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A Study of Nursing Students and Intrinsic Spirituality

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By

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Abstract

This paper describes some theoretical perspectives of spirituality, the concepts of spiritual care and spiritual needs, and barriers to providing spiritual care as described in the literature. The two most frequently described barriers are lack of comfort with the topic and lack of education. Because there is so little written about the discussion of spirituality in schools of nursing, a descriptive study using nursing students on the central coast of California was conducted. The Spiritual Involvement and Beliefs Scale (SIBS) was used to measure intrinsic spirituality. This study looked for relationships between the scores on this scale, and the students' perception of the importance of participating in the spiritual care of their patients. Positive correlations were found between SIBS score and age, and with agreement that nurses should participate in spiritual care. A greater effort by nursing schools to facilitate students' understanding of their own spirituality and belief systems is encouraged.

A Study of Nursing Students and Intrinsic Spirituality

The renewed interest regarding spirituality in our society is reflected in the current nursing literature. The positive relationship between spiritual health and mental and physical health is accepted by most nursing scholars, even though there are unanswered questions about the quality and quantity of spiritual care that is actually being provided by nurses (Boutell & Bozett, 1990; Smucker, 1998; Wright, 1998).

While there is a lack of consensus about many various issues regarding spiritual care and nursing, there is a general agreement on two points. One is that nurses, in general, are ill prepared to provide spiritual care to their patients (Heliker, 1992; McSherry & Draper, 1998; Ross, 1996; Sterling-Fisher, 1998). The second is that there is a need for more education regarding spirituality since the most frequently mentioned barrier to providing spiritual care is lack of comfort with the topic of spirituality (Boutell & Bozett, 1990; McSherry, 1998; Narayanasamy, 1993; Piles, 1990; Ross, 1994). However, there is very little written about the role of nursing educators in formally exploring the topic of spirituality with nursing students. If a primary barrier to providing spiritual care is lack of preparation, then we need to examine this issue at the level of our nursing schools. The American Association of Colleges of Nursing (1997) states that

> Any vision for the future of nursing education must emanate from nursing's core values...In particular, a hallmark of nursing is the profession's emphasis on the whole person. Nursing's focus on promoting optimal health is broadly defined, encompassing not only every stage of development, but also the continuum of health and illness as well as physical, emotional, mental, social, and spiritual dimensions (p.3).

Significance to Nursing

The value of holistic care in nursing is one that is well established, and is based on the premise that the maintenance of health in a person requires an integration and balancing of mind, body, and spirit (Dossey, Keegan, Guzetta, & Kolkmeir, 1988; Narayanasamy, 1993). The

expectation that nurses will provide holistic care is both historical and contemporary (Boutell &

Bozett, 1990; Heliker, 1992; Martsolf & Mickley, 1998; Sterling-Fisher, 1998). Although the nature

and level of spiritual care may vary with the individual nurse, concerns of the spirit must be

considered along with those the body and mind as part of a comprehensive assessment (O'Brien,

1999). It is an assumption of this author that holistic nursing care is a goal of nursing and that holistic

care includes spiritual care.

In addition to being an integral part of holistic care, several governmental bodies and nursing

organizations, both in the United States (US) and the United Kingdom (UK), now specifically

recognize the need for spiritual care. Wright (1998) cites the North American Nursing Diagnosis

Association's (NANDA) nursing diagnoses of spiritual distress and spiritual well-being as an

example of this. The Joint Commission for Accreditation of Health Care Organization (1996)

declares it a "fundamental right [for patients to receive] care that safeguards their personal dignity

and respects their cultural, psychosocial, and spiritual values" (p. RI-1). The International Council of

Nurses' Code for Nurses instructs nurses to create or promote an environment which respects the

values, customs, and spiritual beliefs of the individual in order to promote recovery (Laukhuf &

Werner, 1998; Ross, 1996). In the United Kingdom, government guidelines direct schools of nursing

to address the topic of spirituality. Both the United Kingdom Central Council for Nursing, Midwifery

and Health Visiting and the Patient's Charter provide examples of how government and professional

organizations in the UK are mandating nurses to respect the cultural and spiritual beliefs of patients

(McSherry & Draper, 1997; 1998; Ross, 1996).

Professional Confusion About Spirituality

The lack of a clear definition of spirituality as it relates to health and illness presents a

challenge to researchers, educators, and practitioners (Martsolf & Mickley, 1998; Oldnall, 1996).

