants’ anonymity is protected and confidentiality is maintained (Burns & Grove, 2009). In this study, email addresses were not stored; however, IP addresses were collected to prevent duplicate submissions. Confidentiality of data collected was maintained; the data were stored on two memory sticks and secured in a lock box accessible only to the researcher.

### **Data Analysis**

Descriptive statistics, bivariate correlations and simple regression were used to analyze the data. Frequency distributions were constructed for all demographic items and for all study variables. These distributions were examined for outliers and decisions made to retain or discard outliers. Cronbach’s alpha reliability coefficients were calculated for each of the instruments. For statistical analysis, the level of significance was set at .05.

Parametric tests are based on assumptions that vary depending on type of analysis (Polit, 2010). An assumption common to almost all statistical analyses is the sample is randomly selected. However, this assumption is violated in the majority of nursing research and Polit (2010) recommends selecting from a group that can be

assumed to be representative of the population. If assumptions were violated, a nonparametric test was utilized.

Bivariate correlations were examined with the parametric statistic Pearson's correlation coefficient or the nonparametric statistic Spearman's rho correlation coefficient. Assumptions for Pearson's correlation coefficient and simple regression include: normality, homoscedasticity, and linearity (Salkind, 2007).

Normality was examined graphically and statistically for each variable. A distribution of scores would be considered normal if the histogram approximated a bell shaped curve and if data points were close to the diagonal line in the Q-Q plot. (Bannon, 2013). The Shapiro-Wilk test was performed for each variable. If this test is not statistically significant, the distribution of scores in the variable is not statistically different from a normal distribution (Bannon, 2013).

Homoscedasticity was also examined graphically and statistically. Scatterplots were examined for randomly and evenly dispersed data points around the center signifying homoscedasticity between variables (Bannon, 2013). Levene's test of Homogeneity was also performed; non-significant findings indicate homoscedasticity (Bannon, 2013).

Linearity between variables was assessed by examination of a simple scatterplot produced through a function in SPSS. Scatterplots were examined to assess if data points approximate a straight line (Witte & Witte, 2010).

**Descriptive statistics of variables.** Descriptive statistics are employed to describe categorical and continuous variables (Polit & Beck, 2012). Univariate



descriptive statistics describe one variable at a time, while bivariate descriptive statistics describe relationships between variables. Univariate descriptive statistics were used to describe the categorical and continuous demographic variables of the sample and the scores on the SPS, MAAS, and the NSCTS (continuous variables). Bivariate descriptive statistics and linear regression were performed to describe the relationships between variables.

*Univariate descriptive statistics.* The demographic variables for the study included both categorical and continuous variables. Frequencies and percentages were calculated for the following demographic categorical variables: employment status, gender, race/ethnicity, region of US residence, religious affiliation, entry level nursing degree, highest degree held, professional role, practice setting, practice population, shift, previous education in spiritual care, and where nurse received education about spiritual care. Range, mean, and standard deviation were calculated for the following continuous demographic variables: age, years of experience as an RN/APN, years of experience in hospice and/or palliative care.

The respondents' scale scores were treated as continuous variables. The three instruments utilized in the study employ a Likert-type scale and are scored by averaging the summed score (SPS & MAAS) or computing a total score (NSCTS), and thus can be considered interval data and treated as continuous variables (Nunnally & Bernstein, 1994). Means, standard deviations and range for scores on the SPS, MAAS, and the NSCTS were computed. In addition, frequencies and

percentages of how often (*Never to Very often*) each spiritual care practice listed in the NSCTS was performed were calculated.

***Bivariate correlations.*** Bivariate correlations were used to examine the relationships between variables (Polit and Beck, 2012). A product-moment correlation coefficient (Pearson's  $r$ ) was calculated in order to determine the direction and degree of the relationships between variables (Nunnally & Bernstein, 1994). Pearson's  $r$  was computed to describe the relationship between mindfulness and spiritual care practices. Spearman's rank-order correlation was used to examine relationships between spiritual perspective and mindfulness, as well as spiritual perspective and spiritual care practices.

***Linear Regression.*** A statistically significant correlation was found between mindfulness and spiritual care practices and was entered into a linear regression analysis to evaluate the impact of mindfulness on spiritual care practices. In the linear regression model, the R square ( $R^2$ ), explains the proportion of variance in spiritual care practice that is accounted for by mindfulness.

### **Ethical Considerations**

Before data collection began, permissions to conduct this study were obtained from the Institutional Review Board (IRB) at Seton Hall University and the HPNA Board of Directors.

Participants were recruited from eNewsletters and emails which contained an invitation to participate by accessing a link to the survey. The online survey included screening questions so that ineligible respondents would be exited from the survey.

Participants chose to access the survey or not. If the survey was accessed, a letter of solicitation was provided that explained the purpose of the study, right to refuse to participate or withdraw from survey at any time without consequences, potential risks and benefits, and researcher's responsibilities. Informed consent was implied if the survey was completed and submitted.

Confidentiality of participants was maintained. The ability to store email addresses was disabled through a set function in SurveyMonkey®. IP addresses were only collected for the purpose of preventing duplicate submissions. No attempt was made to identify or contact respondents from IP addresses. The participants were anonymous to the researcher. Responses to the survey can only be accessed by the researcher through a private passcode. Data were stored on two memory sticks and secured in a lock box only accessible to the researcher.

Risks for participating in the survey were minimal. Risks may have included fatigue and boredom from completing the survey. Potential benefit of participation is knowledge that survey results may inform nursing research, education, and practice to the benefit of hospice and palliative care patients and their families. Another potential benefit is an opportunity for introspection and self-reflection due to nature of survey questions. Respondents were advised in the letter of solicitation, that if participation in the survey caused any distress, they should speak with a counselor of their choosing.

### **Summary**

This chapter provided an overview of the study design. A descriptive

correlation design was utilized to explore the relationships between and among spiritual perspective, mindfulness, and spiritual care practices of hospice and palliative care nurses. An invitation to participate in the survey was disseminated to HPNA members via two eNewsletters and emails to members of two HPNA Special Interest Groups. The survey consisted of three instruments and a demographic questionnaire. Anonymity and confidentiality of participants were maintained. The survey was conducted through SurveyMonkey® and data were automatically uploaded into SPSS®. Data were analyzed using descriptive statistics, bivariate correlations, and linear regression.

## **Chapter IV**

### **FINDINGS**

#### **Introduction**

This study investigated the relationships between and among spiritual perspective, mindfulness, and spiritual care practices of hospice and palliative care nurses. Data were collected online via SurveyMonkey® from members of the Hospice and Palliative Nurses Association (HPNA) and analyzed using IBM Statistical Package for the Social Sciences (Version 22). This chapter describes the participant demographics and reports the study findings which answer the research questions.

#### **Description of the Sample**

One hundred thirty-eight respondents started the survey and of those 28 did not meet eligibility criteria and were exited from the survey via the disqualification logic feature in SurveyMonkey®. Six respondents only completed one to two instruments and were excluded. The sample consisted of the remaining 104 respondents. The sample size was adequate for addressing the research questions with .80 power, medium effect size (.30), and level of significance of .05 (Faul et al., 2009).

Demographic information collected from participants pertained to personal characteristics, nursing education, work experience and current work setting.

Information regarding the breakdown of sample demographics is presented in Tables 1 through 3.

Personal demographic information collected regarding participants included: gender, age, race/ethnicity, and region of US residence. The sample was primarily female (96.1%) ranging in age from 28 to 73 ( $M = 54.4$ ,  $SD = 8.36$ ) and predominately White/Caucasian (99%). Participants represented all four regions of the United States based on the divisions per the United States Census Bureau. Table 1 provides a breakdown of participant demographic characteristics.

Table 1

<i>Gender, Age, Race/Ethnicity, Region of Residence (N = 104)</i>		
Characteristic	<i>n</i>	%
<b>Gender</b>		
Female	99	96.1
Male	4	3.9
Missing	1	
<b>Age</b>		
≤ 40	7	6.8
41-50	22	21.4
51-60	48	46.6
61-70	24	23.3
> 70	2	1.9
Missing	1	
<b>Race/Ethnicity</b>		
White/Caucasian	102	99
Asian/Pacific Islander	1	1
Missing	1	
<b>Region of US</b>		
Northeast	21	20.6
South	33	32.4
Midwest	24	23.5
West	24	23.5
Missing	2	

Participants were asked if they have a religious affiliation and if so to specify the affiliation. Seventy participants (67.3%) answered yes to having a religious affiliation while 34 (32.7%) answered no. The majority of religious affiliations were of the Christian faith ( $n = 64$ ) from the following churches: Anglican, Baptist, Catholic, Episcopal, Lutheran, Methodist, Non-Denominational, Non-Denominational-Christian, Presbyterian, Protestant, and Unity. Other religions or spiritual traditions (Pew Research Center, 2013) were also reported: Buddhism ( $n = 3$ , 2.9%), Center for Spiritual Living ( $n = 1$ , 0.96%), Unitarian Universalist ( $n = 1$ , 0.96%), and Wiccan/neopagan ( $n = 1$ , 0.96%).

Participants were asked to indicate their entry level nursing degree and highest degree held. Nine participants' entry level nursing education was obtained from a diploma school (8.7%) while the majority (59.6%) received their entry level nursing education from a baccalaureate program ( $n = 62$ ). The remaining 32 participants (30.8%) received an Associate degree. The majority of the sample had pursued additional education beyond their entry level nursing degree. Table 2 gives the number and percentage for each type of highest degree held.

Table 2

*Highest Degrees Held by Participants (N = 104)*

Degree	<i>n</i>	%
Diploma	3	2.9
Associate	14	13.5
Baccalaureate in Nursing	23	22.1
Baccalaureate/Non-Nursing	2	1.9
Master's degree Nursing	48	46.2
Master's degree Non-Nursing	3	2.9
Doctoral degree Nursing	9	8.7
Doctoral degree Non-Nursing	2	1.9

*Note.* Percentage does not total 100 due to rounding.

The participants were questioned about spiritual care education. Sixty-four out of 104 participants (61.5%) stated they had received spiritual care education. Spiritual care education was acquired in one or more of the following ways: undergraduate nursing program ( $n = 5$ , 4.8%), graduate nursing program ( $n = 14$ , 13.5%), in-service ( $n = 37$ , 35.6%), conference ( $n = 46$ , 44.2%), End-of-Life-Education Consortium (ELNEC) ( $n = 36$ , 34.6%), and other ( $n = 16$ , 15.4%). The participants also indicated other sources of spiritual care education: self-study, religious education, parish nursing, clinical training, end of life training, non-nursing undergraduate program, and George Washington Institute for Spirituality in Health (GWISH) Summer Institute.



Participants were asked about years of experience as a Registered Nurse (RN) and Advanced Practice Nurse (APN), as well as years of experience in the hospice and/or palliative care setting. The RNs ( $n = 102$ ) had a range of 2 to 54 years of experience ( $M = 26.83$ ,  $SD = 11.69$ ) and APNs ( $n = 52$ ) had a range of 1 to 38 years of experience ( $M = 15.29$ ,  $SD = 10$ ). Ninety-six RNs reported on their years of experience in hospice and/or palliative care nursing and years ranged from 0 to 29 ( $M = 8.44$ ,  $SD = 7.48$ ). APNs ( $n = 54$ ) reported a range of 1 to 30 years of experience ( $M = 8.95$ ,  $SD = 6.83$ ) in a hospice or palliative care setting. Thirteen nurses indicated they did not have any RN experience in hospice or palliative care settings; these nurses were APNs who only had experience in hospice or palliative care settings in the advanced practice role.

Information was gathered regarding professional role, employment status, and work setting. The majority of participants (85.4%) worked full time during the day shift (97.1%) with adult patients (81.7%) in both inpatient and outpatient settings in a variety of roles. Eighteen participants worked in more than one setting. Table 3 provides a description of participants' responses.

Table 3

*Professional Role, Employment Status, Practice Settings (N = 104)*

Demographic	<i>n</i>	%
<b>Professional Role</b>		
Staff Nurse	35	34.0
Advanced Practice Nurse	52	50.5
Educator	4	3.9
Manager/Supervisor	8	7.8
Other	4	3.9
Missing	1	
<b>Employment status</b>		
Full-time	88	85.4
Part-time	13	12.6
Per diem	2	1.9
Missing	1	
<b>Shift</b>		
Day	101	97.1
Evenings	1	1.0
Nights	2	1.9
<b>Setting <sup>a</sup></b>		
Inpatient hospice	17	16.3
Home hospice	33	31.7
Palliative care inpatient	45	43.3
Palliative care outpatient	13	12.5
Hospice and palliative care	27	26.0
<b>Practice Population</b>		
All ages	17	16.3
Adults	85	81.7
Pediatrics	2	1.9

*Note.* Percentages based on  $N = 104$  and may not total to 100 due to rounding.

