eCOMMONS

Loyola University Chicago
Loyola eCommons

Dissertations

Theses and Dissertations

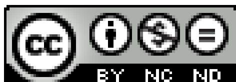
2011

Spiritual Care in Advanced Practice Nursing

Barbara Baele Vincensi
Loyola University Chicago

Recommended Citation
Vincensi, Barbara Baele, "Spiritual Care in Advanced Practice Nursing" (2011). *Dissertations*. Paper 201.
http://ecommons.luc.edu/luc_diss/201

This Dissertation is brought to you for free and open access by the Theses and Dissertations at Loyola eCommons. It has been accepted for inclusion in Dissertations by an authorized administrator of Loyola eCommons. For more information, please contact ecommons@luc.edu.



This work is licensed under a Creative Commons Attribution-Noncommercial-No Derivative Works 3.0 License.
Copyright © 2011 Barbara Baele Vincensi

LOYOLA UNIVERSITY CHICAGO

SPIRITUAL CARE
IN ADVANCED PRACTICE NURSING

A DISSERTATION SUBMITTED TO
THE FACULTY OF THE GRADUATE SCHOOL
IN CANDIDACY FOR THE DEGREE OF
DOCTOR OF PHILOSOPHY

PROGRAM IN NURSING

BY
BARBARA BAELE VINCENSI
CHICAGO, ILLINOIS

AUGUST 2011

Copyright by Barbara Baele Vincensi, 2011
All rights reserved.

ACKNOWLEDGEMENTS

I would like to thank those who made this dissertation possible starting with the American Holistic Nurses Association and Sigma Theta Tau International, Kappa Epsilon chapter-at-large, for grants that partially funded this study. Also my committee chair Dr. Lisa Burkhart, for her assistance and thought-provoking questions which helped to keep me on track and dig deeper into the underlying philosophy of spirituality, expanding my consciousness in Margaret Newman style. My committee members also provided insightful and sage advice: Dr. Vicki Keough, Dr. Mary McDermott, and especially Dr. Barbara Velsor-Friedrich, who had a calming presence throughout this process.

I especially would like to thank my parents who have been supportive of me in all my endeavors in life, and my daughter, Liz, who frequently brought me comfort food and support when I felt I could not continue writing. The comfort and support were much appreciated. In addition I could not have started on this journey without the guidance and encouragement of my cousin and friend, Mary Ann.

I am thankful also for friends of many years who helped celebrate the small accomplishments and provided spiritual care as needed throughout this journey, including assistance with some editing. I appreciate your companionship Mary B., Liz C., Diane, Sally, and Ed. Finally, I would like to acknowledge my sister Mary, who has been an inspiration of courage and determination for me this past year.

To my parents, Roger and Mary,
and to my daughter, Liz

TABLE OF CONTENTS

ACKNOWLEDGEMENTS iii

LIST OF TABLES viii

LIST OF FIGURES x

ABSTRACT xi

CHAPTER ONE: IMPROVING CLIENTS' HEALTH THROUGH SPIRITUALITY 1
Research Questions 6

CHAPTER TWO: SPIRITUAL CARE IN ADVANCED PRACTICE NURSING 9
Overview of the Literature: A Chronological View 9
Defining Spirituality and Spiritual Care 11
Defining Spirituality 11
Defining Spiritual Care 16
Nursing Theories 17
Conceptual Relationships between Spirituality, Spiritual Care, and Related Nursing Theories 17
Conceptual Model of the Geriatric Nurse Practitioner's Role in Expanding Client Consciousness and Supporting Health through Spiritual Care 28
Research in Spiritual Care 31
Attitudes, Beliefs, and Perceptions of Those Providing Spiritual Care 32
Attitudes, Beliefs, and Perceptions of Those Receiving Spiritual Care 42
Perceived Barriers to Providing Spiritual Care 44
Gaps in the Literature 52
Education 52
Time 53
Summary 54

CHAPTER THREE: METHODS 56
Purpose 56
Research Design 57
Sample 57
Variables and Instrumentation 58
Demographic Variables 58
Spiritual Perspectives of Nurse Practitioners 59
Spiritual Care Nursing Assessments 62
Spiritual Care Nursing Interventions 69
Data Collection and Management 76
Content and Face Validity Experts 76
Pilot Study and Research Protocol 79
General Survey 80

Ethical Concerns 81
Data Analysis 82
Summary 88

CHAPTER FOUR: RESULTS 90
Survey Response 90
Data Cleaning and Data Entry 91
Sample and Sample Characteristics 91
Data Analysis Results 93

CHAPTER FIVE: DISCUSSION AND CONCLUSIONS 127
Limitations 127
Generalizability Related to Sample 127
Survey Research 128
Reliability and Validity of VSAT and VSCIT 129
Strengths 130
The Spiritual Perspectives of GNPs 130
Religion and Culture 131
How GNPs Describe Spirituality 133
Integration of Spiritual Assessments into GNP Practice 135
Client Cues and Behaviors 136
Further Follow-up Assessment of Spiritual Care Needs 138
Belief in Ability to Recognize Spiritual Care Needs in Others 139
Specific Tools Used by GNPs to Evaluate Clients' Spiritual Care Needs 140
Integrating Spiritual Care Interventions into Practice 141
Geriatric Nurse Practitioner Generated Spiritual Care Interventions 142
Geriatric Nurse Practitioner Provision of Client-Requested Spiritual Care Interventions 143
Conceptual Model with Influencing Variables 143
The Relationship of Geriatric Nurse Practitioners' Spiritual Perspectives and Integration of Spiritual Assessments and Spiritual Care Interventions into Practice 145
Spiritual Perspectives and Individual Spiritual Assessment Items 146
Spiritual Perspectives and Individual Spiritual Care Intervention Items 147
Implications for Research 148
Implications for Education 149
Implications for Practice 150
Conclusions 150

APPENDIX A: RESEARCH DATABASES 153

APPENDIX B: ATTRIBUTE GRIDS OF SPIRITUALITY(1992–2007) AND SPIRITUAL CARE (1994–2006) 155

APPENDIX C: RESEARCH LITERATURE 168

APPENDIX D: CONCEPTUAL MODEL: MARGARET NEWMAN'S THEORY OF HEALTH AS EXPANDING CONSCIOUSNESS BASED ON PRIGONGINE'S THEORY OF DISSIPATIVE STRUCTURE 240