Spirituality is difficult to quantify by means of a research or assessment tool. Furthermore, the lack

of a clear definition stems from the fact that spirituality is a personal and therefore subjective topic,

making a single definition elusive. The concept of spirituality is multidimensional, depends on the perspective of the individual, and is highly influenced by culture (Heliker, 1992; McSherry, 1998; Narayansamy, 1999). Exploring nursing's long association with religion and religious institutions, as well as the different perceptions, or world-views, of spirituality can help to clarify this construct.

History

Barnum (1996) writes that as early as the 6th century BC health and cure were personified in Greek literature as gods and goddesses, linking religion with the care of the sick and the preservation of health. In pre-Christian Great Britain the practices of the Druids gave rise to priestesses who used herbs both in health and in communicating with the gods. In early Roman times, the 1st century AD, many of the early converts to Christianity were wealthy Roman women who embraced the Christian philosophy of service, manifested in the care of the sick. These women were the founders (and funders) of many hospitals and hospices. The association of nursing and religion continued through the Middle Ages, with monastic religious orders established to provide nursing care for the crusaders and victims of the plague. Many religious nursing communities, both Protestant and Catholic, exist to this day. Florence Nightingale, who viewed nursing as a spiritual vocation and spirituality as intrinsic to human nature, remains a strong influence on modern nursing theories and practice (Barnum; McSherry & Draper, 1998; O'Brien, 1999).

The place of spirituality in health care, however, changed with the beginning of the scientific era, when all ideas came under scientific scrutiny. Only those things that were tangible and measurable were considered legitimate and relevant. The technical aspects of care frequently overshadowed spiritual care. The result was that spirituality, at least in relationship to nursing, "was subsumed under aspects of psychology and sociology...[and] spiritual course content was reduced to a sociological review of the major religions and their applicable tenets" (Barnum, 1996, p. 4). Emblen (1992) examined the history of the words religion and spirituality as used in the nursing literature, and found that in the 1960s the two terms were used synonymously. However, in the

1970s, America became more secularized and the emphasis on religion declined.

The current literature reflects a renewed interest in reviving the spiritual dimension in all aspects of healthcare. There are three factors that have contributed to this renewed interest. The first is the spiritual focus of self-help groups, such as 12-Step programs (Barnum, 1996; Hatch, Burg, Naberhaus & Hellmich, 1998). The second is a renewed attention to the spiritual dimension by traditionally religious nurses, such as the parish nurse and hospice programs (Barnum). The third, which Barnum believes to be the strongest influence, she labels a "New Age" paradigm. This is a world paradigm shift, or "a change in the beliefs, values, and interpretations of reality within the larger society" (p. 58). The increasing number of individuals seeking alternative and complementary therapies such as hypnosis, acupuncture, meditation, and psychic healing exemplifies this in the health care domain. In response to the increased use of and interest in these therapies, Congress established an Office of Alternative Medicine within the National Institutes of Health in 1992 which supports research and training in this area. Third party reimbursement is now available for some therapies, while courses in alternative therapies have been established in several medical schools (Engebretson, 1999). While not negating the role of traditional science, these practitioners acknowledge and accept that there are phenomena pertaining to illness and health that do not easily lend themselves to scientific scrutiny for answers. The spiritual realm is an important component in many of these therapies.

Some Theoretical Perspectives on Spirituality in Health and Illness

World-views, or perspectives on the relationship of humanity to the universe, influence the questions we ask and the interpretations we make. World-views guide the formation of conceptual theories and models, and therefore guide nursing practices, curriculum development, administration, and research (Artinian, 1991; Martsolf & Mickley, 1998). When discussing spirituality, the concept of perspective is as important as a precise definition. If there indeed are "as many different interpretations of spirituality as there are people on this planet" (Long, 1997, p.497), then educators

must start by helping students understand their own perception or definition of spirituality. Doing so will help students identify differences between their beliefs and those of patients or family members which could prevent them from identifying subtle cues indicating a spiritual need. (Boutell & Bozett, 1990).

One perspective on spirituality, developed by and for nurses, is the Intersystem Model. This model describes the process of nurse-client interaction as two systems coming together to form an intersystem. It takes into account that both systems bring values and beliefs to an interaction and that both systems are continually changing because of this interaction. The biological, psychosocial, and spiritual subsystems are illustrated as three concentric circles. The spiritual subsystem is the inner circle, at the core, and is the basis of an individual's decision-making process which in turn directs responses to life situations and provides direction and meaning to life (Artinian, 1997; Cone, 1997; Emblen, 1997).