<sup>a</sup> Participants may work in one or more settings.

### **Statistical Analysis**

Researchers should address issues related to missing values and describe how missing data are handled (Polit, 2010). Missing values were defined as the proportion of missing valid responses among the items for each of the three instruments. Each instrument contained missing values. Of the 104 participants, 3 had at least one missing item on the SPS: 1 participant provided 80% (8/10) and 2 participants provided 90% (9/10) valid responses. For the MAAS, 98 (94.2%) participants provided responses for all 15 items and the remaining 6 provided 14 out of 15 responses. The NSCTS had the most missing values: one participant provided 14 out of 17 items (82%), two participants provided 15 out of 17 items (88%) and 12 participants provided 16 out of 17 (94%) valid responses. Eighty-nine participants (85.6%) provided valid responses for all 17 items.

Missing data can be addressed with deletion or imputation methods (Polit, 2010). Imputation methods include all cases in the analysis but may be a poor estimate of missing values (Bannon, 2013). Pairwise deletion was used to address missing values in data analysis. Pairwise deletion will exclude a participant (case) if data are missing for a specific analysis, but the case will be included in any of the other analyses for which all necessary data are present (Pallant, 2013). Sample size was still adequate to maintain a power of .80 even when certain cases were deleted.

Data were assessed prior to statistical analysis to ensure the following assumptions for parametric testing were not violated: normality, homoscedasticity,

and linearity (Salkind, 2007). If an assumption was violated, a nonparametric test was performed.

### Description of Major Study Variables

Three instruments were used to operationalize the study variables in order to answer the research questions: Spiritual Perspective Scale, Mindful Attention Awareness Scale, and Nurse Spiritual Care Therapeutics Scale. Each instrument has established reliability, and a Cronbach's alpha reliability coefficient was calculated to assess reliability in this study sample. Table 4 provides the means, standard deviations, actual and potential range of scores, and Cronbach's alpha for this sample.

Table 4

#### *Results for SPS, MAAS, NSCTS*

	<i>M (SD)</i>	Actual Range of Scores	Potential Range of Scores	Cronbach's Alpha
SPS	4.92 (.96)	2.10 – 6	1 - 6	.93
MAAS	4.33 (.74)	2.2 – 5.87	1 - 6	.91
NSCTS	55.36 (11.87)	27 - 77	17 - 85	.92

*Note.* SPS = Spiritual Perspective Scale; MAAS = Mindful Attention Awareness Scale; NSCTS = Nurse Spiritual Care Therapeutics Scale.

**Spiritual Perspective Scale (SPS).** The 10 item SPS is scored using a 6-point Likert-type scale to evaluate an individual's perceptions of the extent to which certain spiritual views are held and frequency of spiritually-related interactions. Scores can

range from 1 to 6 with higher scores representing a more salient spiritual perspective in the individual's life (Reed, 1987). The mean score was 4.93 ( $SD = .96$ ) indicating a more salient spiritual perspective in the lives of this sample of nurses.

The mean scores for the SPS were not normally distributed. Examination of the histogram revealed a negative skew with scores peaking to the right on the distribution; the median score was 5.2. Data points on the Q-Q Plot curved around the diagonal line. The non-normal distribution was also evidenced by the statistically significant Shapiro-Wilk test ( $p = .00$ ).

If scores are not normally distributed, methods are available to modify the scale scores to approximate a normal distribution: exclude outlier scores and transform data (Bannon, 2013). Four outlier scores were identified. Tests for normality were repeated with the outliers excluded, but the Shapiro-Wilk test remained significant ( $p = .00$ ). Data were transformed with reflect and logarithm transformation recommended for negatively skewed distributions (Tabachnick & Fidell, 2013), but this did not improve normality; the Shapiro-Wilk remained significant ( $p = .002$ ). Given excluding outliers and transforming data did not result in a normal distribution, the original variable data were used in the analysis.

**Mindful Attention Awareness Scale (MAAS).** The 15 item MAAS measures the presence or absence of attention and awareness of what is occurring in the present moment scored with a 6-point Likert-type scale (*Almost always* to *Almost never*). Scores can range from 1 to 6 with higher scores denoting higher levels of

dispositional mindfulness. In this sample, the mean score was 4.33 ( $SD = .74$ ) indicating a fairly high level of mindfulness for this group of nurses.

Mean scores for the MAAS were normally distributed. The histogram approximated a bell shape curve and the data points fell on or close to the diagonal line in the Q-Q Plot. The Shapiro-Wilk test was not significant ( $p = .290$ ).

**Nurse Spiritual Care Therapeutics Scale (NSCTS).** The 17 item NSCTS measures the frequency of a nurse's use of specific activities with the intent to provide spiritual care. Items are scored using a 5-point Likert-type scale from Never (0) times to Very Often (*at least 12 times*); items are summed to produce a total score which can range from 17 to 85. In this sample, the mean total score was 55.36 ( $SD = 11.87$ ).

Total scores for the NSCTS were normally distributed. The histogram approximated a bell shape curve and the data points fell on or close to the diagonal line in the Q-Q Plot. The Shapiro-Wilk test was not significant ( $p = .140$ ).

***Frequency and percentage of NSCTS items.*** Results for frequency and percentages of how often (*Never to Very Often*) nurses performed each of the spiritual care practices listed on the 17 items of the NSCTS are displayed in Table 5. Over 60% of nurses reported performing the majority of spiritual care practices listed on the NSCTS *Occasionally to Very Often*.

Table 5

*Frequency and Percentage for Items on the Nurse Spiritual Care Therapeutics Scale (N = 104)*

Item	Never	Rarely	Occ.	Often	Very Often
1. Asked a patient about how you could support his or her spiritual or religious practices	5 4.8%	18 17.3%	40 38.5%	28 26.9%	13 12.5%
2. Helped a patient to have quiet time or space for spiritual reflection or practices	10 9.6%	31 29.8%	46 44.2%	15 14.4%	2 1.9%
3. Listened actively for spiritual themes in a patient's story	0	6 5.8%	28 26.9%	37 35.6%	33 31.7%
4. Assessed a patient's spiritual or religious beliefs or practices that are pertinent to health	2 2%	7 6.9%	32 31.4%	35 34.3%	26 25.5%
5. Listened to a patient talk about spiritual concerns	1 1%	11 10.6%	39 37.5%	34 32.7%	19 18.3%
6. Encouraged a patient to talk about how illness affects relating to God/Ultimate Other or transcendent reality	6 5.8%	28 26.9%	31 29.8%	33 31.7%	6 5.8%
7. Encouraged a patient to talk about his or her spiritual coping	5 4.8%	18 17.3%	30 28.8%	37 35.6%	14 13.5%
8. Documented spiritual care you provided in a patient chart	5 5%	32 31.7%	26 25.7%	23 22.8%	15 14.9%
9. Discussed a patient's spiritual care needs with colleague/s (eg, shift report, rounds)	2 1.9%	8 7.8%	33 32%	44 42.7%	16 15.5%

Item	Never	Rarely	Occ.	Often	Very Often
10. Arranged for a chaplain to visit a patient	6 5.8%	7 6.8%	29 28.2%	35 34%	26 25.2%
11. Arranged for a patient's clergy or spiritual mentor to visit	22 21.4%	25 24.3%	36 35%	16 15.5%	4 3.9%
12. Encouraged a patient to talk about what gives his or her life meaning amidst illness	6 6.1%	14 14.1%	18 18.2%	34 34.3%	27 27.3%
13. Encouraged a patient to talk about the spiritual challenges of living with illness	9 8.8%	20 19.6%	28 27.5%	34 33.3%	11 10.8%
14. Offered to pray <i>with</i> a patient	41 40.2%	26 25.5%	16 15.7%	14 13.7%	5 4.9%
15. Offered to read a spiritually nurturing passage (eg patient's holy scripture)	51 49%	31 29.8%	16 15.4%	5 4.8%	1 1%
16. Told a patient about spiritual resources	9 8.8%	20 19.6%	29 28.4%	31 30.4%	13 12.7%
17. After completing a task, remained present just to show caring	0	4 3.8%	13 12.5%	49 47.1%	38 36.5%

*Note.* Percentages based on  $N = 104$  and may not total to 100 due to rounding. The following items have missing values: 4, 8, 9, 10, 11, 12, 13, 14, 16. Never = 0 times, Rarely = about 1-2 times, Occasionally (Occ.) = about 3-6 times, Often = about 7-11 times, and Very Often = at least 12 times.



**Bivariate correlations between study variables.** Relationships between two variables were assessed with correlation coefficients. The relationship between spiritual perspective (SPS) and spiritual care practices (NSCTS) was assessed with the nonparametric Spearman's rho coefficient because the SPS violated the normality assumption. Spiritual perspective (SPS) and mindfulness (MAAS) were also assessed with Spearman's rho coefficient; the SPS violated the normality assumption, and heteroscedasticity was present as evidenced by a significant Levene's Test for Homogeneity ( $p = .00$ ). Heteroscedasticity occurs "when there is unequal variance of residuals at each level of the predictor variable" (Bannon, 2013, p. 332). Pearson's  $r$  correlation coefficient was used to explore the relationship between mindfulness (MAAS) and spiritual care practices (NSCTS) because scores on the scales had a normal distribution, the scatterplot indicated a linear relationship, and the scatterplot and a non-significant Levene's Test for Homogeneity ( $p = .063$ ) indicated homoscedasticity.

The only statistically significant relationship was a positive correlation between mindfulness and spiritual care practices ( $r(86) = .212, p = .05$ ). Values to interpret  $r$  in the social sciences are guided by parameters suggested by Cohen (1988): .10 (weak), .30 (moderate), and .50 (strong). The Pearson's  $r$  of .212 indicates a positive weak relationship between the two variables. Table 6 summarizes the correlation results.

Table 6

*Means, Standard Deviations, and Bivariate Correlations of Study Variables*

Variable	<i>M</i>	<i>SD</i>	1	2	3
SPS	4.93	.96	—	.122	.121
MAAS	4.33	.74	—	—	.212*
NSCTS	55.36	11.87	—	—	—

*Note.* SPS = Spiritual Perspective Scale. MAAS = Mindful Attention Awareness Scale. NSCTS = Nurse Spiritual Care Therapeutics Scale.

\*  $p = .05$

### **Demographics and Study Variables**

Key demographic factors were examined in relation to spiritual perspective, mindfulness, and spiritual care practices. Categorical groups were examined with either parametric (independent  $t$  test) or nonparametric (Mann-Whitney  $U$  test) statistics to determine if differences existed between groups. Assumptions for independent  $t$  tests include both underlying populations are normally distributed and have equal variances (Witte & Witte, 2010). Continuous variables were assessed with Pearson's  $r$  or Spearman's rho correlation coefficient to examine the relationships to study variables.

**Spiritual perspective and demographic factors.** Categorical groups and the continuous demographic variables were assessed with nonparametric tests because assumptions of normality and/or homoscedasticity were violated.

The Mann-Whitney  $U$  test was used to assess if differences in spiritual perspective were present in the following groups: religious affiliation (Yes or No), professional role (staff nurse or APN), and education in spiritual care (Yes or No). No significant differences in spiritual perspective were found between staff nurses and APNs ( $U = 798.5, p = .591$ ) and receiving or not receiving education in spiritual care ( $U = 975.5, p = .103$ ). There was a statistically significant difference in spiritual perspectives with nurses based on reporting a religious affiliation ( $U = 392.5, p < .001, r = .54$ ); nurses with a religious affiliation had a higher median score ( $Mdn = 5.5, n = 67$ ) than nurses without a religious affiliation ( $Mdn = 4.1, n = 34$ ).

Relationships between spiritual perspective and the continuous variables age, years as APN, years as RN, years as APN in hospice or palliative care, and years as RN in hospice or palliative care were examined using Spearman's rho correlation coefficient because assumptions of normality and/or homoscedasticity were violated. No significant relationships were found between spiritual perspective and years as APN ( $r_s(52) = .168, p = .233$ ), years as APN in hospice or palliative care ( $r_s(54) = .144, p = .298$ ), and years as an RN in hospice or palliative care ( $r_s(80) = .092, p = .416$ ). There was a positive correlation between age and spiritual perspective ( $r_s(100) = .2, p = .046$ ), and years of experience as an RN and spiritual perspective ( $r_s(99) = .208, p = .039$ ).