APPENDIX E: CONCEPTUAL MODEL BASED ON HEALTH AS EXPANDING CONSCIOUSNESS, SPIRITUALITY, AND GNP-CLIENT RELATIONSHIP 242

APPENDIX F: TOOLS IN THE LITERATURE 244

APPENDIX G: SOCIAL EXCHANGE THEORY & NURSING SPIRITUAL CARE CONCEPTS 248

APPENDIX H: POWER ANALYSIS 250

APPENDIX I: LETTER TO CONTENT VALIDITY EXPERTS 252

APPENDIX J: CONTENT VALIDITY SUMMARY: VSAT AND VSCIT 255

APPENDIX K: PARTICIPANTS' SURVEY PACKAGE 267

APPENDIX L: COMPARISON OF RECOMMENDED COMPETENCIES AND CURRICULIM FOR NURSE PRACTITIONERS IN GERIATRIC CARE 277

APPENDIX M: CONTENT ANALYSIS: DIRECT QUOTES AND MEANING UNITS MAPPED INTO THE RESEARCH DEFINITION 283

APPENDIX N: CONTENT ANALYSIS: DIRECT QUOTES AND M EANING UNITS WHICH DID NOT MAP INTO RESEARCH DEFINITION 293

REFERENCE LIST 298

VITA 312

LIST OF TABLES

Table Page

1. Reed's Spiritual Perspective Scale 61

2. Referenced Vincensi Spiritual Assessment Tool (VSAT) 65

3. Content Validity Summary of Vincensi Spiritual Assessment Tool (VSAT) 68

4. Vincensi Spiritual Assessment Tool (VSAT) 71

5. Referenced Vincensi Spiritual Care Interventions Tool (VSCIT) 74

6. Content Validity Summary of Vincensi Spiritual Care Interventions Tool (VSCIT) 77

7. Vincensi Spiritual Care Interventions Tool (VSCIT) 78

8. Demographic Information of the Sample 92

9. SPS Items with Above Average Means 94

10. Content Analysis: Themes Mapping into the Research Definition 97

11. Content Analysis: Themes Which Did Not Map into the Research Definition 100

12. Inter-item Correlation Matrix for Vincensi Spiritual Assessment Tool (VSAT) Cues and Behaviors 102

13. Inter-item Correlation Matrix for Vincensi Spiritual Assessment Tool (VSAT) Further Assess 103

14. Cronbach's Alpha for the Vincensi Spiritual Assessment Tool (VSAT) Subscales and Items 8 & 9 103

15. Descriptive Statistics of the Vincensi Spiritual Assessment Tool (VSAT) Subscale of Cues and Behaviors and Demographic Data 105

16. Vincensi Spiritual Assessment Tool Cues (VSAT) and Behaviors Significant *t*-test Scores for Differences Based on Demographic Variables 107

Table | Page

17. Vincensi Spiritual Assessment Tool (VSAT) Subscale Mean Scores and Overall Tool Mean 107

18. Descriptive Statistics of the Vincensi Spiritual Assessment Tool (VSAT) Subscale of Further Assess and Demographic Variables 109

19. Vincensi Spiritual Assessment Tool (VSAT) Further Assess Significant *t*-test Scores for Differences Based on Demographic Variables 110

20. Descriptive Statistics of Item 10 on the Vincensi Spiritual Assessment Tool (VSAT): Belief in Ability to Recognize When Clients Need Spiritual Care 111

21. Spiritual Assessment Tools Utilized by GNPs 113

22. Inter-Item Correlation Matrix for Vincensi Spiritual Care Interventions Tool (VSCIT) GNP Generated Items 1–10 116

23. Inter-Item Correlation Matrix for Vincensi Spiritual Care Interventions Tool (VSCIT) Client Generated Items 11–15 117

24. Cronbach's Alpha if Item Deleted from Vincensi Spiritual Care Interventions Tool (VSCIT): Items 1–10 118

25. C Cronbach's Alpha if Item Deleted from Vincensi Spiritual Care Interventions Tool (VSCIT): Items 11–15 119

26. Descriptive Statistics of the Vincensi Spiritual Care Interventions Tool (VSCIT) Subscale of GNP Initiated Interventions 121

27. Descriptive Statistics of the Vincensi Spiritual Care Interventions Tool (VSCIT) Subscale of Client Requested Interventions 123

LIST OF FIGURES

Figure Page

1. Vincensi Conceptual Framework with Influencing Factors for Provision of Spiritual Care 31

2. Vincensi Spiritual Assessment Tool (VSAT) Cues and Behaviors 102

3. Vincensi Spiritual Assessment Tool (VSAT) Subscale Further Assess 104

4. Vincensi Spiritual Assessment Tool (VSAT) Entire Tool Mean Scores 106

5. Histogram for Vincensi Spiritual Assessment Tool (VSAT) Item 10: Belief in Ability to Recognize When Clients Need Spiritual Care 112

6. Histogram Vincensi Spiritual Care Intervention Tool (VSCIT) GNP Initiated Interventions 118

7. Histogram Vincensi Spiritual Care Intervention Tool (VSCIT) Client Initiated Interventions 119

8. Vincensi's Expanded Conceptual Framework with Influencing Variables 144

ABSTRACT

Spiritual care has the potential to improve clients' health and quality of life. Since clients desire spiritual care from their health care providers as they age or as their health worsens, geriatric nurse practitioners (GNPs) were chosen to participate in this study. This cross-sectional, descriptive, survey design investigates the relationships and differences between practicing GNPs spiritual perspectives and their ability to assess clients' spiritual care needs (SCN) and provide specific spiritual care interventions (SCI). Differences and relationships were also investigated based on demographic variables of the GNPs. In addition, participants were asked to define spirituality in an open ended question. Using a conceptual framework based on Newman's Theory of Health as Expanding Consciousness and the spirituality/spiritual care literature, this research suggested expanding the consciousness of the GNP. This could be accomplished with an increased intrapersonal relationship as well as pattern recognition by the GNP and client within an interpersonal relationship and energy exchange.

Practicing GNPs were surveyed using Reed's Spiritual Perspectives Scale and two new tools developed for this research: Vincensi Spiritual Assessment Tool (VSAT) and Vincensi Spiritual Care Intervention Tool (VSCIT). Content validity was completed and internal reliability scores ranged from 0.87 to 0.93 on the new tools. Findings indicated GNPs' spiritual perspectives are high-moderate at 4.73 on a 1-6 Likert scale,
and are influenced by religion and ethnicity/race/culture. Significant relationships were

not found between the GNPs' spiritual perspectives and subscales of the VSAT and the GNP generated subscale of the VSCIT. Significant differences were found with gender, graduate education on spiritual care, and further education on spirituality/spiritual care outside of the academic setting. The frequency of assessing SCNs and providing SCIs to clients increased when significant differences existed. These findings highlight the importance of including content on spiritual care in graduate curricula and continuing education programs for practicing GNPs. Including spiritual care content in the graduate curricula may increase spiritual self awareness and spiritual care skills for use in practice.

The participants' definition of spirituality mapped into the conceptual definition developed for this study, however two new themes emerged. These included spirituality as a moral and ethical base for being and acting in the world, and spirituality as an influence in fulfilling human needs. Further research into the literature is recommended on these two new themes and their relationship to spirituality as they were not part of the research definition or found in the literature.

CHAPTER ONE

IMPROVING CLIENTS' HEALTH THROUGH SPIRITUALITY

Supporting clients' spirituality through spiritual care has the potential to improve the health of clients in a number of ways including better adherence to a plan of care, encouraging health promoting behaviors, and buffering psychological distress and social isolation (Boland, 2005; Springer, Newman, Weaver, Siritsky, Linderblatt, Flannelly, & VandeCreek, 2003). Clients not only may benefit from spiritual care but express a desire for it as they age or as their health worsens (Conner & Eller, 2004).