Using this model, Cone (1997) writes that spirituality is "the sense of self or personhood as well as that sense of relationship with a Supreme Being.... [and is] an experiential reality"(p.272). She emphasizes that it is not the same as religiosity, since religions are systems of ideas and principles, and tends to be culture bound. Spirituality, on the other hand, is transcultural, universal, and necessary for completeness. Contrasting views are expressed by Heliker (1992) who writes, "the roots of one's spirituality are culture bound" (p.16), and by Engebretson (1996) who declares that it is very necessary to explore culture in order to understand the spiritual domain. These three perspectives demonstrate how difficult it is to separate the concepts of spirituality, culture, and religion, because for many people they are closely intertwined.

This differentiation of religion and spirituality is also described, especially in the medical literature, as the difference between intrinsic and extrinsic spirituality (Hatch et al., 1998; McBride, Arthur, Brooks, & Pilkington, 1998). Extrinsic spirituality is described as shallow participation in religious activities and rituals, while intrinsic spirituality is the application of spiritual principles in

daily life, or the internal effects of the religious activities. McBride et al. feel that it is the intrinsic spirituality that may be associated with better health outcomes, and that research findings will be more consistent if intrinsic factors are measured.

Narayanasamy (1999) adds a biological component, citing researchers who hypothesize that spirituality is part of the biological make up of the human species, has a biological survival value, and is present in all individuals. Experiences associated with the spiritual dimension evoke feelings such as love, faith, hope, trust, awe, and inspiration, which provide meaning for an individual and a reason for existence. The spiritual dimension especially comes into focus when an individual faces emotional stress, physical illness, or death, periods when nurses are most likely to be involved.

Spiritual Care and Spiritual Needs

Since spirituality is so difficult to define, it is often discussed in terms of sub-concepts that are more quantifiable. Examples of these are spiritual need, spiritual care, spiritual well-being or distress, and spiritual assessment. Although they are all interrelated, it is usually only one or two of them that are the subject of discussion or research. In this paper, spiritual care and spiritual needs are the concepts that are studied.

Spiritual needs are "those resources that nourish the life force or spirit within each one of us" (Smucker, 1998, p. 96). Examples of these resources are (a) meaning and purpose of life, (b) the ability to give and receive love, hope, and forgiveness, and (c) faith or trust in someone or something that is highly valued. Smucker then defines spiritual care as any nursing action that strengthens or promotes any of these resources. Emblen (1992) writes that spiritual care is "helping people to identify meaning and purpose in their lives, maintain personal relationships, and transcend a given moment" (p.47). In contrast to spiritual care, religious care is that which includes "helping people maintain their belief system and worship practices" (Emblen, p. 47). Cone (1997) emphasizes the importance of individual assessment in order to avoid categorizing an individual by their cultural or religious label since even individuals within the same religion have different spiritual views and

needs.

Barriers to Providing Spiritual Care

Lack of a clear definition of spirituality has been discussed as one barrier to the provision of spiritual care, but there are other barriers identified in the literature. McSherry (1998) mailed a questionnaire to nurses in the UK in order to determine their perceptions of the concepts of spirituality and spiritual care. From the 559 responses that he received, he identified five barriers to the provision of spiritual care. Several of these barriers have been identified by other researchers as well (Narayanasamy, 1993; Ross, 1996; Sterling-Fisher, 1998; Wright, 1998).

The first barrier is economic, which includes lack of staff, time, and resources. Boutell and Bozett (1990), in a survey of 340 registered nurses in Oklahoma, found that the more acutely ill a patient, the less likely spiritual needs would be assessed. This suggests that high acuity may reduce time and resources for assessing spiritual needs.

The second barrier is educational, which McSherry (1998) described as lack of confidence due to lack of knowledge. Fifty-three percent of the nurses surveyed said that they had no educational preparation regarding spiritual care, and 72% indicated that they felt inadequately prepared to address spiritual care.

The third barrier identified by McSherry (1998) is ambiguity, described as fear of mismanagement related both to lack of education and difficulty of an individual in understanding their own belief system. The consequences of this personal lack of awareness are that difficulties in communication can arise when the beliefs of the nurse are threatened. Energy focused on personal feelings impairs the ability to actively listen, and this can negatively impact nursing assessment and patient care (Sterling-Fisher, 1998).

The fourth barrier identified by McSherry (1998) is environmental factors, such as lack of physical privacy. The fifth barrier he calls sensitivity, and refers to the personal nature of spirituality. He received comments such as "too personal" and "not an area nurses should be addressing" (p. 38).