**Mindfulness and demographic factors.** Parametric statistics were used to assess differences between groups as assumptions for normality and equal variances

were not violated. Parametric and nonparametric tests were used to assess relationships with continuous variables.

Independent *t* tests were used to assess differences in mindfulness between three categorical groups. No statistically significant differences were found between categorical demographic variables and mindfulness: nurses with or without a religious affiliation ( $t(96) = -.388, p = .699$ ), staff RNs and APNs ( $t(80) = -.954, p = .343$ ), and nurses who had or had not received education in spiritual care ( $t(96) = .958, p = .341$ ).

Relationships between mindfulness and four of the five continuous variables were evaluated with Spearman's rho correlation coefficient because assumptions of normality and/or homogeneity were violated. Only Pearson's *r* was used to assess the relationship between mindfulness and years as an APN. No statistically significant relationships were found: age ( $r_s = .132, p = .198$ ), years as RN ( $r_s = .104, p = .313$ ), years as RN in hospice or palliative care ( $r_s = .015, p = .899$ ), years as APN ( $r = .127, p = .384$ ), and years as APN in hospice or palliative care ( $r_s = .001, p = .993$ ).

**Spiritual care practices and demographic factors.** Independent *t* tests were utilized to assess if there was a difference in spiritual care practices between the categorical groups. Assumptions were not violated in each of the three groups; Shapiro-Wilk tests for normality and Levene's Test for Equality of Variances were not significant indicating a normal distribution of scores and equal variances (Bannon, 2013). No significant differences were found between spiritual care practices and the three groups: religious affiliation ( $t(87) = -1.040, p = .301$ ),

professional role ( $t(73) = -.881, p = .381$ ), and education in spiritual care ( $t(87) = -.976, p = .332$ ).

The relationship between spiritual care practices and the continuous demographic variable years as an APN was examined with a Pearson's  $r$ . Assumptions for use of parametric statistics were met; years as an APN was normally distributed (Shapiro-Wilks test,  $p = .054$ ) and homoscedasticity was present (Levene's test for homogeneity of variances  $p = .133$ ).

The relationships between spiritual care practices and the remaining continuous variables were assessed with Spearman's rho correlation coefficient because assumptions of parametric statistics were violated. All of the variables had a non-normal distribution as evidenced by a significant Shapiro-Wilk test: age ( $p = .034$ ), years of experience as RN ( $p = .004$ ), years of experience as RN in hospice or palliative care ( $p = .000$ ), and years of experience as APN in hospice or palliative care ( $p = .000$ ). Examination of scatterplots did not suggest a linear relationship between the variables and spiritual care practices. In addition, heteroscedasticity was present with years of experience as APN in hospice and palliative care (Levene's test for homogeneity of variances  $p = .02$ ).

None of the correlations between the continuous variables and spiritual care practices were significant. Results of correlations are displayed in Table 7.

Table 7

*Bivariate Correlations: Age/Professional Experience and NSCTS*

Variable	Correlation	Significance
Age	-.023	.830
Years of experience as RN	-.145	.181
Years of experience as RN in hospice or palliative care	.041	.741
Years of experience as APN*	-.095	.517
Years of experience as APN in hospice or palliative care	-.048	.738

*Note.* \* denotes Pearson's  $r$

**Simple linear regression.** In performing the bivariate analyses between study variables and spiritual care practices and demographic characteristics, only mindfulness and spiritual care practices had a statistically significant correlation ( $r = .212, p = .050$ ). Therefore, a simple regression was performed to determine how well nurses' mindfulness could predict spiritual care practices in hospice and palliative care nurses.

The assumptions for linear regression include normality, homoscedasticity and linearity (Salkind, 2007). As was previously reported, the scores for MAAS and NSCTS did not violate these assumptions.

The regression equation was statistically significant ( $F(1, 84) = 3.95, p = .05$ ). The R square in this equation was .045 indicating 4.5% of the variance in nurses' spiritual care practices is predicted by nurses' mindfulness. The remaining variance in

spiritual care practices (95.5%) is explained by other variables not included in this regression equation.

### **Summary**

The overarching research question that guided this study was to examine the relationships between and among spiritual perspective, mindfulness, and spiritual care practices of hospice and palliative care nurses. Scale scores for each instrument indicated nurses in this sample had a high spiritual perspective, a high level of mindfulness, and over 60% of nurses reported performing the majority of spiritual care practices listed on the NSCTS *Occasionally* to *Very Often*.

Relationships between the main study variables and spiritual care practices were examined using Pearson's  $r$  and Spearman's rho correlation coefficients. No statistically significant relationship was found between spiritual perspective and mindfulness. No statistically significant relationship was found between spiritual perspective and spiritual care practices. A weak positive relationship ( $r = .212$ ) was found between mindfulness and spiritual care practices. Given there was a statistically significant correlation ( $p = .05$ ) between mindfulness and spiritual care practice, a linear regression model was computed to explain the variance in spiritual care practices. The regression equation was significant ( $p = .05$ ), and mindfulness explained 4.5% of the variance in spiritual care practices.

Relationships between key demographic factors and spiritual perspective, mindfulness, and spiritual care practices were also explored. No significant differences in categorical groups were found for mindfulness and spiritual care

practices, nor were any statistically significant correlations found between the continuous demographics and mindfulness or spiritual care practices. Statistically significant positive correlations were found between spiritual perspective and age, and spiritual perspective and years of RN experience. In addition, significant differences in spiritual perspective were present between nurses who reported having a religious affiliation and those nurses without a religious affiliation.



## Chapter V

### DISCUSSION OF FINDINGS

#### Introduction

The purpose of this descriptive, correlational study was to examine relationships between and among spiritual perspective, mindfulness, and spiritual care practices of hospice and palliative care nurses. This chapter will discuss the study findings in relation to the empirical literature and Watson's theory of human caring. Limitations and strengths of the current research will be addressed.

#### Study Sample

The current study recruited nurses from the Hospice and Palliative Nurses Association via an online survey. The national sample of 104 hospice and palliative care nurses was predominately White/Caucasian (99%), female (96.1%), and 67.3% identified a religious affiliation. Sixty of the 70 nurses, who identified a religious affiliation, were of a Christian background. The mean age of nurses was 54.4 years with only 6.8% of nurses aged 40 or less. Nurses had a mean of 26.83 years of experience as a RN and a mean of 8.4 years of hospice or palliative care experience. The APNs ( $n = 52$ ) in the sample had a mean of 15.29 years of experience and mean of 8.95 years of hospice or palliative care experience. This sample was highly educated; more than half the sample ( $n = 62$ ) obtained a master's (49.1%) or doctoral

degree (10.6%). More than half of the nurses (61.5%) had some type of spiritual care education.

Several studies discussed in the literature review exploring nurses' spiritual perspectives and spiritual care practices did not report on all demographic categories. However, samples generally consisted of White/Caucasian females with Christian backgrounds (Cavendish et al., 2004; Geary & Rosenthal, 2011; Hubbell et al., 2006; Mamier, 2009; Pullen et al., 1996; Sellers & Haag, 1998; Taylor et al., 1995; Taylor et al., 1999, Taylor et al., 2008; Tuck et al., 2001; Vance, 2001). Only two nurse samples had more racial diversity (Mamier, 2009; Taylor et al., 2009). Ages of nurses were not reported consistently. Several studies stated 50 to 90 percent of nurses were age 40 or older (Gray et al., 2004; Pullen et al., 1996; Vance, 2001), while others reported mean age ranges from 40 to 50 (Geary & Rosenthal, 2011; Hubbell et al., 2006; Ronaldson et al., 2012; Sellers & Haag, 1998; Stranahan, 2001; Taylor et al., 1995; Taylor et al., 1999; Tuck et al., 2001). Samples from three studies consisted of younger nurses with mean ages ranging from 33.5 to 39 (Mamier, 2009; Ronaldson et al., 2012; Taylor et al., 2009). Mean years of nursing experience ranged from 8.5 to 23 (Hubbell et al., 2006; Mamier, 2009; Ronaldson et al., 2012; Sellers & Haag, 1998; Taylor et al., 1995; Taylor et al., 1999; Taylor et al., 2009). Vance (2001) reported 41% of nurses had 16 or more years of nursing experience. Two studies consisted solely of APNs with mean APN years of experience ranging from 7.8 to 9 years (Hubbell et al., 2006; Stranahan, 2001); these nurses were also more highly educated with 77% to 85% having obtained master's degrees (Hubbell et al., 2006;

Stranahan, 2001). Nurses in other samples did obtain advanced degrees: 6% to 27% master's degree (Geary & Rosenthal, 2011; Pullen et al., 1996; Sellers & Haag, 1998; Taylor et al., 1995; Taylor et al., 1999; Tuck et al., 2001; Vance, 2001) and less than 1% to 5% had doctoral degrees (Sellers & Haag, 1998; Stranahan, 2001; Taylor et al., 1995; Tuck et al., 2001). Cavendish et al. (2004) reported more than 19% of the nurses had degrees beyond a BSN, while Mamier (2009) reported 7.6% had master's or doctoral degrees.

Several studies reported if nurses received spiritual care education. Approximately 90% of parish nurses in Tuck et al.'s (2001) study received education regarding parish nursing. Mamier (2009) and Pullen et al. (1996) reported 24% to 65% of nurses received some type of spiritual care education, while 22% to 28% of the nurses did not receive spiritual care education in the studies by Hubbell et al. (2006) and Stranahan (2001).

Studies pertaining to mindfulness contained samples that included physicians, hospice caregivers, medical students, and community dwellers (Beach et al., 2013; Beckman et al., 2012; Bruce & Davies, 2005; Carmody et al., 2008; Shapiro et al., 1998). Only one study consisted primarily of White/Caucasian female nurses mean age of 46.5 and 21 years of experience (Cohen-Katz et al., 2005a, 2005b). Not all researchers provided demographics regarding the samples. Studies that did report demographics were predominately White/Caucasian, 50% to 75% female with mean ages ranging from 44.5 to 49 (Beach et al., 2013; Bruce & Davies, 2005; Carmody et al., 2008; Shapiro et al., 1998).

Nurses in the current study had some similarities and differences from nurses in the samples presented in the review of the literature. As in the majority of studies, the current sample was homogenous, consisting primarily of White/Caucasian females with the majority having a Christian background. Although ages were not reported in a consistent manner, nurses in this study were older with a mean age of 54.4 compared to mean ages of 40 to 50. Nurses in the current study had more mean years of nursing experience and advanced practice experience, as well as the most doctorates in nursing. A high percentage of nurses in this sample had received spiritual care education. In conclusion, the current study's homogenous sample of primarily White/Caucasian, female nurses with the majority having a Christian background was older, highly educated with more nursing experience compared to most of the nurses in prior research examining spiritual perspective, or mindfulness, or spiritual care practices. These differences may have impacted on the relationships found between and among the study variables.

### **Spiritual Perspective**

**Description of nurses' spiritual perspective.** For the purpose of this study, spiritual perspective was measured with the Spiritual Perspective Scale (SPS). This scale assessed the participants' perceptions of the extent to which six spiritual views are held and the frequency of four spiritually-related activities (Reed, 1986a). The mean score on a scale of one to six for the sample of hospice and palliative care nurses was 4.93 ( $SD = .96$ ) indicating that spiritual perspective is significant in the lives of these nurses.

The SPS has been used by researchers to describe the spiritual perspectives of nurses from various practice settings. Nurses in previous studies had similar demographics to the current study; nurses were predominately White/Caucasian, Christian, females age 40 and older (Cavendish et al., 2004; Gray et al., 2004; Pullen et al., 1996; Ronaldson et al., 2012; Stranahan, 2001; Tuck et al., 2001). The majority of nurses in these samples had high spiritual perspectives with mean scores ranging from 3.7 to 5.65. The lowest mean SPS score was obtained from acute care RNs (Ronaldson et al., 2012). The highest mean SPS was found in parish nurses with a mean score of 5.65 (Tuck et al., 2001), which is not surprising, as the spiritual dimension is central to parish nursing and the spiritual maturity of the nurse is emphasized (Solari-Twadell, 1999).

Relationships between the SPS and selected demographics were examined in the current study. Positive correlations were found between age ( $r_s(100) = .2, p = .046$ ) and years of experience as an RN ( $r_s(99) = .208, p = .039$ ). Ronaldson et al. (2012) reported similar findings: “The only demographic variable of significance related to palliative care RNs’ [ $n = 42$ ] delivery of spiritual care or to their spiritual perspective was years of experience as a RN ( $p < 0.05$ )” (p. 2130). Although Ronaldson et al. did not find any further significant relationships between the SPS and demographics, the lowest mean SPS score of 3.7 came from acute care RNs ( $n = 50$ ) with a mean age of 33.5 and a mean of 9.6 years of experience as an RN.