Spiritual care in western nursing has historical roots in ancient and medieval times (Achterberg, 1990). Spirituality, spiritual beliefs, and spiritual care were closely tied to health in these historical settings until the advent of the scientific revolution in the 16th century, when logical positivism separated the individual into three distinct areas cared for by three different disciplines: mind (psychology), body (medicine), and spirit (theology) (Dossey, Keegan, & Guzzetta, 2005; Klemke, Hollinger, & Rudge, 1998; Moser & VanderNat, 2003). Florence Nightingale later formalized and established nursing as a calling from God and a holistic discipline (Nightingale, 1969). Reintegrating these three dimensions into care of the individual began to reemerge in the late-20th century, when spirituality and spiritual care were incorporated into nursing care in the last two decades (Hagedorn, 2004; Maddox, 2001; Mesnikoff, 2002; Stranahan, 2001; Tuck, 2004).

Research on spiritual care has shown that spirituality is associated with higher states of health (Conner & Eller, 2004). Individual spirituality is linked to better physical, psychological, and social health dimensions in the research literature. These improved dimensions are demonstrated by higher levels of spiritual well-being (SWB) that support elders in committing to health promoting behaviors, and clients with chronic diseases committing to follow their plan of care (Bingham & Habermann, 2006; Boland, 2005; Peterman, Fitchett, Brady, Hernandez, & Cella, 2002; Singleton, 2002). Other research has indicated an inverse relationship between depression and SWB, as well as loneliness and SWB (Daaleman & Frey, 2004; Frey, Daaleman, & Peyton, 2005; Springer, et al., 2003). Spirituality for clients with chronic or life limiting diseases is life affirming and provides a means of coping and developing hope, which improves their quality of life, decreases depression, and promotes social interactions (Mactavish & Iwaski, 2005; Taylor, 2003; Walton, 2002). Quality of life, changes in depression, enhanced coping, and social interactions are frequently used to quantify health in the spirituality research.

This evidence of linking spiritual care to improved client outcomes has led accrediting agencies such as the Joint Commission of Accrediting Healthcare Organizations (JCAHO), as well as professional organizations such as the American Nurses Association (ANA) to recognize the importance of spiritual care in their standards, social policy statement, and code of ethics (ANA, 2001; ANA, 2003; JCAHO, 2004). The role of the nurse in providing care to the whole person is confirmed by specialty and professional standards that delineate the nurses' role in promoting the health and well-being of clients (ANA, 2003). Care of the spirit is considered part of the

holistic care of nursing as identified within the standards of practice and curricula competencies for nursing programs (American Association of Colleges of Nursing [AACN], 1995; AACN, 2006; ANA, 2001; ANA, 2003; National Organization of Nurse Practitioner Faculty [NONPF], 2002). Certain nursing specialties highlight the importance of spiritual care in their practice, for example, parish, oncology, and hospice nursing (Sellars & Haag, 1998; Solari-Twadell, 2002; Taylor, 2008).

Nurse practitioners (NPs) in particular have the potential to promote spiritual well-being because they are often the only Health Care Provider (HCP) many clients see, and they build long-term relationships with their clients (Donohue, 2003). Development of long-term relationships with clients is a hallmark of NP practice in primary care. Nurse practitioners are educated and socialized to think in a person-centered, holistic way about their clients and provide holistic approaches to health and health promotion as well as chronic disease and health maintenance care (NONPF, 2002). Looking beyond the physical and psychological complaints of clients, NPs provide care to the whole person which includes or incorporates the clients' spiritual beliefs into a holistic plan of care (AACN, 1995; AACN & The John Hartford Foundation [AACN/JHF], 2004; NONPF, 2002). Although NPs are well positioned to provide spiritual care, it is unclear whether NPs actually engage in spiritual care with their clients, which is generally not taught in graduate nursing education programs (AACN [MSN], 1995; AACN [DNP], 2006; AACN/JHF, 2004; NONPF, 2002; NONPF, 2006; Stranahan, 2001).

The NONPF has published strict guidelines that delineate the scope of practice and standards of care for NPs (NONPF, 2002; NONPF, 2006). Core educational

competencies for NPs briefly address how they are expected to meet clients' spiritual needs. These competencies address the need for NPs to support client health and spiritual needs through the NP-client relationship and use of NP self-reflection (NONPF, 2002). The NONPF guidelines support the self-reflection process; however, other national accrediting bodies for NPs do not address the spiritual care component of the NP role. Further research is needed to better understand current NP practice in providing spiritual care. Very little attention has been given to the provision of spiritual care by NPs, who potentially develop long-term relationships with clients with chronic diseases, especially in primary care settings (Donohue, 2003; Gray, 2006; Hubbell, Woodard, Barksdale-Brown & Parker, 2006).

Increased medical and technological advances allow for increased longevity, but these advances need to be tempered with care to the human spirit (Gray, 2006). Diseases impacting mortality and morbidity of Americans have changed significantly over the past century, with chronic diseases such as cardiovascular disease, diabetes, chronic lower respiratory disease, and cancer being the primary causes of disability and death (Council of State Governments, 2006). Such diseases account for 70% (1.7 million) of all deaths in the United States. In 2005, 133 million people, or close to 50% of all Americans, were living with at least one chronic health condition. Disabling pain and suffering due to chronic disease causes major limitations in activity for 1 in every 10 Americans (25 million) and significantly decreases quality of life (National Center for Chronic Disease Prevention and Health Promotion, 2008). There will be increased numbers of those who

will have to endure disability and decreased quality of life as larger numbers of the population ages and lives with chronic health conditions.

Clients have also identified a desire for humanistic and holistic care, where spirituality and relationships are seen as important to healing and health (Reed, 1991; Conner & Eller, 2004). An emerging developmental theory and field of research in gerotranscendence has provided new evidence of how important spiritual, cosmic, and transcendent experiences and relationships are to health and human development in the later years of life (Jonson & Magnusson, 2001; Tornstarn, 2003; Wadensten & Carlsson, 2001). Because clients of geriatric nurse practitioners (GNPs) are “generally” or by definition older than 65 years of age, and most are managing at least one chronic disease, GNPs are in a position to enhance the health of their clients by providing spiritual care. However, it is uncertain if spiritual care is provided by GNPs, and spiritual care lacks visibility in the curriculum of graduate nursing education (AACN, 2006; AACN/HGNI, 2004; NONPF, 2002; Stranahan, 2001). Lack of spiritual care by GNPs could potentially impact clients’ health since the provision of spiritual care has been shown to have a relationship to enhanced psychological, physical, and social health dimensions, especially of the older adult and those with chronic diseases (Boland, 2005; Mactavish & Iwasaki, 2000; Singleton, 2002; Taylor, 2003; Walton, 2002).