Narayanasamy (1993) concluded from her study that there is an assumption "that spiritual care is the realm of the religious agents (hospital chaplains) and other religious representatives" (p. 199). One probable reason for this is that there is still confusion between the concepts of religion and spirituality.

Teaching Spiritual Care

Piles (1990) did a survey of nurses across the US designed to determine to what extent nurses were providing spiritual care, and came to similar conclusions as McSherry (1998). She identified four variables that predict the extent to which practicing nurses will provide spiritual care. They are (a) perceived ability; (b) education, or the degree of exposure in a basic program; (c) opinion, values, or attitudes; and (d) perceived obstacles, such as lack of time and lack of knowledge. All of these could be addressed through education, starting with the middle two in basic nursing education. What are some strategies and content suggested that nurse educators utilize when addressing these issues?

McSherry and Draper (1997) suggest several reasons for the absence of spirituality in many nursing curricula. One is a scarcity of resources such as time, energy, and financial. These are significant in many programs which already feel overstretched, with too much to teach in too little time. There are also social, cultural, or religious barriers that may exist within a society or within individual nurses. One conclusion that they reach is that self-awareness and introspection, for both faculty and students, is necessary if the issue is to be addressed adequately. Dossey et al. (1988), Smucker (1998), and O'Brien (1999) agree with this recommendation.

Piles (1990) recommends teaching (a) the difference between the psychosocial and spiritual dimensions, (b) the manifestations of spiritual needs, (c) necessary assessment skills, (d) appropriate intervention skills, and (e) evaluation of care. This recommendation, however, does not address the issue of attitudes and may be too simplistic. Widerquist (1991) cautions that it is very difficult to separate psychosocial and spiritual needs, since they often overlap. The nurse must often utilize "both psychological and spiritual interventions to meet the complex needs of human beings –

especially during stress and disease" (p.5). She also issues a reminder that it is necessary to differentiate between religious and spiritual needs and practices.

Cone (1997) agrees that it may be an oversimplification to separate the psychosocial and spiritual dimensions. She states that a nurse's ability to provide spiritual care depends on his/her own level of comfort with spiritual issues. "Spiritual care does not require a shared religious or philosophical worldview...[but] an empathetic concern and willingness to accept the other person's views and to assist that person along his or her own spiritual journey"(p. 273).

Berggren-Thomas and Griggs (1995) and Heliker (1992) echo the concept of assisting a client on their individual spiritual journey. Berggren-Thomas and Griggs advocate "an approach to spiritual care that sees each individual as being on a unique spiritual journey"(p. 9). Heliker writes that "to journey with a patient in this dimension, one must first recognize one's own spiritual journey and be willing, on some level, to share the process, decreasing barriers and eliminating biases" (p. 19). On this journey change is inherent, for both the nurse and the client.

This concept of journey and change is consistent with the concept of holism and with the Intersystem Model discussed previously. The implications for nursing educators are clear. Before a student can use the assessment tools we give them, they need to be open to change and diversity. They must be willing to be touched as well as to touch. However, are nurse educators assisting students with this process? Are we keeping up with the changing paradigm that society is experiencing? Although the literature regarding spirituality has increased over the last decade, there are few published studies regarding spirituality and nursing students. Since students are the reflection of the nursing education system, it is appropriate that they be included in research of issues regarding education.

<center>Methodology</center>

<u>Design</u>

Due to the lack of research with nursing students, especially on the West Coast, a descriptive

study in the form of a questionnaire was conducted, using a convenience sample.

Spirituality was measured by the Spiritual Involvement and Beliefs Scale (SIBS) developed by Hatch et al., (1998). This is a 39 item questionnaire that uses a 7-point Likert scale ranging from strongly disagree (1) to strongly agree (7). Scores can range from 39 to 273. First published in the Journal of Family Practice in June 1998, the primary author provided me with a revised version of the instrument, along with permission to use it and information on the testing for reliability and validity (R. Hatch, personal communication, March 26, 1999). The SIBS was designed to be applicable across religious traditions, to assess actions as well as beliefs, and to address key components of spirituality not assessed in other available measures (Hatch et al.). When discussing the aspect of spiritual involvement, the authors of the tool state that the majority of items measure intrinsic spiritual orientation rather than extrinsic orientation. Although not specifically developed to measure spiritual well-being, construct validity was measured against the Spiritual Well-Being Scale developed in 1983, an instrument which seems to be correlated with spiritual well-being.