Religious affiliation and spiritual perspective were examined in the current study. There was a statistically significant difference in spiritual perspectives between

groups of nurses reporting having a religious affiliation ( $n = 70$ ) and reporting no religious affiliation ( $n = 34$ ) ( $U = 392.5, p < .001, r = .54$ ). Nurses with a religious affiliation had a higher median SPS score ( $Mdn = 5.5, n = 67$ ) than nurses without a religious affiliation ( $Mdn = 4.1, n = 34$ ). This finding is consistent with similar results from other researchers. Stranahan (2001) found a positive correlation ( $r = .433, p < .001$ ) between the SPS and how religious an individual perceived themselves to be (*Not at all to Very religious*). Nurses with a religious affiliation in the study by Cavendish et al. (2004) had a higher mean SPS regardless of age category (younger than 40 or 41 or older)  $F(5.535) = 17.689, p = .001$ . Mean SPS scores were not reported for the age categories.

Nurses' spiritual perspective had been measured with other instruments in research presented in the review of the literature. The Spiritual Well-Being Scale (SWBS) (Ellison, 1983) assesses the relationship to God and experience of purpose and meaning in life with scores ranging from 20 to 120. Nurses in studies by Tuck et al. (2001) and Vance (2001) had high scores (108.58, 101.7, respectively). Vance also assessed spiritual perspective with the Spiritual Involvement and Beliefs Scale (SIBS) (Hatch et al., 1998). The SIBS measures spiritual activities and beliefs with terms that avoid cultural or religious bias. Scores were also high with a mean score of 97.1 out of a potential range of 24 to 130. Mamier (2009) used the Daily Spiritual Experiences Scale (DSES) (Underwood & Teresi, 2002) which measures daily life experiences of connection with the transcendent. The range for mean scores is 1 to 6 with lower scores indicating a high spiritual perspective. Participants in Mamier's study had a

mean DSES of 2.07. Regardless of instrument used to assess spiritual perspective, nurses in these studies had high spiritual perspectives similar to those in the current study.

The current study only utilized the SPS to measure spiritual perspective. Tuck et al. (2001) and Vance (2001) used more than one instrument to measure spiritual perspective and then evaluated the strength of the relationship between the two. In Tuck's et al. (2001) sample, there was a correlation between the SWBS and the SPS ( $r = .358, p < .01$ ). So although the SWBS assesses different aspects of spiritual perspective, there is a positive relationship to the SPS. Vance (2001) assessed the relationship between two instruments used in her study: SWBS and SIBS. A strong positive correlation was found between the SWBS and the SIBS ( $r = .72, p < .05$ ). Although only Tuck et al. (2001) evaluated the relationship of another measure of spiritual perspective to the SPS, a strong positive correlation was also found between two other measures of spiritual perspective (SWBS and SIBS). It would not be appropriate to compare total or mean scores between instruments, but relationships exist between measures of spiritual perspective, for each assesses a component of the individual's sense of connection to a higher being, nature, others or some purpose greater than the self (Reed, 1987).

**Nurses' spiritual perspective and spiritual care practices.** In the current study, the relationship between spiritual perspective and spiritual care practices was evaluated to answer the research question: What is the relationship between hospice and palliative care nurses' spiritual perspective and spiritual care practices?

Using a Spearman's rho correlation coefficient, no statistically significant relationship was found between spiritual perspective as measured by the SPS and spiritual care practices as measured by the Nurse Spiritual Care Therapeutics Scale (NSCTS) ( $r_s(87) = .121, p = .266$ ).

Prior research has shown statistically significant relationships between spiritual perspective and spiritual care practices. However, not all studies utilized the SPS to assess spiritual perspective (Mamier, 2009; Vance, 2001), and different instruments were employed to assess spiritual care practices in three studies (Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001).

The range of conceptualizations for spiritual perspective is broad and inconsistent (Berry, 2005), and lack of agreement regarding definitions makes research challenging (Cohen et al., 2012). Mamier (2009) measured spiritual perspective with the Daily Spiritual Experience Scale. This scale evaluates the frequency of how often (*Many times a day to never or almost never*) an individual experiences the transcendent (God, the divine or holy) in daily life and his or her perception of the transcendent (Underwood & Teresi, 2002). The SPS does not evaluate experiences, but rather how frequent an individual participates in spiritually related behaviors (*Not at all to About once a day*) and the extent to which certain spiritual views are held (*Strongly disagree to Strongly agree*) (Reed, 1986a). Vance (2001) examined spiritual perspective with two instruments, the Spiritual Well Being Scale (SWBS) and the Spiritual Involvement and Beliefs Scale (SIBS). The SWBS assesses an individual's perception of their relationship to God and sense of life



purpose and satisfaction (Ellison, 1983), while the SIBS measures activities and beliefs (Hatch et al., 1998). The SWBS, SIBS, and the SPS assess several common themes such as forgiveness and prayer, but the SWBS has more of a focus on the relationship with God or the divine, and the SIBS addresses other matters such as the ability to apologize and find meaning from suffering (Hatch et al., 1998). The non-significant findings in this study may stem from assessing different components of spiritual perspective.

Spiritual care practices were also measured with different instruments in prior research investigating the relationship between spiritual perspective and spiritual care practices. The NSCTS was used in this study and by Mamier (2009) to measure spiritual care practices. Stranahan (2001) used the modified Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS), while Vance (2001) and Ronaldson et al. (2012) used the Spiritual Care Practice Questionnaire (SCPQ). Although the instruments used to assess the frequency of spiritual care practices use Likert-type scales, each has different anchor points. The anchors for the NSCTS contain both subjective and objective terminology (ie. *Occasionally, about 3 -6 times*). This differs from the ONSCPS where options on the Likert-type scale read *Rarely to Always*. The SCPQ provided the options of *Very seldom to Very often* to measure frequency of spiritual care provision. Each nurse may define “very seldom” or “rarely” differently, and therefore frequency measurements may not be consistent across instruments. In comparing the anchors from these two instruments to the NSCTS used in this study, it is clear that varying anchor points on instruments that do not have the same

parameters will likely influence the measurement of frequency of spiritual care practices. This could account for why significant correlations were found between spiritual perspective and spiritual care practices in the studies by Ronaldson et al. (2012), Stranahan (2001), and Vance (2001), and not found for this study.

In addition to differing anchor points, instruments do not have the same time frame parameters when considering frequency of spiritual care practices. For the NSCTS, nurses are instructed to consider how often in the past 72 or 80 hours of providing patient care did they perform each spiritual care practice. The Oncology Nurse Spiritual Care Perspectives Survey asks nurses “How often in your recent experience have you employed the following interventions while providing spiritual care?” No time frame parameters are reported with the Spiritual Care Practice Questionnaire. In the current study as well as the study by Mamier (2009), nurses had provided at least 36 hours of direct patient care prior to completing the NSCTS, but no requirement for recent patient care delivery was reported in other studies (Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001).

The current study did not find statistically significant relationships between spiritual perspectives and spiritual care practices as was found in prior research, but methodological differences may explain the non-significant findings. The NSCTS has only been used in one prior study which measured spiritual perspective with an instrument assessing experiences rather than beliefs and actions. The subjective nature of the anchor points for Likert-type scales and the lack of a consistent time frame for nurses to consider how often spiritual care was provided may not be

consistently capturing frequency of spiritual care practice as defined by the NSCTS used in this study. Asking nurses to consider a specific time period, such as the past 72 or 80 hours of patient care, may not produce the same responses as asking nurses to consider “recent experience”. However, evaluating a specified time period for spiritual care practices, as in the NSCTS, may lessen the impact of memory limitations and reflect actual practice.

### **Mindfulness**

**Measuring mindfulness.** The Mindful Attention Awareness Scale (MAAS) was used in this study to measure trait mindfulness in participants. The MAAS assesses mindfulness by measuring how frequently an individual experiences attributes uncharacteristic of mindfulness (*Almost always* to *Almost never*). Scores can range from 1 to 6 with higher scores reflecting higher levels of trait mindfulness. Participants’ scores ranged from 2.2 to 5.87 with a mean score of 4.33 ( $SD = .74$ ), indicating a somewhat high degree of mindfulness.

In the study by Beach et al. (2013), the MAAS was used to investigate mindfulness in health care providers and its relationship to quality of patient care. Participants in that study had a mean MAAS score of 4.33 ( $SD$  not reported) as in the current study, with a slightly different range (2.57 to 5.93). High mindful clinicians were more likely to have more patient-centered patterns of communications similar to the current study findings of nurses with higher MAAS scores having higher spiritual care practice scores. Participants in the Beach et al. (2013) study had different demographics compared to the current study: 56 % females, mean age of 44.5, and

67 % White/Caucasian. Findings from Beach et al. (2013) and the current study indicate higher mindfulness scores in health care providers can impact patient care regardless of demographic factors.

Relationships between the MAAS and selected demographics were examined in the current study. No statistically significant relationships were found between the categorical variables: religious affiliation (Yes or No), professional role (staff RN or APN), and education in spiritual care (Yes or No). There were no statistically significant correlations between the following continuous variables: age, years as an RN, years as an RN in hospice or palliative care, years as an APN, and years as an APN in hospice or palliative care.

Two researcher teams who have used the MAAS to evaluate mindfulness have reported on relationships between the MAAS and certain demographics. Carmody et al. (2008) reported no significant relationships between demographics and changes in mindfulness scores after a Mindfulness-Based Stress Reduction (MBSR) program. Beach et al. (2013) found that MAAS scores were not related to age or professional training, but were related to gender and race; females and those of non-Caucasian and non-Asian race category had high MAAS scores. However the non-Caucasian and non-Asian sample size was small ( $n = 4$ ) and results should be interpreted with caution. This study did not evaluate race/ethnicity or gender in relation to MAAS scores because there were only 4 males and 1 Asian/Pacific Islander in the sample.

**Mindfulness and spiritual perspective.** The relationship between spiritual perspective and mindfulness was evaluated to answer the research question: What is

the relationship between hospice and palliative care nurses' spiritual perspective and mindfulness? Using a Spearman's rho correlation coefficient, no statistically significant relationship was found between spiritual perspective as measured by the SPS and mindfulness as measured by the Mindful Attention Awareness Scale ( $r_s(95) = .122, p = .240$ ). This question was descriptive in nature and sought to evaluate the relationship between the two variables.

Prior researchers have examined mindfulness and spiritual perspective; however, the study designs were different and measurement strategies were not comparable. Carmody et al. (2008) quantitatively examined mindfulness and spiritual perspective before and after a Mindfulness-Based Stress Reduction course (MBSR) and found increases in mindfulness predicted increases in spiritual perspective, but did not look at the associations between the two variables. Cohen-Katz et al. (2005b) reported on qualitative findings which included enhanced spirituality after participating in a MBSR course.

**Mindfulness and spiritual care practices.** The relationship between mindfulness and spiritual care practice was examined to answer the research question: What is the relationship between hospice and palliative care nurses' mindfulness and spiritual care practices? There was a weak positive correlation between mindfulness and spiritual care practice ( $r(86) = .212, p = .05$ ).

Mindfulness and spiritual perspective were evaluated to answer the research question: What is the impact of hospice and palliative care nurses' spiritual perspective and mindfulness on spiritual care practices? Since there was no

statistically significant relationship between mindfulness and spiritual perspective, mindfulness was entered into a linear regression equation to determine the impact of mindfulness on spiritual care practices. Nurses' mindfulness explained 4.5% of the variance in spiritual care practices.

To date, researchers have not examined the relationship between mindfulness and spiritual care practices. In a related study, Beach et al. (2013) reported that high-mindfulness clinicians had more patient centered communication with rapport building and communication about psychosocial issues and a more positive emotional atmosphere. The researchers posited that mindfulness may free clinicians' attention to better focus on the patient's experience and clinicians would be less likely to distance themselves from distressing situations (Beach et al., 2013).

Correlational research evaluates the relationship between two variables but does not infer causality (Polit & Beck, 2010). Nurses with high mindful scores as measured with the MAAS have more ability to be "attentive to and aware of what is taking place in the present" (Brown & Ryan, 2003, p. 822). Since spiritual care practice necessitates the ability to be present, nurses with high mindful scores may be more capable of providing spiritual care.

Individuals vary on their level of mindfulness, but mindfulness can be enhanced through disciplined practice (Nhât, 2009; Sitzman & Watson, 2014). Bruce and Davies (2005) found that hospice caregivers who regularly engaged in mindfulness meditation considered practicing mindfulness as an approach to being present. By being open to people and situations without predetermined expectations,

caregivers had experienced kindness and an availability with patients and each other. Participants of mindfulness training reported developing skills necessary for spiritual care provision such as being present and listening (Beckman et al., 2012; Cohen-Katz et al., 2005a, 2005b).