This study will focus on spirituality and the spiritual care provided by GNPs working in the geriatric environment. Most of the literature in spirituality and spiritual care in nursing has focused on the staff nurse and not the advanced practice nurse. Research now demonstrates that client response and health dimensions improve with the

provision of spiritual care. Research has also indicated that those who desire spiritual care from their health care providers are advancing in age and have progression of chronic disease processes (Conner & Eller, 2004). Since research indicates there is a relationship between the provision of spiritual care and improved health, it is important to examine current GNP practice regarding the assessment of spiritual care needs and provision of spiritual care to clients as it relates to health. Therefore, research is needed to better understand GNPs' perspective on spirituality and how they integrate spiritual care into their practice.

Research Questions

To gain a better understanding of spiritual care within present GNP practice, this descriptive study will seek to answer the following questions:

1. What are the spiritual perspectives of GNPs?

    1 a. Do spiritual perspectives differ based on any of the following GNP characteristics: gender; age; race/ethnicity; religious affiliation; years in practice as an RN prior to GNP certification; years in practice as a GNP; type of NP education; spiritual care education in undergraduate and graduate curriculum; and whether further spiritual care education was sought beyond the academic environment.

    1 b.What is spirituality from the GNP perspective?

2. How do GNPs integrate spiritual assessments into their practice?

2 a. What client cues or behaviors are found in the literature that GNPs recognize as a potential need for spiritual care in clients?

2 b. Describe content and face validity measurements and reliability measurements of a tool developed from content analysis of the literature, which measures frequency of recognizing client cues and behaviors which indicate a need for spiritual care; and which measures frequency of further assessing for the spiritual care needs of clients based on these identified cues and behaviors?

2 c. How frequently do GNPs recognize specific clients' cues and behaviors as indicators of a need for spiritual care?

2 d. How frequently do GNPs further assess clients for spiritual care needs once a cue or behavior has been recognized?

2 e. How often, if ever, do GNPs believe they are able to recognize when clients need spiritual care?

2 f. What are the specific tools used by GNPs to evaluate clients' spiritual care needs?

2 g. What other information do GNPs want to share about spiritual care?

3. How do GNPs integrate spiritual care interventions into their practice?

3 a. What specific spiritual care interventions are found in the literature that GNPs are likely to utilize in their practice?

3 b. Describe content and face validity measurements and reliability measurements of a tool developed from content analysis of the literature, to measure the frequency of GNPs providing specific spiritual care interventions to their clients.

3 c. How frequently do GNPs initiate specific client-centered spiritual care interventions?

3 d. How frequently do GNPs provide specific client-requested spiritual care interventions?

3 e. What other information do GNPs want to share about spiritual care interventions?

4. What is the relationship between the spiritual perspectives of GNPs and the degree to which GNPs integrate spiritual assessments and spiritual care interventions into their practice?

4 a. What is the relationship between the spiritual perspectives of GNPs and the frequency of recognizing the client cues and behaviors indicating a need for spiritual care?

4 b. What is the relationship between the spiritual perspectives of GNPs and the frequency of further assessing a need for spiritual care once clients' cues and behaviors indicating such a need have been recognized?

4 c. What is the relationship between the spiritual perspectives of GNPs and the frequency of initiation of GNP-specific client centered spiritual care interventions?

4 d. What is the relationship between the spiritual perspectives of GNPs and the frequency of GNP follow-through on client-initiated requests of specific spiritual care interventions?

CHAPTER TWO

SPIRITUAL CARE IN ADVANCED PRACTICE NURSING

Although spirituality and spiritual care can improve health dimensions, the literature is inconsistent in the definition of these concepts. In addition, there is little research related to the provision of spiritual care by NPs. This chapter will present a description of spirituality and spiritual care as defined in the literature, a conceptual framework and model that will guide this study, a description of current research related to spirituality and spiritual care, and research methods and tools that measure spirituality and spiritual care. Gaps in the research will also be discussed, especially as they relate to spiritual care provided by NPs.

Overview of the Literature: A Chronological View

An electronic search was conducted in nursing, medicine, social work, behavioral health, palliative and hospice care, education, pastoral care, college health, and rehabilitation literature related to spirituality and spiritual care. This search was limited to English and included dates between 1980-2009, as early and related classic and seminal articles of conceptual, qualitative, and descriptive papers began appearing in the literature in the 1980s (Appendix A). Data bases used included CINAHL (Nursing), Medline (Medicine), Sociological Abstracts (Social Work), PsychInfo (Psychology), and ALTA (Religion/Pastoral Care). Keywords for this search included Nurse, Spirituality, Advanced Practice Nurse, Spiritual Care, Holistic Nursing, Hospice, Healing,

Health, Research, and Physician. In order to understand the links between spirituality, spiritual care, health, and the GNP-client relationship within the proposed conceptual model, an understanding of spirituality and spiritual care is needed and will be addressed first.

The conceptual understanding of spirituality in various disciplines over the years was apparent in the search. Nursing, hospice, and social work viewed spirituality existentially, looking at what meaning and purpose one found in life, health, and illness (Carroll, 2001; Reed, 1992; Smith, 2006). Medicine on the other hand viewed spirituality through the lens of religious affiliation and beliefs, often using religion and spirituality interchangeably or defining spirituality as attendance at religious services (Glas, 2007; Handzo & Koenig, 2004; Koenig, 2004; Wright, 2002). In addition, physicians tend to perform spiritual assessments and refer clients to chaplains without offering spiritual care interventions themselves (Brady, Peterman, Fitchet, Mo, & Cella, 2000; Luckhaupt, Yi, Mueller, Mrus, Peterman, Puchalski, & Tsevat, 2005). The development of tools for spiritual assessments, such as the FICA tool (Faith/spirituality, Importance/influence, belong to a faith Community, how should the physician Address concerns), were frequently found within the physician literature to help guide spiritual assessments (Puchalski & Romer, 2000).

Much of the early articles in the pastoral care literature discussed spirituality in the context of religiosity (Sinclair, Pereira, & Raffin, 2006). Starting in the late 1990s, pastoral care literature focused on specific research methods and relationships between health and religious affiliation or individual spirituality (O'Connor, Meakes, McCarrol, Butler, Davis, & Jadad, 2002). In the past few years, there has been an identified need by

chaplains to collaborate with disciplines more familiar with evidenced based research methods (such as medicine and nursing), in order to provide evidence to support the relationship of religion, spirituality, spiritual care, and health within the pastoral care settings (O'Connor, et al., 2002; Springer, et al., 2003).

Defining Spirituality and Spiritual Care

Much of the initial work in spirituality and spiritual care has been epistemological; that is, the literature needed to converge on an understanding of what is spirituality and spiritual care. The literature offered definitions and attributes of spirituality and spiritual care within and across various health care disciplines. Spirituality is an individual resource influencing health and is essential for holistic care, having multiple dimensions and different connotations (Gray, 2006; McEwan, 2004). Spiritual care, on the other hand, strengthens individual spirituality and facilitates improved health and well-being (Reynolds, 2006; Tyler & Raynor, 2006). Therefore, to facilitate a better understanding of spiritual care, spirituality will be defined first. The following sections describe how spirituality and spiritual care are defined in the literature.