The use of a new instrument, which is still being tested, is one of the limitations of this study. However, I chose to use the SIBS over the Spiritual Well-Being Scale because I believe it reflects a more inclusive and less Judeo-Christian perspective on spirituality.

In addition to the SIBS, I administered an additional questionnaire which asked for brief demographic data, and a rating (on a scale of 1-7) of the students' agreement or disagreement with two statements. In order to be consistent with the SIBS, 7 was strongly agree, and 1 was strongly disagree. Question one (Q1) was: I feel that it is important for nurses to participate in the spiritual care of patients. Question two (Q2) was: I feel prepared by my nursing program to address the spiritual needs of my patients. For the third question (Q3), the students were asked to indicate (from none to >5 hours) the amount of time that they thought was formally spent in the nursing program discussing spirituality. The mean response was between 2.7 hours.

The research questions were (a) Is there a relationship between senior nursing students'

scores on the SIBS and their perception of the importance for nurses to participate in the spiritual

care of their patients? (b) Is there a relationship between senior nursing students' scores on the SIBS

and how well they perceive their nursing school curricula prepared them to address the spiritual

needs of patients? and (c) Is there a difference in the mean scores on the SIBS between students in

baccalaureate (BSN) and Associate Degree (ADN) schools?

Subjects and Setting

The subjects were senior nursing students at two California State University BSN nursing

programs and four Community College ADN programs. The schools are all located in the central

coastal area of California. Senior nursing students were selected because it is assumed that they have

received the didactic knowledge regarding spirituality offered by their nursing program. Since many

ADN programs start new classes only in the fall semester, students in three of the ADN programs

were in the start of their third (of four) semesters. This raised the concern that they may not have yet

had this didactic learning. However, instructors at these schools indicated that spirituality was not

part of the course content for this semester, so this was not felt to be a significant factor. Students in

the other programs were in their last semester or quarter.

Sampling and Procedure

The Human Subjects-Institutional Review Board of one of the participating State Universities

approved the study and permission was received from each of the schools of nursing to recruit

volunteers. For all but one group the study was explained verbally and each participant was provided

with a letter that explained the purpose of the study and their rights. One group received only the

letter. Turning in a completed questionnaire was considered implied consent. Confidentiality was

assured since the questionnaires were anonymous. Students were given a choice of filling out the

questionnaire and turning it in directly, or taking a self-addressed envelope and returning it by mail.

The age of the respondents ranged from 20 to 53, with a mean age of 31 years. There were

135 (90%) females, and 15 (10%) males. Ninety-seven students (65%) indicated their spiritual

practice was Christian, 4 (3%) Buddhist, 4 Hindu, 2 (1 %) agnostic, 1 (< 1%) atheist, 1 Jewish, and 9 (6%) identified a category which was labeled other. Thirty-two (21%) wrote none, or left the line blank.

Data Analysis

A total of 150 questionnaires were returned, although twelve questionnaires had one or more questions on the SIBS left unanswered. Therefore, whenever there was a correlation that involved the SIBS, n=138. The mean was calculated for the SIBS and for each question (Table 1). For the three research questions, the Pearson product-moment correlation coefficient (r) was calculated to determine if there was a relationship between the SIBS score and the corresponding question on the first page of the questionnaire.

Table 1: Descriptive Statistics for SIBS and the three research questions

The first research question asked about a relationship between SIBS scores and the students' agreement with the statement that it is important for nurses to participate in the spiritual care of patients. Eleven respondents (7%) disagreed with this statement to some degree, 115 (66%) agreed, and 23 (15%) were neutral. There was a positive correlation between SIBS total score and the level of agreement, with $r = .287$ at the .01 level.

The second research question asked about a relationship between SIBS scores and the statement that their nursing curriculum prepared them to address the spiritual needs of patients. There was no significant relationship found between the two. However, the majority (57%) of students did agree to some extent that their program had prepared them to address the spiritual needs of their patients. There was also no relationship between the mean scores on this question and the type of school (ADN vs. BSN).

The third research question asked if there was a significant difference in the mean scores on the SIBS between students in the BSN programs and the ADN programs. No significant difference was found. There was a difference in numbers of students from each of the two programs, and it is

unknown if this was a factor. Table 2 illustrates the mean scores of each school.

Table 2 – SIBS Means by School

Discussion

One of the limitations of the study was the convenience sample. The use of volunteers implies self-selection, and raises the question of diversity. Although all students in a class had an equal chance of participating, it is possible that those who identified themselves as 'not spiritual' might have chosen to not complete the questionnaire. However, since 21% of the respondents described themselves as not having a spiritual or religious practice, it is not felt that this was a significant factor.