In this study, spiritual care practice is defined as actions or ways of being employed by the nurse to promote the integration of spirituality into all aspects of life for the patient. This study evaluated mindfulness (way of being) and its relationship to spiritual care practice. Although one of the first requirements to practice in a caring healing model is to be fully present in the moment (mindful) (Watson, 2008), quantitative instruments to measure spiritual care may not be able to capture how this foundation influences spiritual care practice. An inability to capture how mindfulness influences such items on the NSCTS as listening, facilitating spiritual practices or encouraging patient dialogue, may account for the weak correlation found in this study between mindfulness and spiritual care practice.

### **Spiritual Care Practices**

**Nurse Spiritual Care Therapeutics Scale.** The Nurse Spiritual Care Therapeutics Scale (NSCTS) operationalized spiritual care practices in the current study. The NSCTS measures the frequency of 17 activities a nurse may employ in providing spiritual care. The NSCTS was first used by Mamier (2009) to evaluate spiritual care practices in nurses ( $N = 554$ ) from four hospitals in a faith-based, tertiary health care system in southern California and was found reliable ( $\alpha = .93$ ). The current study provided further evidence of reliability in a national sample of

hospice and palliative care nurses with a Cronbach's alpha reliability coefficient of .92.

Several similarities and differences existed between the nurses in the two studies. The majority of nurses in both the Mamier and current study were female (86%, 96%, respectively) and had received education in spiritual care (65.3%, 61.5%, respectively). Nurses were recruited from the Hospice and Palliative Nurse Association for the current study, whereas Mamier (2009) recruited nurses from all types of practice settings. Nurses in the current sample were predominately White/Caucasian (99%) with a mean age of 54.4, 26.8 years of experience, 50% practiced as APNs, 60% held a Master's or doctoral degree, and 67% reported a religious affiliation. Mamier's sample was: racially diverse (47% White/Caucasian, 32% Asian/Pacific Islander, 13.5 % Hispanic /Latino, 4.7 % African American/Black), younger ( $M = 39$  years), less experienced ( $M = 11$  years RN experience), fewer practicing APNs (2%), fewer nurses with advanced degrees (7.6%), and had more nurses reporting a religious affiliations (95.5%).

Both studies evaluated selected demographic information in relation to NSCTS scores. In this study, there were no statistically significant differences or relationships found between age, years of nursing experience, having a religious affiliation, staff nurse versus APN, or having received education in spiritual care. Mamier (2009) also did not find a relationship between age, years of nursing experience, professional role, but did find NSCTS scores were statistically different for a nurse who had received education in spiritual care.



Almost two thirds of the nurses in both studies received spiritual care education, yet this study did not find statistically significant differences in NSCTS scores with nurses who had some type of spiritual care education as in Mamier's study. Comparing varying sources of spiritual care education does not seem to be prudent given the many confounding variables that may be present in examining undergraduate and graduate education, conferences, and personal study.

Mean total scores for the NSCTS differed between the two studies. Mamier (2009) reported a mean of 36.98 ( $SD = 12.01$ ) with a range of 17 to 79 from a potential range of 17 to 85. Hospice and palliative care nurses in the current study had a mean score of 55.36 ( $SD = 11.87$ ) with a range of 27 to 77. Higher spiritual care practice scores in these nurses is not unexpected, for spiritual care is an essential component of hospice and palliative care (HPNA, 2010); hospice and palliative care nurses deal with patients who may have increased spiritual needs (Ferrell & Munevar, 2012; Hermann, 2007) and an awakening of the spiritual dimension (Edwards, Pang, Shiu, & Chan, 2010).

The top three spiritual care practices were the same for the Mamier and current study. The most frequent spiritual care practices performed by the hospice and palliative care nurses occasionally to very often were: After completing a task, remained present just to show caring (96%), listened actively for spiritual themes in a patient's story of illness (94%), and assessed a patient's spiritual or religious beliefs or practices that are pertinent to health (91%).

In the current study, the following were the three practices never or rarely performed: Offered to read a spiritually nurturing passage (79%), offered to pray with a patient (66%), and arranged for a patient's clergy or spiritual mentor to visit (46%). Hospice and palliative care nurses provide care as a part of an inter-disciplinary team, and therefore these practices may overlap with care provided by the chaplain which may explain the reason these activities are never or rarely performed by nurses.

Mamier (2009) found the three practices never or rarely performed were: offered to read a spiritually nurturing passage (90%), arranged for a patient's clergy/spiritual mentor to visit (86.5%), and documented spiritual care you provided in a patient chart (82%).

Thirty-seven percent of nurses in the current study and 82% of nurses in Mamier's study (2009) never or rarely documented in the patient's chart that spiritual care was provided. These findings are not surprising and are consistent with qualitative research findings regarding difficulty with spiritual care documentation: lack of consistent assessment tools (Bailey et al., 2009; Belcher & Griffiths, 2005; Carroll, 2001), or concern that the individual nature of spiritual needs will be lost using a standardized form (Bailey et al., 2009). Difficulty with documentation may also arise because of the sensitive and confidential nature of what a patient may share with a nurse; this information may not be appropriate to document given many health care providers have access to the health record (McSherry, 2006).

**Measuring spiritual care practices.** As was previously discussed in the section Spiritual Perspective and Spiritual Care Practice, comparison between other

instruments that measure spiritual care practices and the NSCTS is problematic. The Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS) (Taylor et al., 1995) asks nurses to consider recent experience, while the NSCTS asks nurses to consider the past 72 or 80 hours of providing care when considering frequency of spiritual care practices. Although the anchor points for the Likert-type scales for the ONSCPS and the NSCTS are related, they are not interchangeable; the ONSCPS uses terms *Rarely or Never* to *Very often or Always* while the NSCTS uses terms *Never (0 times)* to *Very often (at least 12 times)*. The studies that used the NSCTS had eligibility criteria which required nurses to provide 36 hours of direct patient care prior to survey completion and asked nurses to consider the past 72 or 80 hours of providing care when considering frequency of spiritual care practices, which the other instruments did not.

The Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS) contains 12 questions regarding frequency of spiritual care practices that are the same or similar to those in the NSCTS. The most frequently employed ONSCPS practice was “Pray privately for a patient” (Hubbell et al., 2006; Stranahan, 2001; Taylor et al., 1995, 1999). This practice was not included on the NSCTS. The next two most frequently employed practices that were on both the ONSCPS and the NSCTS were refer patient to clergy or religious leader and talk with patient about spiritual or religious topic (Hubbell et al., 2006; Stranahan, 2001; Taylor et al., 1995, 1999).

Additional items on the NSCTS included questions pertaining to listening, asking how to support spiritual or religious practices, encouraging patient dialogue,

documentation, and presence. With these additional items included on the NSCTS, the most frequent practices for nurses in the Mamier (2009) study and current study were items not found on the ONSCPS: After completing a task, remained present just to show caring, listened actively for spiritual themes in a patient's story, and assessed a patient's spiritual or religious practices that are pertinent to health.

The least employed practices by nurses in the current and other studies that are included on both the ONSCPS and the NSCTS were: offered or read a religious or spiritual writing with or to a patient and offering to pray with a patient (Stranahan, 2001; Taylor et al., 1995, 1999). Different spiritual orientation between a patient and nurse has been reported as a barrier to spiritual care and may cause some nurses to disengage (Daaleman et al., 2008; Mamier, 2009). Although these activities have been identified as spiritual care, nurses may equate these practices to religious rituals, and therefore not feel these are appropriate nursing interventions.

Other researchers using both qualitative and quantitative methodologies have identified spiritual care practices that were employed by nurses in the current study as measured on the NSCTS: listening (Bailey et al., 2009; Belcher & Griffiths, 2005; Emblen & Halstead, 1993; Grant, 2004; Harrington, 1995; Sellers & Haag, 1998; Tuck et al., 2001), prayer (Emblen & Halstead, 1993; Grant, 2004; Harrington, 1995; Sellers & Haag, 1998; Tuck et al., 2001), presence (Bailey et al., 2009; Carroll, 2001; Daaleman et al., 2008; Dennis, 1991; Grant, 2004; Sellers & Haag, 1998), referral (Emblen & Halstead, 1993; Harrington, 1995), conducting a spiritual assessment (Bailey et al., 2009; Belcher & Griffiths, 2005; Sellers & Haag, 1998), and exploring

issues (Burkhart & Hogan, 2008; Harrington, 1995; Touhy et al., 2005; Tuck et al., 2001). Findings from this study provide further evidence to support its use, as over 60% of the nurses provided all but a few of the practices on the NSCTS occasionally to very often. Since the NSCTS measures spiritual care practices identified in the literature, not only does this provide evidence to validate previous research findings, but also provides evidence to support its use for this study.

**Watson's theory of human caring.** Watson's theory of human caring provided the theoretical framework for the current study evaluating the relationships between and among spiritual perspective, mindfulness, and spiritual care practices in hospice and palliative care nurses. Although there was not a statistically significant relationship between spiritual perspective and spiritual care practices, the nurses in the current study had a high spiritual perspective as measured by the Spiritual Perspective Scale, and for all but three spiritual care practices, over 60% of the nurses employed practices occasionally to very often in the past 72 or 80 hours of patient care. There was a statistically significant relationship between mindfulness and spiritual care practices which explained a small percentage (4.5%) of variance in spiritual care practices, thus providing evidence to support Watson's assertion that the first requirement for practicing within a caring-healing model is to be fully present in the moment in order to be more open and accessible to oneself and the situation (Watson, 2008).

The fifth caritas process, *Being Present to, and Supportive of, the Expression of Positive and Negative Feelings-Listening to, Holding another person's story*, is

addressed in six items on the NSCTS that deal with listening and encouraging patient dialogue. The following percentages of nurses in the current study reported performing the spiritual care practices occasionally to very often: listened actively for spiritual themes in a patient's story (94%) and listened to a patient talk about spiritual concerns (89%). Nurses encouraged patients to talk about the following topics: how illness affects relating to God/Ultimate Other or transcendent reality (67%), his or her spiritual coping (78%), what gives his or her life meaning amidst illness (80%), and challenges of living with illness (72%). Items that address listening also pertain to the fourth caritas process, *Developing and Sustaining a Helping-Trusting Caring Relationship*.

A number of items on the NSCTS address both the second and eighth caritas processes. In the second caritas process, *Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner-Subjective Life World of Self/Other*, the nurse not only honors the belief system of the patient, but assists him or her to access this belief system (Watson, 2008). This may help to create a healing environment. In the eighth caritas process, *Creating a Healing Environment at All Levels*, the nurse attends to the environment which encompasses acknowledging spiritual needs (Watson, 2008). Several practices on the NSCTS speak to assessing a patient's spiritual needs and the importance of carrying out specific practices that can help create a healing environment for certain patients. The following practices were performed occasionally to very often in the current study: Asked a patient about how you could support his or her spiritual or religious

practices (78%) and assessed a patient's spiritual or religious beliefs or practices that are pertinent to health (91%). The following practices to create a healing environment were utilized occasionally to very often: helped a patient to have quiet time or space for spiritual reflection or practices (61%), arranged for a chaplain to visit a patient (87%), arranged for a patient's clergy or spiritual mentor to visit (54%), offered to pray with a patient (34%), offered to read a spiritually nurturing passage (21%), told a patient about spiritual resources (71.5%), and after completing a task, remained present just to show caring (96%).

This study found that mindfulness was positively correlated to spiritual care practices and the majority of nurses provided spiritual care as operationalized by the NSCTS. Study findings support Watson's assertion that nurses need to be fully present in the moment in order to practice in a caring-healing model. Almost all of the activities listed on the NSCTS are consistent with the second, fourth, fifth and eighth caritas processes which lends further support for utilizing Watson's theory not only as a theoretical framework for research, but also as a guide for implementing spiritual care.

### **Limitations**

Limitations were noted and need to be taken into consideration when interpreting findings. The sample was a convenience sample solicited from the Hospice and Palliative Nurses Association via an online survey. Convenience sampling did not control for biases, such as only nurses interested in the subject matter responding. Overall, the response was low ( $N = 138$ ) with a final sample size

of 104 after data cleaning. The sample was homogenous and consisted primarily of White/Caucasian females, with two thirds reporting a religious affiliation (mainly Christian) which limits generalizability.