Defining Spirituality

Spirituality is a universal phenomenon derived out of our human experiences, subjectively defined, and found to be as important to atheists as to religious individuals (Smith, 2006; Tyler & Raynor, 2006). Some authors describe individuals as multidimensional beings, with spirituality as one dimension of this multidimensional profile (Pesut, 2006). Others view it as a unifying aspect of our humanness. Spirituality builds our relationship to the world (Carroll, 2001). It connects humans with a universal order, provides harmony, congruence and unity within the internal and external world of

the individual (Buck, 2006; Friedemann, Mouch & Racey, 2002; Gaskamp, Sutter, & Meravigilia, 2006; Henderson, 2006; Malinski, 2002; McEwan, 2004; McManus, 2006; Narayanasamy, 2004; Narayanasamy, Clissett, Parumal, Thompson, Annasamy, & Edge, 2004; Newlin, Knafl, & Melkus, 2002; Puchalski, Lunsford, Harris, & Miller, 2006; Sawatzky & Pesut, 2005; Tanyi, 2002; Tuck, 2004). Spirituality bridges all the dimensions into which the individual has been artificially divided (mind, body, spirit), while promoting a connection to the world and reintegration of the individual. It is the source of balance, harmony or order, and promotes a sense of well-being (Reed, 1992).

Attributes of spirituality. The literature describes distinct attributes of spirituality, which include connections to self, others, and a higher power/God with transcending potential; a search for meaning and purpose in life and illness; and a means of finding inner strength, peace, hope, and energy or the transforming and reparative processes.

Intrapersonal connectedness. Connection is vital to spirituality as identified in the literature. This is frequently discussed in terms of the relationship or connection one has to self, others and the world, as well as to God/Supreme Being. Loss of wholeness may occur without such connections (Reed, 1992). The intrapersonal aspects contain ideas of existential well-being and connection to self by gaining a deeper understanding of self through human experience and personal reflection (Burkhart & Hogan, 2008; Burkhart & Solari-Twadell, 2001; Reed, 1992). The inner-self connection allows for healing, growth, liberation, strength, coping, hope, and development of purpose in life (McEwan, 2004; Newlin, et al., 2002). Inner-self connection is the process and energy that provides the foundation for existence and wholeness, integrating the mind, body, and

spirit (Gill, 2005; McEwan, 2005; Tuck, 2004; Tyler & Raynor, 2006). Connection to self provides coherence and unity within, and allows patterns of higher consciousness to evolve (Friedemann, et al., 2002).

Interpersonal connectedness. Connection to the world and the interpersonal allows for intersection with others, art, music, literature, and nature as well as the world around us (Buck, 2006; Burkhart, 2001; Burkhart & Solari-Twadell, 2001; Gaskamp, et al., 2006; Malinski, 2002; McBrien, 2006; Puchalski & Romer, 2000; Puchalski, et al., 2006; Solomon & Hunter, 2002; Tuck, 2004). The individual consciousness thus gains awareness of the rhythms and patterns of the surrounding world and develops harmonious relationships or connections (Como, 2007; Friedemann, et al., 2002; Narayanasamy, 2004; Smith, 2006). This type of connection is individually defined by those in relationship, has external dimensions to self, occurs through the spirit, and uses presence in connecting with others (Burkhart & Solari-Twadell, 2001; Newlin, et al. 2002; Pesut, 2006; Sawatzky & Pesut, 2005).

Transcendent connectedness. Connection to and being in relationship with God, a Supreme Being, Purpose, or the Transcendent, is also an attribute of spirituality and often mediated through our connections to self and others (Goldberg, 1998; Narayanasamy, 2004; Pesut, 2003; Tanyi, 2002). Other phrases used to describe this relationship include transcending self (Buck, 2006; Friedemann, et al., 2002) or a relationship to, sense of, or search for the sacred or holy (Gilbert, 2007; Handzo & Koenig, 2004; McManus, 2006). This connection to the Transcendent allows us to move to a deeper awareness of being through a connection to something greater than self (Hollins, 2005).

Connection, although on different levels, is a consistent attribute of spirituality, and occurs in relationship to self, others, and the world around us, as well as beyond this material world through connection to the Transcendent. Without connections, there is potential loss of order, wholeness, harmony, well-being, and balance.

Transcendence. Transcendence is more than the corporeal and extends beyond the physical boundaries. It is often associated with experiences that promote an "evolution of consciousness" of self-expansion, greater connectedness to others and the world around us (Newman, 2000; Reed, 1991). Transcendence of consciousness moves one beyond the physical body of occupying a position in the dimensions of specific space at a specific time. This shifts one outside of the physical self and provides insights and knowledge derived from a greater awareness or receptivity which allows one to move beyond present perceived limitations (Como, 2007; Newman, 2000; Pesut, 2006; Reed, 1991). Transcendence allows for consciousness to expand, perspectives to broaden, and boundaries to become limitless while promoting a greater sense of connectedness to self and the world around us.

Meaning, purpose, and fulfillment as work of connections. The work of connections is the search for meaning, purpose, and fulfillment in life. These three are also described as attributes of spirituality (Burkhart, 2001; Burkhart & Solari-Twadell, 2001; Fawcett & Noble, 2004; Gaskamp, et al., 2006; Handzo & Koenig, 2004; Hollins, 2005; Martsolf & Mickley, 1998; Narayanasamy, 2004; Pesut, 2006; Post, Puchalski & Larson, 2000; Puchalski & Romer, 2000; Reed, 1991; Reynolds, 2006; Ross, 1994; Sawatzky & Pesut, 2005; Smith, 2006; Tinley & Kinney, 2007). Finding meaning in illness or crisis, for example, brings significance, purpose, and direction to life (Connelly

& Light, 2003). In this sense, spirituality is said to provide a framework to respond to these concerns and promote the development of an awareness of meaning and purpose in life (Solomon & Hunter, 2002; McEwan, 2004; Gilbert, 2007).

Transformative and reparative processes. Spirituality provides a source of inner peace, strength, and hope for the individual (Narayanasamy, 2004; Narayanasamy, et al., 2004; Tanyi, 2002). This allows for the development of the transformative and reparative processes of spirituality. The transformative includes inner peace, strength, liberation, and self-knowledge while the reparative includes healing, forgiveness, coping, and hope (Newlin, et al, 2002; Shaw, 2005). In both of these processes, life unfolds or is in the process of evolving through the use of reflection and through our human experiences (Hollins, 2005).

Operational definition of spirituality. The following definition of spirituality is proposed based on the literature. Spirituality is a universal and individually defined phenomenon based on human experiences. It is person-centered, promoting the reintegration of the individual which has been artificially divided into body, mind, and spirit. Spirituality restores balance, harmony, and a sense of well-being by reconnecting the individual to self, others, and the Transcendent. It is through connecting that one finds meaning, purpose, and fulfillment in life. Spirituality provides the structure from which to support the discoveries of meaning and purpose in order to find fulfillment in life. Without meaning and purpose, spiritual discomfort and disconnection from relationships could potentially occur, with loss of wholeness and health. Thus, spirituality is a resource for health and well-being found within the individual and mediated through connections to others, the world around us, and/or God/Supreme Being/the Transcendent.