The significant demographic factor was age, perhaps because with age comes life experience. Widerquist (1991) states that in order to provide effective spiritual intervention, life experience is required in addition to academic preparation. Ross (1994) concluded from her study that spiritual care is performed on different levels, and described characteristics that suggest life experience and maturity as high factors. Those nurses who performed spiritual care at a deep level demonstrated the following four characteristics to a greater degree than those who gave such care at a more superficial level. The first is that they were aware of the spiritual dimension in their own lives. The second was the experience of a life crisis that acted as a stimulus for growth. The third was a willingness to give of themselves at a deep, personal level. The fourth was that they were sensitive/perceptive people. This is also consistent with the theme of a journey mentioned earlier, and the fact that spiritual growth is an ongoing task of life.

The positive correlation of SIBS score and agreement that nurses should participate in spiritual care corresponds to some degree with five studies cited by Ellison and Smith (1991). These studies suggested that the spiritual well-being of nurses had a positive impact on their attitude and practice of providing spiritual care to patients.

Implications

I think that it is encouraging that the majority (66%) of students felt that it was important for nurses to participate in the spiritual care of patients, and that 57% of the participants felt prepared by their nursing programs to do this. The students had varied perceptions as to the time formally spent in discussing this topic. There was no agreement among students in each school as to the amount of time that had been spent. Many students thought that much more time had been spent when compared to the time reported by instructors at the schools. This suggests that the subject of spirituality may be covered informally, perhaps during clinical conference or at other times when smaller groups meet. Because coverage of this issue is dependent on the individual instructor's interest and comfort level, it means that the amount and quality of time spent may be inconsistent. It also means that the time is available in the curriculum to discuss spirituality. The first step is for each school to be intentional about including spirituality in the curriculum. Brittain and Boozer (1987) describe how spiritual care was integrated into the curriculum of an ADN program. Their experience showed that "it is not necessary...to devote specialized courses or seminars or to usurp large blocks of teaching time in order to address religious, spiritual, and ethical concerns" (p.159). They started with self-reflection, which has been recommended repeatedly in this paper. The SIBS is a tool that could be used for reflection, and as a starting place for discussion. This is an area for further research. Other areas for exploration are the relationship of intrinsic spirituality, as measured by the SIBS, to other factors that are known to affect student performance, such as depression, hope, and self-esteem.

Many of the nursing students today are coming to nursing school with a greater amount of life experience. The mean ages at all of the schools surveyed ranged from 29 to 33. Still, many of them are unprepared for the magnitude of despair that confronts them during their hospital rotation, leaving them at risk for experiencing spiritual distress. The students do need to have knowledge about different religions, and tools which can assist them in performing spiritual assessments. It is even more imperative, however, that they understand what gives them hope and meaning in life, and

that they learn how not to be threatened by beliefs other than their own. Educators can facilitate this process. If we expect students to assist patients or clients on their spiritual journey, then we need to be ready to assist the students on theirs. This process starts with educators reflecting on their feelings about spirituality, and where they are on their spiritual journeys.

Gallia (1996) suggests that this process can be encouraged if schools of nursing, and their parent colleges or universities, provide an environment that creates a support network for the students. This could include wellness courses, financial aid, and social programs such as parenting classes and childcare. Gallia suggests that faculty also provide a nurturing, supportive environment for themselves.

Conclusion

California is known to be an incredible mix of cultures, with a large number of people without a specific religious affiliation. A broad understanding of spirituality, which differentiates the spiritual from the religious, is necessary for the effective practice of spiritual care. The literature has shown that this is an important concept regardless of an area's cultural diversity, however. Schools of nursing need to facilitate their students' understanding of their own spirituality and belief systems by intentionally including this topic in the curriculum. This process will start with educators becoming comfortable with their own spirituality.

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Table 1: Descriptive Statistics of SIBS and Questions 1, 2, and 3.

	Mean	SD	N
SIBS total	201.2	33.1	138
Q1	5.6	1.4	149
Q2	4.4	1.5	150
Q3	2.7 hr.	1.8	145

Table 2: Mean scores of SIBS by School

School # and Type	N	Mean	SD
#1 – ADN	25	197.84	32.11
#2 – ADN	11	202.81	30.83
#3 – ADN	28	204.82	37.03
#4 – ADN	31	208.42	30.32
#5 – BSN	13	204.62	27.23
#6 – BSN	30	191.20	35.87