The current study did not find a statistically significant relationship between spiritual perspective and spiritual care practices as in prior research (Mamier, 2009; Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001). However, this study did not utilize the same instruments to measure spiritual perspective and spiritual care. Although Ronaldson et al. (2012) and Stranahan (2001) used the Spiritual Perspective Scale to measure spiritual perspective, each used different instruments to measure spiritual care. Mamier used the same instrument to measure spiritual care practices as the current study, but measured spiritual perspective with an instrument that assessed experiences rather than views and behaviors.

Self-report measures allow researchers to gather retrospective data but have the disadvantage of relying on an individual's perceptions that may not be accurate or valid (Polit & Beck, 2012). As Mamier and Taylor (2014) acknowledge the self-report responses for the NSCTS are subjective and may be shaped by memory limitations and social desirability. Hospice and palliative care nurses may be more susceptible to a social desirability bias in a study of spiritual care given that a key tenant of palliative care is provision of spiritual care.

### **Strengths**

Although limitations exist in the current study, there are noted strengths. The online survey was conducted utilizing SurveyMonkey® which imported data directly



into SPSS eliminating data entry errors. Even though the sample size was small given access to the Hospice and Palliative Nurses Association membership, participants were from all four geographic regions of the United States.

Two of the instruments used in the study, the Spiritual Perspective Scale (SPS) and the Mindful Attention Awareness Scale have proven validity and reliability in prior research and were found reliable in this sample as well: SPS ( $\alpha = .93$ ) and MAAS ( $\alpha = .91$ ). The NSCTS is a new instrument to measure spiritual care practice that is psychometrically sound and found to be reliable in this sample of hospice and palliative care nurses ( $\alpha = .92$ ). Using the NSCTS to measuring spiritual care practice in hospice and palliative care nurses provides further evidence for reliability of the NSCTS.

To date, there is limited research evaluating clinician's mindfulness and patient care. This study adds to this emerging body of research by evaluating clinician mindfulness and spiritual care practices.

### **Conclusion**

Using Watson's theory of human caring as a theoretical framework, the relationships between and among spiritual perspective, mindfulness, and spiritual care practices were examined in hospice and palliative care nurses. No statistically significant relationship was found between spiritual perspective and mindfulness. Prior research has investigated spiritual perspectives and mindfulness in relation to Mindfulness-Based Stress Reduction programs; this study explored if a relationship exists apart from participating in courses designed to cultivate mindfulness. No

significant relationship was found between spiritual perspective and spiritual care practices. This non-significant finding may be related to use of different instruments to assess spiritual perspective and spiritual care. There was a statistically significant relationship between mindfulness and spiritual care practices which explained 4.5% of the variance in spiritual care practices.

Frequency of spiritual care practices were measured with the NSCTS which asks nurses to consider the past 72 or 80 hours of direct patient care when determining how often a spiritual care practice was used: Never (0 times), Rarely (about 1-2 times), Occasionally (about 3-6 times), Often (about 7 to 11 times), Very Often (at least 12 times). More than 60% of the nurses provided the majority of spiritual care practices occasionally to very often in the specified time frame. Spiritual care practices employed were consistent with practices identified in both qualitative and quantitative research.

Limited research concerning clinician mindfulness and patient care is available to date. This study provides evidence that clinician mindfulness impacts spiritual care practice and provides support for continued research efforts investigating how clinician mindfulness influences other aspects of patient care.

## Chapter VI

### SUMMARY, IMPLICATIONS, CONCLUSION

#### Introduction

The purpose of this study was to examine the relationships between and among nurses' spiritual perspective, mindfulness, and spiritual care practices. A statistically significant relationship was found between two of the main study variables, mindfulness and spiritual care practices. This chapter provides a summary of the research findings and discusses implications for nursing practice, education and future research.

#### Summary

This descriptive correlational study used an online survey to explore the relationships between and among nurses' spiritual perspective, mindfulness, and spiritual care practices. A convenience sample was solicited from the Hospice and Palliative Nurses Association (HPNA). Email invitations were sent to the Research and Advanced Practice Special Interest Groups, and two advertisements were placed in the bimonthly HPNA eNewsletter. A total of 138 members responded. The final sample ( $N = 104$ ) was primarily female (96.1%), White/Caucasian (99%), Christian (61.5%) with ages ranging from 28 to 73 ( $M = 54.4$ ,  $SD = 8.36$ ).

Participants completed three instruments and a demographic questionnaire. All the instruments were found to be reliable in this sample of hospice and palliative care nurses with the Cronbach's alpha reliability coefficients ranging from .91 to .93.

The Spiritual Perspective Scale (SPS) (Reed, 1987) was used to assess spiritual perspective with a sample mean score of 4.92 ( $SD = .96$ ) indicating a relatively high level of spiritual perspective for these nurses as a group. The Mindful Attention Awareness Scale (MAAS) (Brown & Ryan, 2003) measured trait mindfulness. Nurses' mean score was 4.33 ( $SD = .74$ ) signifying a fairly high level of mindfulness. Spiritual care practices were measured with the Nurse Spiritual Care Therapeutics Scale (NSCTS) (Mamier & Taylor, 2014) with more than 60% of the nurses providing the majority of spiritual care practices listed on the NSCTS occasionally (about 3 – 6 times) to very often (at least 12 times) in the specified time frame (past 72 or 80 hours). The mean score on the NSCTS was 55.36 ( $SD = 11.87$ ) out of a possible range of 17 to 85.

A significant relationship was found between two of the study variables. There was a positive correlation between mindfulness and spiritual care practices ( $r = .212, p = .05$ ). Given only one independent variable (mindfulness) was significantly correlated to the dependent variable (spiritual care practice), a linear regression analysis was conducted to predict the impact of mindfulness on spiritual care practices. The regression model was statistically significant ( $F(1,84) = 3.95, p = .05$ ) with mindfulness predicting 4.5 % of the variance in spiritual care practices. No statistically significant relationship was found between spiritual perspective and mindfulness or spiritual perspective and spiritual care practices.

Relationships between selected demographics and study variables were also explored. Nurses who reported having a religious affiliation had statistically

significant higher median spiritual perspective scores than nurses who did not report having a religious affiliation ( $U = 392.5, p < .001, r = .54$ ). Positive correlations were found between spiritual perspective and age ( $r_s(100) = .2, p = .046$ ), and spiritual perspective and years of experience as an RN ( $r_s(99) = .208, p = .039$ ). There were no statistically significant differences or relationships found between the demographic categorical or continuous variables and mindfulness or with spiritual care practices.

### **Implications**

This study was guided by Watson's theory of human caring to examine relationships between and among spiritual perspective, mindfulness, and spiritual care practice. The research findings have implications for nursing education, practice, and research.

**Implications for nursing education.** Nurse educators are mandated to provide spiritual care education. The Essentials of Baccalaureate Education for Professional Nursing Practice (American Association of Colleges of Nursing, 2008) require that baccalaureate nursing programs prepare graduates to conduct spiritual assessments, develop an awareness of how spiritual beliefs and values impact health care, and implement holistic patient-centered care. Methods to teach spiritual care to nursing students have been described in the nursing literature (Baldacchino, 2008; Callister, Bond, Matsumura, & Mangum, 2004; Lovanio & Wallace, 2007; Taylor, Testerman, & Hart, 2014), yet utilizing Watson's theory of human caring to prepare students to provide spiritual care has not been considered.

The current research has demonstrated that Watson's caritas processes can be used to implement spiritual care practices. Practices on the NSCTS that deal with listening and encouraging patient dialogue are addressed by the fourth and fifth caritas processes: *Developing and Sustaining a Helping-Trusting Caring Relationship* and *Being Present to, and Supportive of, the Expression of Positive and Negative Feelings-Listening to, Holding another person's story*. Several spiritual care practices listed in NSCTS address themes of the second and eighth caritas processes: *Being Authentically Present: Enabling, Sustaining, and Honoring the Faith, Hope, and Deep Belief System and the Inner Subjective Life World of Self/Other* and *Creating a Healing Environment at All Levels*. Not only does a nurse create a healing physical environment, but a non-physical environment which encompasses acknowledging spiritual needs (Watson, 2008).

This study found a positive correlation between mindfulness and spiritual care practices which supports Watson's assertion that to practice in a caring-healing model, an individual first needs to be fully present in the moment to be available to self and to the situation (Watson, 2008). Given that trait mindfulness impacts spiritual care practices, nursing educators should consider adding a course to the nursing curriculum designed to cultivate mindfulness and to encourage students to develop their own personal mindfulness practices.

The research findings did not show significant correlations between mindfulness and age or with years of nursing experience, nor between spiritual care practices and age or with years of nursing experience. There were only a small

percentage of nurses age 40 or younger (6.8%) which needs to be considered when interpreting findings. However, the lack of significance suggests that undergraduate nursing students, who are typically younger and lack nursing experience, may be just as likely as older or more experienced nurses to be mindful and provide spiritual care.

Although no statistically significant relationship was found between spiritual perspective and spiritual care practices in this study, prior research demonstrated positive correlations between spiritual perspective and spiritual care practices (Mamier, 2009; Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001). Therefore, nurse educators should encourage nursing students to develop their own spiritual perspective. Furthermore, clinical practice guidelines (NCP, 2013) and the HPNA Position Statement on Spiritual Care maintain health care professionals should acknowledge and explore their own spiritual perspective.

**Implications for nursing research.** Findings from this study did not show a significant relationship between spiritual perspective and spiritual care practices as demonstrated in prior research. The Spiritual Perspective Scale has been used in previous studies but with instruments other than the NSCTS to measure spiritual care practice (Ronaldson et al., 2012; Stranahan, 2001). The only study to use the NSCTS used the Daily Spiritual Experience Scale to measure spiritual perspective (Mamier, 2009). A gold standard to measure spiritual perspective does not exist (Monod et al., 2011). Instruments to measure spiritual perspective can be differentiated into the following categories: intensity of attitudes/convictions and experiences, frequency of distinct practices/activities, spiritual well-being and meaning/purpose, coping

strategies and resources, and psychosocial and spiritual needs (Büssing, 2012). Future researchers need to be aware of the challenges of measuring spiritual perspective and consider prior work when choosing instruments (Cohen et al., 2012).

This study used a convenience sample from the Hospice and Palliative Nurses Association. This sample was homogenous with the majority of participants being White/Caucasian females over the age of 40, with Christian backgrounds; researchers in the future may consider recruiting participants from ethnic nursing organizations such as the National Coalition of Ethnic Minority Nurses Association, the National Association of Hispanic Nurses, or the National Black Nurses Association. The sample may also have been biased with nurses who have interest in the topics of spiritual perspective and spiritual care practices. Future research with diverse samples is necessary, and random sampling is indicated to guard against potential biases with self-selection.

To date, there is limited published research regarding the newly developed NSCTS to explore spiritual care practices (Mamier, 2009; Mamier & Taylor, 2014, Taylor, 2008). The current research established reliability of the NSCTS in this sample of hospice and palliative care nurses with a Cronbach's alpha coefficient of .92. Further use of the NSCTS to measure spiritual care practices in nurses is indicated to provide additional proof of reliability and evidence to support the validity of the NSCTS.

Research exploring the relationship between clinician mindfulness and patient care is almost nonexistent. Beach et al. (2013) found clinicians with higher



mindfulness scores as measured by the MAAS engaged in more patient-centered communication patterns and had higher overall patient satisfaction scores. The current study provided evidence that clinician mindfulness impacts spiritual care practices. Studies evaluating clinician mindfulness need to be replicated and expanded in order to determine the impact of clinician mindfulness on patient care and patient outcomes.

Although mindfulness was shown to have a statistically significant impact on spiritual care practice, it only explained a small percentage of the variance. Future research efforts should also focus on additional factors that may influence spiritual care practices such as communication skills (McSherry, 2006) or spiritual care education (Mamier, 2009).

**Implications for nursing practice.** This study found that nurses' mindfulness was positively correlated with spiritual care practices and has a small but significant impact on these practices. Clinicians who are mindful are attentive to and aware of what is taking place in the present (Brown & Ryan, 2003), which may influence interactions and create a connection and intimacy with a patient (Sitzman, 2002). Individuals vary on their level of mindfulness but it can be enhanced through disciplined practice (Nhât, 2009; Sitzman & Watson, 2014). Employers may consider offering courses for nurses to enhance their mindfulness.

A frequently cited barrier to spiritual care provision is lack of time (Daaleman et al, 2008; Edwards et al., 2010; Piles, 1990; Puchalski et al., 2006; Ronaldson et al., 2012; Sellers & Haag, 1998; Touhy et al., 2005; Vance, 2001), yet being mindful

does not take any more time than being mindless. Mindfulness was not significantly correlated with age or years of nursing experience in this study. Therefore, findings suggest all nurses (novice to experts) may be capable of practicing mindfully.