Spirituality differs from religiosity in that religiosity reflects religious affiliation and is limited to a community that shares similar beliefs, values, and rituals (Allport & Ross, 1967; Berry, 2005; Govier, 2000; Leininger & McFarland, 2002). Spirituality is personally defined and individually practiced (Buck, 2006; Malinski, 2002; Tanyi, 2002). Some individuals express their spirituality through religion, but others do not express their spirituality with faith rituals (Berry, 2005; Burkhart & Solari-Twadell, 2001; Govier, 2000; Leininger & McFarland, 2002).

Defining Spiritual Care

Spiritual care involves supporting another as they attempt to discern meaning and purpose in life and health (Gaskamp, et al., 2006). This support may be expressed through presence, active listening, and attention, and involves enabling the receiver of care to use inner resources when meeting life's challenges or crises in order to gain self knowledge (Gaskamp, et al, 2006; Emotional and Spiritual Care Committee of the National Voluntary Organizations Active in Disaster, 2004; Hunter, 2005; McEwen, 2004; Narayanasamy, 2004; Sawatzky & Pesut, 2005; Taylor, 2003;). Spiritual care is an interpersonal phenomenon and, like spirituality, is person-centered (Burkhart & Hogan, 2008; McEwen, 2004; Reed, 1991; Sawatsky & Pesut, 2005).

Spiritual care is focused on the individual and is based on our human experiences, supporting the use of all the resources of the client when faced with illness, doubts, anxieties, crisis, and questions (ISD Data Dictionary, 2002). This type of care is usually given in a one-to-one mutual relationship and does not make assumptions about those receiving care. Spiritual care is not necessarily religious care, but religious care should

always contain the spiritual (Friedemann, et al, 2002; National Health Service in Scotland, SEHD, 2008; Hunter, 2005; McEwen, 2004; Gill, 2005).

Operational definition of spiritual care. Spiritual care supports another, enabling the individual to find meaning, purpose, and fulfillment in life which is the work of spirituality. Through an interpersonal relationship, spiritual care promotes access to inner strengths and resources that will enhance the health and spiritual well-being of the individual. These resources may emanate from within the individual client (intrapersonal), originate from the NP who is providing care at that moment in time (interpersonal), or provided through various community referrals (environment, interpersonal).

Nursing Theories

Conceptual Relationships between Spirituality, Spiritual Care, and Related Nursing Theories

Clients consider spirituality as a resource for health (Gaskamp, et al., 2006; Gray, 2006). Within spirituality, connections or relationships to self, the world around us, and the Transcendent are important (Reed, 1991). Self-connection or the intrapersonal connection allows for increased self-awareness, with research suggesting an increased sensitivity and ability to provide spiritual care by those with increased spiritual self awareness (Olson, Sandor, Sierpina, Vanderpool, & Dayao, 2006). Self-reflective practices often help to promote an increased spiritual self-awareness (Burkhart & Hogan, 2008). The need for self-reflection is often triggered by an interaction with the environment or the world around us.

Connection to others and the world around us allows the individual

consciousness to gain an awareness of the rhythms and patterns of the surrounding world and develop patterns of relating or connecting to this world (Como, 2007; Narayanasamy, 2004; Newman, 2000; Smith, 2006). Spiritual care frequently occurs within this relationship between self and the surrounding world/other, or in the nurse-client-environment relationship. These connections can also mediate a relationship with God, a Supreme Being or purpose, or the Transcendent for those who are seeking this relationship (Goldberg, 1998).

Transcendence or transcending allows for consciousness to move beyond time and space and to develop a deeper awareness of being without constraints in the physical world. It can also help with the work of spirituality which is to find meaning, purpose, and fulfillment in life and health. The various concepts mentioned will be further discussed within theoretical frameworks that relate to the present research.

Reed's Theory of Self-Transcendence. The Theory of Self-Transcendence (Reed, 1987) is based on later adulthood developmental and lifespan theories, Rogers' theory of Unitary Human Beings, and Reed's clinical work with older adults in the area of psychiatric and mental health (Reed, 2008). This theory provides a framework where the development of complex health concerns heightens awareness of increased personal mortality and vulnerability. This increased sense of vulnerability may be due to the aging process as well as chronic disease and end-of-life concerns which face many aging adults. Increased vulnerability triggers an increase in self-transcendence which enhances the ability to expand individual boundaries intrapersonally (increased sensitivity to self, one's values, philosophy), interpersonally (relationships to others and the environment), temporally (relate past and future to a meaningful present), and transpersonally (connect

to dimensions beyond the physical world). An outcome of self-transcendence is well-being, which is a sense of feeling whole and healthy based on personal criteria (Reed, 2008).

Although there are specific components of Reed's theory that are salient for this research on spirituality and spiritual care, the theory was not used because of the focus on the individual client and not GNPs. However, the theory helps to support why those who are advanced in age and have chronic diseases might desire spiritual care from health care providers. One of the advanced practice nurses serving this population are GNPs.

Watson's Philosophy and Science of Caring. In the Philosophy and Science of Caring, Watson (1987, 2008) posits that effective caring promotes health, healing, and a sense of well-being that allows for evolved consciousness, inner peace, and transcendence of crisis and fear. Caring is most effectively demonstrated on the interpersonal level, in a human-to-human process and connection, and is "healthogenic" or healing versus curing. This grand theory provides an alternative to the positivist worldview where technology, curing, and illness care dominates. Watson includes as the basic constructs of the theory an authentic and intentional presence to enable a deep belief of the other; cultivation of one's own spirituality; and the nurse being the caring-healing environment. Caring responses accept the person as they are and what they may become, merging present and future. A caring relationship thus allows the emergence of the other's spirit.

Watsons's theory addresses the caring moment between nurse-client within a relationship. The caring relationship that is established between nurse-client is important since the nurse becomes or supports the healing environment for the client through the

use of the established *Caritas* principles of the theory (Watson, 2008). Thus Watson addresses some of the components of the interpersonal relationship found in spiritual care, and the energy exchange that occurs within this environment between nurse-client. It is within this interpersonal relationship that spiritual care can occur. However, this theory does not take into account the learning of new patterns of interacting with self and the environment, and expanding ways of knowing and knowledge acquisition. This is important to GNPs' practice, where expanded consciousness and insights gained by the GNP may be used in practice to assist clients in expanding their consciousness related to health.

Burkhart and Hogan's Experiential Theory of Spiritual Care in Nursing Practice. The Experiential Theory of Spiritual Care in Nursing Practice was developed by Burkhart and Hogan (2008) to guide research in spiritual assessment and spiritual care in nursing. Seven major processes emerged during the development of this theory that are relevant to discussion for this present research. The theory first begins with the nurse receiving a "Cue" from the client which indicates a need for spiritual care. This is followed by several processes if the nurse decides to take action, starting with the provision of a "Spiritual Care Intervention" during the client encounter. This elicits a positive or negative "Immediate Emotional Response" from the nurse following this intervention.

Next there is a "Search for Meaning in the Encounter" and the emotional response, in which the nurse uses self-reflective processes, reflection with colleagues, or faith rituals. Following this process is the "Formation of Spiritual Memory." This spiritual memory was identified as critical by the theorists, whether the client encounter

and experience were positive or negative. If there was no meaning to be found in the encounter and response, then this may become a distressing memory that could continue to elicit feelings of pain, guilt, or anguish and deter further attempts at the provision of spiritual care. If meaning could be found in either a positive or negative response, then this could become a growth-filled memory for the nurse. The final process, "Nurse Spiritual Well-Being," is a personal aspect of conveying meaning and purpose in life. The theorists discovered the provision of spiritual care could enhance the nurse's own spiritual well-being and the ability to provide spiritual care to others, but could also test the nurse on a day-to-day basis and decrease one's spiritual well-being in the process.

This theory has implications for use with this research. It incorporates aspects of knowledge acquisition regarding spiritual care specifically through use of reflective processes on professional experiences and nurse-client interactions. As with spirituality, the nurse's response to spiritual care experiences and encounters included a search for meaning and a potential increase in spiritual well-being. Increased spiritual well-being could potentially assist the nurse in enhancing future spiritual care encounters with clients. Reflective practices to increase the intrapersonal (self) connection found within spirituality would be useful for GNPs to experience transcendence, gain insights, and promote knowledge expansion. However, Burkhart and Hogan's theory does not address how the provision of spiritual care post-spiritual care intervention affects the nurse-client interrelationship (environment). In addition, it also does not provide a foundation for promoting pattern recognition and expansion of consciousness of the client to improve their health through the provision of spiritual care by the nurse.

Reed (2008), Watson (1987, 2008), and Burkhart and Hogan (2008) all have

concepts or processes that support various aspects of why spiritual care provided by nurses is important to health. All address the intrapersonal (self) connection of either the individual client or nurse, which is often enhanced by an increased sense of mortality (Reed, 2008), or through interactions with the environment (interpersonal relationships) (Burkhart & Hogan 2008; Watson 2008). Burkhart and Hogan (2008) also address the potential insights and knowledge gained by nurses through use of reflective processes after the provision of a spiritual care intervention. However, none address how the provision of spiritual care by the nurse within the interpersonal relationship contributes to improved health dimensions for clients. Because of this, Newman's Theory of Health as Expanding Consciousness (HEC) (2000, 2008) will be used as a framework for this research with GNPs.

Margaret Newman's Theory of Health as Expanding Consciousness. Health is the primary metaparadigm focus in Newman's (2000) theory of nursing. In this theory, the evolution of health is the same process as the expansion of consciousness which includes gaining self awareness and knowledge through interaction with the environment, an open energy system (Appendix D). Consciousness is defined by Newman (2000) as the "informational capacity of a system to interact with the environment" (pp. 33- 34). Consciousness and person are one in the same open energy field interacting with the environment. As a person's consciousness expands and gains knowledge and insights, varied "response patterns" occur. The person then begins to gain insights and knowledge about their relationships or how they interact with their surrounding environment. Recognition of these patterns promotes higher knowledge development, increasing insights, and eventual transformation. This expanding consciousness allows one to find

greater meaning and purpose in life and health, as well as to increase connections to self, others, and the surrounding world. This movement and process are called transcending, something that is also found in the spirituality literature that occurs through our connections (Marchione, 1993).

Transcendence of time, space, and physical concerns to reach an expanded level of consciousness is a means of developing self awareness (Newman, 2000). Higher levels of self awareness and expanded consciousness allow for more complex interactions with the environment to develop, higher levels of health and pattern recognition to emerge, and greater insights into the meaning of one's life and experiences. Finding meaning in the patterns is important to health, and occurs within the interactions between person (self) and environment (others, the world around us). This interaction is actually a connection or relationship that mediates the process of transcending (moving beyond or rising above). The person then discovers the meaning these patterns of relating have in their life and on their health.

Health, a new paradigm of Newman's theory (2000, 2008) that the other theorists did not have, includes both disease, "a subjective sense of diminished health," and non-disease states. Disease becomes a meaningful aspect of health that is reflective of a unitary pattern of the whole person. Consciousness, and thus health and person, expands to a higher level with this pattern recognition of the whole. This change to a higher level is measured by time and reflected by movement which is an essential property of matter, perceiving reality, and becoming self aware. This movement over time could include changes in life-style known as patterns of relating to the environment, which would

produce changes in physiological functions such as lowered blood pressure, decreased cholesterol levels, and improved blood glucose control.

With regard to time and space, Newman (2000) posits that we experience time differently when transcending the limits of three-dimensional space. Our sense of time increases when our ability to move in space decreases. This non-movement may be intentional as with choosing to be in the present moment, or unintentional as with disability, aging, or social constraints (Newman, 2008). This allows for focus on interior space and again for the evolution and expansion of consciousness. Thus, expanding consciousness is again a process of finding greater meaning in one's life and health and evolving to new heights of connectedness towards the environment and self. This is accomplished within a sense of expanded time and limited space by focusing on becoming self aware. Our sense of time and space changes with this expanding consciousness and impacts our perceptions of reality, self-awareness, and ability to transcend.

Nurses assist the person to recognize their own patterns of interaction with the environment and to use internal resources to evolve towards higher levels of health and consciousness. Peaks and troughs of organization and chaos occur for a person as part of the unitary process of health, and it is typically during the periods of chaos where nurses can influence a person's patterns of relating. This is often done through the intentional presence of the nurse in a rhythmic authentic connecting of nurse and person in a mutual relationship. Nurse and person are also individual consciousness, open energy fields, and part of the others' environment. Their mutual interactions, patterns of relating, and energy exchanges will in some manner affect each other. Thus higher levels of

consciousness for both are promoted through interaction and relationship with the environment-other-self and pattern recognition (Newman, 2000, 2008). This implies that as consciousness expands and evolves to higher levels, movement of health, interaction with the environment, increased self awareness, and recognition of patterns of relating also evolve to higher, more complex levels.

Health as Expanding Consciousness (HEC), spirituality, and spiritual care. Connections and relationships to person (self), environment (the world around us, others), and some manner of transcending are found in both HEC and the spirituality literature. Movement over time to expand consciousness to assist one in finding meaning and purpose in life and health are also important concepts common to both a spirituality framework and HEC. This movement is facilitated through the interactions of person-environment in HEC, or the intrapersonal-interpersonal relationships in spiritual care. Expanding consciousness promotes the development of insights, finding meaning and purpose in life and health, recognizing patterns of relating to environment-other and changing patterns over time to promote health and thus transcend and continue to expand consciousness.

The interpersonal connections found within spirituality are relationships between self and others, nature, and the rest of the world around us. Spiritual care, which enables one to support another as they pursue connections, meaning and purpose in life, often occurs within the exchanges of the interpersonal connections between the environment, other, and person. Providing spiritual care within the HEC framework, the nurse supports and joins the person and their inner resources to search for meaning and purpose in life and health within this interpersonal relationship.