Another frequent barrier to spiritual care practice cited in the literature is lack of adequate education (Delaney, 2005; Harrington, 1995; Hubbell et al., 2006; Piles, 1990; Puchalski et al., 2006; Ronaldson et al., 2012; Vance, 2001). The most frequently employed spiritual care practice for nurses in this study, *after completing a task, remained present just to show caring*, does not require any formal education other than to recognize that this intervention is actually spiritual care.

Watson's theory of human caring was used as the theoretical framework for this study, and can also be used as a guide for nurses in practicing spiritual care. A necessary component for spiritual care provision is a trusting nurse-patient relationship (O'Brien, 2003), which Watson discusses in the fourth caritas process, *Developing and Sustaining a Helping-Trusting Caring Relationship*. Attending to one's own spiritual needs and development is essential in providing good spiritual care (Sulmasy, 2012), which Watson addresses in the third caritas process, *Cultivation of One's Own Spiritual Practices and Transpersonal Self*. The caritas processes can be used as a professional-theoretical map and guide for nurses to promote the integration of spirituality into all aspects of the patient's life.

## **Conclusion**

Spiritual care is an essential component of palliative care, particularly because the ability to experience and integrate meaning and purpose in life may become

compromised as an individual faces a life-threatening illness or is dying (Ferrell & Munevar, 2012; HPNA, 2010; McSherry, 2006; Puchalski et al., 2006; Taylor, 2002). No consensus on the definition for spiritual care exists (Daaleman et al., 2008; Gijssberts et al., 2011; Narayanasamy & Owens, 2001) but it is defined for this study as: actions or ways of being employed by the nurse to promote the integration of spirituality into all aspects of life for the patient (Taylor, 2002).

Spiritual care practices were measured with a newly developed instrument, the NSCTS, which has demonstrated reliability and validity (Mamier & Taylor, 2014). The NSCTS was found to be reliable ( $\alpha = .92$ ) in this study. Over sixty percent of the hospice and palliative care nurses provided all but three of the activities on the NSCTS occasionally (about 3 to 6 times) to very often (at least 12 times) within the past 72 or 80 hours of providing patient care.

The relationships between and among spiritual perspectives, mindfulness, and spiritual care were examined. Nurses in this study were found to have high spiritual perspectives and trait mindfulness scores. No significant relationship was found between spiritual perspective and mindfulness. No significant relationship was found between spiritual perspective and spiritual care practices as had been found in previous research (Mamier, 2009; Ronaldson et al., 2012; Stranahan, 2001; Vance, 2001). There was a weak, but statistically significant relationship between mindfulness and spiritual care practices. Findings demonstrate that mindfulness explained 4.5 % of the variance in spiritual care practices.

Findings from this research add to nursing's body of knowledge. Using the newly developed NSCTS in this research helps to further establish reliability and supports validity for this instrument. Identifying a statistically significant relationship between mindfulness and spiritual care practices, adds to an emerging body of research investigating clinician mindfulness and patient care. Identifying mindfulness as a factor that influence spiritual care practices, also has implications for nursing education, research, and practice.

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## Appendix A

## Letter of Support



**One Penn Center West, Suite 450, Pittsburgh, Pennsylvania 15276-1000**

March 27, 2014

Institute Review Board  
Seton Hall University  
South Orange, NJ

Dear Board Members,

I write in support of the research proposal "Spiritual Perspective, Mindfulness and Spiritual Care in Hospice and Palliative Care Nurses", by Ms Patricia Ricci-Allegra, who is a Robert Wood Johnson New Jersey Nursing Scholar at your institution.

Her research will provide important information about the relationships among nurses' spiritual perspective and mindfulness and the provision of spiritual care by hospice and palliative care nurses.

Once her study is approved by the IRB, I will submit the proposal to the Board of Directors of the Hospice and Palliative Nurses Association (HPNA) for approval to disseminate it. An email invitation to participate will be sent to the members of two HPNA Special Interest Groups: the Research SIG (with approximately 372 members) and the Advance Practice Nurse SIG (with about 486 members). An invitation to participate in the survey will also be included in an eNewsletter sent to all members of HPNA. Since Ms Ricci-Allegra is a member of HPNA, and her research is consonant with the goals of the organization, I anticipate Board approval.

Please do not hesitate to contact me with any further questions. We look forward to supporting Ms Ricci-Allegra in her research.

Sincerely yours,

A handwritten signature in black ink that reads "June R. Lunney". The signature is written in a cursive, flowing style.

June R. Lunney, PhD RN  
Director of Research

**(412) 787-930 - fax (412) 87-9305 - email: [HPNA@hpna.org](mailto:HPNA@hpna.org)  
<http://www.HPNA.org>**

Appendix B

Seton Hall University IRB Approval

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

All material must be typed.

PROJECT TITLE: Spiritual Perspectives, Mindfulness and Spiritual Care Practices of Hospice and Palliative Care Nurses

CERTIFICATION STATEMENT:

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

Signature of Researcher(s) or Project Director(s) and date 8/18/14

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

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

Signature of Researcher's Advisor or Departmental Supervisor and date 8/18/14

\*\*Please print or type out name below signature\*\*

The request for approval submitted by the above researcher(s) was considered by the IRB for Research Involving Human Subjects Research at the Sept 2014 meeting.

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

Signature of Director, Seton Hall University Institutional Review Board for Human Subjects Research and date 9/24/14

## Appendix C

## Email Invitations to Special Interest Groups

**From:** "June Lunney" <JuneL@hpna.org>  
**To:** "ResearchSIG"  
**Date:** 10/20/2014 12:22:47 PM  
**Subject:** invitation to participate in a dissertation study about Spiritual Care Practices

HPNA Research Special Interest Group - Remember Reply goes to all

*Spiritual Care Practices Survey*

Registered Nurses and Advanced Practice Nurses who provide direct patient care are invited to participate in the *Spiritual Perspective, Mindfulness and Spiritual Care Practices of Hospice and Palliative Care Nurses* study. This research is being conducted by Patricia Ricci-Allegra, a PhD student at Seton Hall University, South Orange, NJ.

Please feel free to contact me at [patricia.ricciallegra@student.shu.edu](mailto:patricia.ricciallegra@student.shu.edu) for any questions.

If you would like to participate in this study, follow the link to a secure website where you will be able to access the survey

<https://www.surveymonkey.com/s/spiritualcarepracticeforhpna>

**Sent:** Tuesday, October 21, 2014 11:01 AM

**To:** hpnaapnsig

**Subject:** Invitation to Participate in a Study on Spiritual Care Practices

*Spiritual Care Practices Survey*

Registered Nurses and Advanced Practice Nurses who provide direct patient care are invited to participate in the *Spiritual Perspective, Mindfulness and Spiritual Care Practices of Hospice and Palliative Care Nurses* study. If you would like to participate in this study, follow the link to a secure website where you will be able to access the survey <https://www.surveymonkey.com/s/spiritualcarepracticeforhpna>

The HPNA Board approved the invitation for this study to be distributed among members. This research is being conducted by Patricia Ricci-Allegra, a PhD student at Seton Hall University, South Orange, NJ. Please feel free to contact her at [patricia.ricciallegra@student.shu.edu](mailto:patricia.ricciallegra@student.shu.edu) for any questions.

Constance Dahlin, ANP-BC, ACHPN, FPCN, FAAN

Director of Professional Practice

One Penn Center West, Suite 425  
Pittsburgh, PA 15276  
t. 412.787.9301 f. 412.787.9305

## Appendix D

eNewsletter Survey Link October 30, 2014

# Spiritual Care Practices Survey Opportunity

Registered Nurses and  
Advanced Practice  
Nurses who provide direct  
patient care are invited to  
participate in the Spiritual  
Perspective, Mindfulness  
and Spiritual Care  
Practices of Hospice and  
Palliative Care Nurses

study. This research is being conducted by  
Patricia Ricci-Allegra, a PhD student at Seton  
Hall University, South Orange, NJ.



Please feel free to contact her at  
[patricia.ricciallegra@student.shu.edu](mailto:patricia.ricciallegra@student.shu.edu) for any  
questions. If you would like to participate in this  
study, follow the link to a secure website where  
you will be able to access the survey.

[Take Me To The Survey](#)

## Appendix E

eNewsletter Survey Link November 14, 2014

# Last Call: Spiritual Care Practices Survey Opportunity

Registered Nurses and Advanced Practice Nurses who provide direct patient care are invited to participate in the Spiritual

Perspective, Mindfulness and Spiritual Care Practices of Hospice and Palliative Care Nurses study. This research is being conducted by Patricia Ricci-Allegra, a PhD student at Seton Hall University, South Orange, NJ.



Please feel free to contact her at [patricia.riccialegra@student.shu.edu](mailto:patricia.riccialegra@student.shu.edu) for any questions. If you would like to participate in this study, follow the link to a secure website where you will be able to access the survey.

[Take Me To The Survey](#)

## Appendix F

### Letter of Solicitation

#### **Invitation to Participate**

Licensed registered nurses and advanced practice nurses who provide direct patient care in hospice or palliative care settings are invited to participate in the “Spiritual Perspective, Mindfulness and Spiritual Care Practices of Hospice and Palliative Care Nurses” study. The primary investigator, Patricia Ricci-Allegra RN, APN, is a PhD student at Seton Hall University, College of Nursing. This research is in partial fulfillment of the requirements for the degree.

To be eligible to participate in the study you must be a licensed registered nurse or advanced practice nurse with one or more years of direct patient care in hospice or palliative care settings and have provided at least 36 hours of direct patient care in the two weeks prior to completing the survey.

#### **Purpose**

The purpose of this study is to examine the relationships between and among nurses’ spiritual perspective, nurses’ mindfulness and spiritual care practices of hospice and palliative nurses. Examining relationships that can affect spiritual care practices may impact nursing practice and education and offer new areas of inquiry for research in an area of hospice and palliative care nursing that is often misunderstood.

#### **Procedures**

The survey will take approximately 10 to 15 minutes to complete. The survey consists of a short demographic questionnaire and 3 Likert-type scales. The Spiritual Perspective Scale (Reed, 1987) contains 10 items measuring the saliency of one’s spiritual perspective such as “My spirituality is a significant part of my life”. The Mindful Attention Awareness Scale (Brown & Ryan, 2003) contains 15 items measuring mindfulness in everyday activities, for example “I find myself doing things without paying attention”. The 17 item Nurse Spiritual Care Therapeutics Scale (Mamier & Taylor, 2014) measures the frequency of spiritual care practices such as “arranged for a chaplain to visit a patient”.

#### **Voluntary Participation**

Participation is voluntary and there are no consequences for not participating. You may choose not to complete the survey or omit any questions without penalty. If you start and then decide not to complete the survey, you can simply log out of the survey and no data will be submitted or saved.

#### **Confidentiality**

A set function in SurveyMonkey® will ensure that email addresses will not be collected. IP addresses will be collected only to prevent duplicate submissions; no attempt will be made to identify or contact participants from IP addresses. Responses

will only be accessible to the primary investigator. To ensure confidentiality of responses, data submitted will be stored on two memory sticks and secured in a lock box only accessible to the researcher

**Risks/Benefits**

There are no anticipated risks with completion of the survey and benefits of individual participation are unknown.

If responding to any of the questions causes distress, you are encouraged to speak with a counselor of your choosing.

**Questions**

For any questions or concerns regarding this survey, please contact Patricia Ricci-Allegra RN, APN, PhD student  
Seton Hall University College of Nursing  
(973) 761-9306 or via email  
patricia.ricciallegra@student.shu.edu

If there are any questions or concerns that cannot be discussed with the investigator, you may contact her advisor, Dr. Jane Cerruti Dellert at  
(973) 761-9283 or jane.dellert@shu.edu.

If you have any questions concerning your rights as a research participant, you may contact Dr. Mary F. Ruzicka, Director of Seton Hall University's IRB at  
(973) 313-6314 or via email at irb@shu.edu

By completing and submitting this survey, you are giving your consent to participate.

Your time and participation are greatly appreciated.

THANK YOU

Patricia Ricci-Allegra RN, APN



## Appendix G

## Permission for the Spiritual Perspective Scale

Reed, Pamela G - (preed) <preed@email.arizona.edu>

Mon 9/23/2013 5:34 PM

1 attachment

[SPS\\_packet\\_2010.pdf](#)

Hello Patricia,

Thank you for your interest in the SPS. As you may know, many researchers have used it with success. I have sent it to you, along with some background information. If you have any questions about it, please let me know.

Best wishes in your plans for your doctoral research into spiritual care in the hospice setting.

Sincerely,  
Pam

*Pamela G. Reed, PhD, RN, FAAN  
Professor  
The University of Arizona  
College of Nursing  
1305 N. Martin St.  
Tucson, AZ 85721-0209  
USA*

Reed, Pamela G - (preed) <preed@email.arizona.edu>

Tue 9/24/2013 10:32 AM

Hi Patti -- oh yes, I forgot to mention that it's fine to use online. I expect you'll have to develop an electronic-friendly format for it. Great idea!

Also, you might include that open-ended question at the end, since respondents sometimes have views about spirituality that any instrument may not capture.

Thanks -- Pam

**SPS REQUEST FORM**

I, Patricia Ricci-Allegra request to copy the Spiritual Perspective Scale (SPS) for use in  
*(insert your name)*

my research titled Mindfulness , Spiritual Perspective Spiritual Care

for the following purpose: Dissertation  
*indicate the nature of the research (e.g. thesis, dissertation, work-related)*

In exchange for this permission, I agree to submit to Dr. Pamela G. Reed the following:

1. An abstract of my study purpose, framework, and findings, especially which includes the correlations between the SPS scale scores and any other measures used in my study, and the reliability coefficient (Cronbach's alpha) as computed on the scale from my sample.
2. Any other information or findings that could be helpful in assessing the reliability or validity of the instrument would be greatly appreciated (e.g., problems with items, comments from subjects, other findings).

This information will be used only to help determine the instrument's psychometric properties across various samples. No other use will be made of the information submitted. Credit will be given to me in any reports of normative statistics that make use of the information I submitted for aggregated analyses.

Date: November 12, 2013

Researcher's Name: Patricia Ricci-Allegra RN, APN

Professional Position: PhD student

Mailing Address:

Email Address: patricia.riccialegra@student.shu.edu

-----

Permission is hereby granted to copy the SPS for use in the research described above.

Pamela G. Reed, RN, PhD, FAAN

[preed@nursing.arizona.edu](mailto:preed@nursing.arizona.edu)

***Please return this form completed to Dr. Reed by email, and keep a copy for your own records.***

## Appendix H

## Permission for the Mindful Attention Awareness Scale

**Monroe Campus**

V i r g i n i a C o m m o n w e a l t h U n i v e r s i t y

**Department of  
Psychology**

White House  
806 West Franklin Street  
P.O. Box 842018  
Richmond, Virginia 23284-2018

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Dear Colleague,

The trait Mindful Attention Awareness Scale (MAAS) is in the public domain and special permission is not required to use it for research or clinical purposes. The trait MAAS has been validated for use with college student and community adults (Brown & Ryan, 2003), and for individuals with cancer (Carlson & Brown, 2005). A detailed description of the trait MAAS, along with normative score information, is found below, as is the scale and its scoring. A validated state version of the MAAS is also available in Brown and Ryan (2003) or upon request.

Feel free to e-mail me with any questions about the use or interpretation of the MAAS. I would appreciate hearing about any clinical or research results you obtain using the scale.

Yours,

Kirk Warren Brown, PhD  
Department of Psychology  
Virginia Commonwealth University  
806 West Franklin St.  
Richmond, VA 23284-2018  
e-mail [kwbrown@vcu.edu](mailto:kwbrown@vcu.edu)

## Appendix I

## Permission for the Nurse Spiritual Care Therapeutics Scale

Elizabeth Johnston Taylor <ejtaylor@llu.edu>  
Fri 4/4/2014 11:40 AM  
Inbox  
To:

You replied on 4/4/2014 5:53 PM.

Dear Patricia,

I am most willing to share the Nurse Spiritual Care Therapeutics Scale with you and have you use it to collect data via an online survey method. Again, we just ask that you cite its authors appropriately (and you can use the forthcoming West J Nurs Res article for it). And then at the end, we ask for a copy of your abstract so that we can learn from you, and if we choose to do further psychometric evals on the tool, that you share just the NSCTS data with us.

Thanks and all the best now as you proceed!

Beth

Elizabeth Johnston Taylor, PhD, RN  
Professor  
School of Nursing  
West Hall  
11262 Campus Street  
Loma Linda University  
Loma Linda, CA 92350  
Tel. (909) 558-1000 ext. 45465 [LLU office]  
Email. [ejtaylor@llu.edu](mailto:ejtaylor@llu.edu)

**From:** Patricia Ricci-Allegra  
**Sent:** Thursday, February 5, 2015 10:09 AM  
**To:** Elizabeth Johnston Taylor  
**Subject:** Permission

Dear Dr. Taylor,

I have met with my committee and they have agreed I am ready to defend my dissertation, *Spiritual Perspective, Mindfulness, and Spiritual Care Practices of Hospice and Palliative Care Nurses*.

Do I have permission to place the NSCTS as an Appendix in the dissertation that will be published online and accessed through online databases?

Thank you,

Patricia Ricci-Allegra RN, APN  
*Robert Wood Johnson New Jersey Nursing Scholar*  
*Seton Hall University*  
*College of Nursing*  
*South Orange, NJ*  
[patricia.riccialegra@student.shu.edu](mailto:patricia.riccialegra@student.shu.edu)

**From:** Elizabeth Johnston Taylor <ejtaylor@llu.edu>  
**Sent:** Thursday, February 5, 2015 12:13 PM  
**To:** Patricia Ricci-Allegra  
**Subject:** Re: Permission

Of course you do! Let me attach here the version you need to use. I realized a couple weeks ago that I've released it possibly with the wrong response options (some we toyed with at one point...yikes!). Here you go...

All the best at the defense!

Beth

CONFIDENTIALITY NOTICE: This e-mail communication and any attachments may contain confidential and privileged information for the use of the designated recipients named above. If you are not the intended recipient, you are hereby notified that you have received this communication in error and that any review, disclosure, dissemination, distribution or copying of it or its contents is prohibited. If you have received this communication in error, please notify me immediately by replying to this message and destroy all copies of this communication and any attachments. Thank you.

## Appendix J

## Mindful Attention Awareness Scale

## Day-to-Day Experiences

**Instructions:** Below is a collection of statements about your everyday experience. Using the 1-6 scale below, please indicate how frequently or infrequently you currently have each experience. Please answer according to what *really reflects* your experience rather than what you think your experience should be. Please treat each item separately from every other item.

	1	2	3	4	5	6
	Almost Always	Very Frequently	Somewhat Frequently	Somewhat Infrequently	Very Infrequently	Almost Never
I could be experiencing some emotion and not be conscious of it until some time later.	1	2	3	4	5	6
I break or spill things because of carelessness, not paying attention, or thinking of something else.	1	2	3	4	5	6
I find it difficult to stay focused on what's happening in the present.	1	2	3	4	5	6
I tend to walk quickly to get where I'm going without paying attention to what I experience along the way.	1	2	3	4	5	6
I tend not to notice feelings of physical tension or discomfort until they really grab my attention.	1	2	3	4	5	6
I forget a person's name almost as soon as I've been told it for the first time.	1	2	3	4	5	6
It seems I am "running on automatic," without much awareness of what I'm doing.	1	2	3	4	5	6
I rush through activities without being really attentive to them.	1	2	3	4	5	6
I get so focused on the goal I want to achieve that I lose touch with what I'm doing right now to get there.	1	2	3	4	5	6
I do jobs or tasks automatically, without being aware of what I'm doing.	1	2	3	4	5	6
I find myself listening to someone with one ear, doing something else at the same time.	1	2	3	4	5	6

I drive places on 'automatic pilot' and then wonder why I went there.	1	2	3	4	5	6
I find myself preoccupied with the future or the past.	1	2	3	4	5	6
I find myself doing things without paying attention.	1	2	3	4	5	6
I snack without being aware that I'm eating.	1	2	3	4	5	6

Appendix K

Nurse Spiritual Care Therapeutics Scale

**Nurse Spiritual Care Therapeutics Scale\***

Used with Permission from Dr. Elizabeth Johnston Taylor

Dear Nurse:

Please mark how often you used each of these activities. If you work 12-hour shifts, please consider the last 72 hours of work as the basis for your rating; if you work 8-hour shifts, please report on the last 80 hours.

Note that the word “patient” is used here in a broad sense. Interpret it to mean any person receiving your nursing care (e.g., family members as well as patients). Also, the term “illness” is used. You may need to substitute health challenge, loss, or other circumstance requiring nursing care. There are no right or wrong answers. Not frequently including a spiritual care activity in your practice could result from your determination that it was not appropriate for the circumstances. Thank you.

<b>During the past 72 (or 80) hours of providing patient care, how often have you:</b>	<b>Never (0 times)</b>	<b>Rarely about 1-2 times)</b>	<b>Occasion-ally (about 3-6 times)</b>	<b>Often (about 7-11 times)</b>	<b>Very Often (at least 12 times)</b>
Asked a patient about how you could support his or her spiritual or religious practices					
Helped a patient to have quiet time or space for spiritual reflection or practices					
Listened actively for spiritual themes in a patient’s story of illness					



Assessed a patient’s spiritual or religious beliefs or practices that are pertinent to health					
Listened to a patient talk about spiritual concerns					
Encouraged a patient to talk about how illness affects relating to God—or whatever is his or her Ultimate Other or transcendent reality					
Encouraged a patient to talk about his or her spiritual coping					
Documented spiritual care you provided in a patient chart					
Discussed a patient’s spiritual care needs with colleague/s (eg, shift report, rounds)					
Arranged for a chaplain to visit a patient					

Arranged for a patient's clergy or spiritual mentor to visit					
Encouraged a patient to talk about what gives his or her life meaning amidst illness					
Encouraged a patient to talk about the spiritual challenges of living with illness					
Offered to pray <i>with</i> a patient					
Offered to read a spiritually nurturing passage (e.g., patient's holy scripture)					
Told a patient about spiritual resources					
After completing a task, remained present just to show caring					

\* Current version of the NSCTS does not include the following in the response options: Never, Rarely, Occasionally, Often, and Very Often. The response options only include the number of times an activity was performed.

Appendix L  
Demographic Questionnaire

1. Please indicate your current professional role
  1. Staff nurse
  2. Advanced Practice Nurse
  3. Educator
  4. Manager/Supervisor
  5. Other \_\_\_\_\_
  
2. What is your present employment status?
  1. Full-time
  2. Part time
  3. Per diem
  
3. What is your gender?
  1. Male
  2. Female
  
4. What best describes your race/ethnicity?
  1. White/Caucasian
  2. Black/African American
  3. Asian/Pacific Islander
  4. Hispanic/Latino
  5. Other-Please Specify\_\_\_\_\_
  
5. What is your age in years? \_\_\_\_\_
  
6. What region of the country do you reside in?
  1. Northeast (CT, MA, ME, NH, NJ, NY, PA, RI, VT)
  2. South (AL, AR, DC, DE, FL, GA, KY, LA, MD, MS, NC, OK, SC, TN, TX VA, WV)
  3. Midwest (IA, IL, IN, KS, MI, MN, MO, NE, ND, OH, SD, WI)
  4. West (AK, AZ, CA, CO, HI, ID, MT, NM, NV, OR, UT, WA,WY)
  
7. Please indicate entry level nursing degree
  1. Associate degree
  2. Diploma graduate
  3. Baccalaureate

8. Please indicate your highest degree held
  1. Diploma
  2. Associate
  3. Baccalaureate in Nursing
  4. Baccalaureate/non nursing
  5. Master's degree Nursing
  6. Master's degree/non nursing
  7. Doctoral degree Nursing
  8. Doctoral degree/non nursing
  
9. Please indicate years of experience as an RN \_\_\_\_\_
  
10. If you are an Advanced Practice Nurse (APN), please indicate years of experience as an APN \_\_\_\_\_
  
11. Please indicate years of experience in hospice or palliative care nursing as a RN \_\_\_\_\_
  
12. Please indicate years of experience in hospice or palliative care nursing as an APN \_\_\_\_\_
  
13. Which shift do you primarily work?
  1. Days
  2. Evenings
  3. Nights
  
14. What type of setting do you practice in? (Check all that apply)
  1. Inpatient hospice
  2. Home hospice
  3. Palliative care inpatient
  4. Palliative care outpatient
  5. Hospice and palliative care
  
15. What is your practice population?
  1. Adults
  2. Pediatrics
  3. All ages
  
16. Have you ever received education in providing spiritual care?
  1. Yes
  2. No

17. Where did you receive education about spiritual care? (Check all that apply)

1. Undergraduate nursing program
2. Graduate Nursing program
3. In service/orientation
4. Conference/Continuing Education Units
5. ELNEC course
6. Other Please specify \_\_\_\_\_

18. Do you have a religious affiliation?

1. Yes
2. No

19. If you answered Yes, please indicate your religious affiliation\_\_\_\_\_