This support from the spiritual care framework is consistent with the HEC description of the nurse and client relationship. Nurse-client relationship is a mutual relationship that is rhythmic and authentic. It is usually when the nurse-client connect at a time of chaos or distress for the client that the nurse can assist in pattern recognition to influence client health. The nurse uses specific spiritual care interventions that support the internal resources of the client to gain knowledge of their patterns of relating. The provision of spiritual care within the HEC framework by nurses can influence the chaos of a client's health into more complex and less chaotic patterns of relating to the environment. This allows the client to expand their consciousness through spiritual care which has been provided within the interpersonal relationship of the nurse-client.

Another consideration is the effect this movement has on the intrapersonal relationship to self, not only for the client, but also for the nurse. Because the nurse and client are open energy fields and are in fact part of the other's environment, their interactions and energy exchange impact each other. Higher levels of consciousness or transcendence allow the nurse to develop a deeper intrapersonal connection when a reflective practice is developed and used. This allows for specific memories to develop to guide future experiences and interactions related to spiritual caregiving (Burkhart & Hogan, 2008).

Those nurses who have developed increased spiritual self awareness have been better able to recognize clients who have spiritual care needs related to health (Burkhart & Hogan, 2008; Olson, et al., 2006; Reed, 1991). The nurse can assist the client to expand consciousness and improve health by entering into a mutual relationship to provide spiritual care at this time. Spiritual care allows the client to expand knowledge,

gain insight, and find meaning and purpose in life and health. Patterns of relating to the environment can show movement over time, with higher levels of health and consciousness gained by the client.

Nurse-client interaction also affects perception of reality and self awareness of the nurse over time through insights and expanded consciousness. Barriers for health care providers to promote spiritual care have been identified in the literature as lack of education and lack of time, both of which can be studied within the framework of HEC (Luckhaupt, et al., 2005; Stranahan, 2001). Education relates to knowledge gained through interactions with the environment. Knowledge can be gained formally as within an educational setting or by acquiring other experiences such as self-reflection after an interaction with other/client or environment (Burkhart & Hogan, 2008).

Self-reflection for the nurse is part of an intrapersonal relationship and promotes self awareness and expanded levels of knowledge, insights, and consciousness (Newman, 2000). The ability of the nurse to recognize patterns of relating and to facilitate changes in the nurse's patterns to promote increased spiritual self awareness is reflected in movement over time (Newman, 2008). Health care providers with increased spiritual self awareness indicate improved sensitivity to those who are in need of spiritual care related to health (Olson, et al., 2006). Increased sensitivity to others' spiritual needs is important in the nurse-client relationship in order to assess and support the client's individual spirituality. The individual client's spirituality serves as an internal resource for health (Gaskamp, et al., 2002; Gray, 2001).

Conceptual Model of the Geriatric Nurse Practitioner's Role in Expanding Client Consciousness and Supporting Health through Spiritual Care

Because of their advanced education and ongoing relationships with elderly clients with chronic diseases, practicing GNPs are in an important position to potentially expand clients' consciousness and improve health through spiritual care. Patterns of relating and energy exchange occur between person-environment at the intrapersonal-interpersonal connections which allow for the expansion of consciousness. This makes the GNP-client relationship or person-environment interaction very important. As previously discussed, it is within the energy exchange of this interpersonal relationship of GNP-client that spiritual care potentially occurs.

Spiritual care and spiritual care interventions. In providing spiritual care, the GNP supports the client to discern meaning and purpose in health and life by recognizing patterns of relating using the client's own spiritual framework. This is done by supporting clients through the use of a variety of spiritual care nursing interventions, which are nursing actions or behaviors (Bulechek, Butcher, & McCloskey-Dochterman, 2007). Spiritual care nursing interventions are focused on enabling clients to tap into inner resources to meet life's challenges and gain meaning, purpose, and insights into their health. The client then gains self awareness and knowledge, finds meaning in health and insight through pattern recognition, and expands consciousness through transcending and self awareness. Geriatric nurse practitioners may use skills gained through their own pattern recognition, expanded consciousness, and processes of transcending, as well as advanced education, to assist clients in this movement over time and process of transcending or expanding consciousness.

Self-reflection and intrapersonal connection. Interactions between self and environment often trigger a need for self-connection and self-reflection. Self-reflection assists in recognizing patterns of relating to the environment-others and gaining insight into these patterns. This self connection is vital to finding meaning in life, developing internal unity, promoting patterns of higher consciousness, and increasing self awareness (Burkhart and Hogan, 2008). The intrapersonal connection can be enhanced by personal experiences as well as education. The development of spiritual self awareness is especially important for the GNP as it relates to spiritual caregiving. For the GNP this allows for reflection on recent interpersonal interactions with the client in order to discover patterns, meaning, or insights in the exchange promoting expanded consciousness and transcendence. This transcendence can potentially support future sensitivity to assessing clients' needs for spiritual care as well as the GNPs ability to provide spiritual care interventions.

Assessment. Increased sensitivity to clients' spiritual needs is useful in the assessment process which includes gathering information and data, and identifying specific client cues and behaviors on clients' spiritual care needs. Assessments are important for the implementation of appropriate interventions and improved client outcomes (Scherb & Weydt, 2009). Spiritual care in this framework allows for the GNP's journey of reflection in order to gain insights on patterns of relating or interacting while finding meaning and purpose in pattern recognition. The process can be transcending, allow movement or change over time to higher levels of consciousness which includes knowing, relating, or being, and can be utilized in future interpersonal interactions with clients. For the client, this may promote insights regarding recognition of unhealthy

patterns or other interior activity to transcend and expand consciousness and improve health.

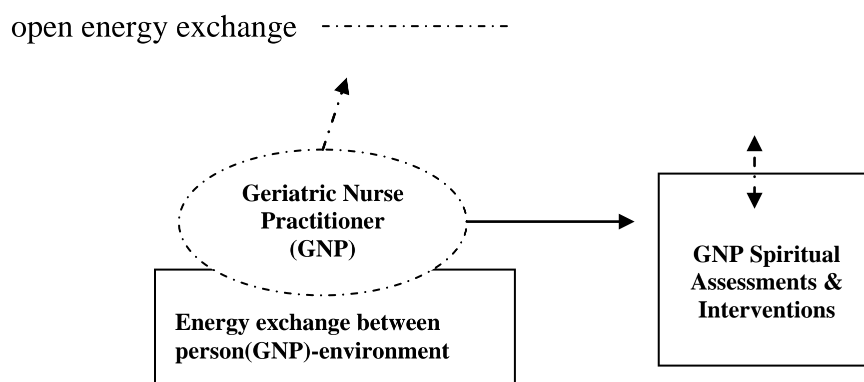
Interpersonal and environment connection. Geriatric nurse practitioners build long-term mutual relationships with their clients who are managing chronic diseases. Within this interpersonal relationship, GNPs have the opportunity to expand their clients' consciousness and health by relating with certain patterns of interaction to enable clients to find meaning and purpose in health and life. This interaction occurs at a time of chaos in the client's health. In turn this will have the potential to influence the chaos the client is experiencing in health and elevate the client's consciousness to make changes in patterns of relating to the environment.

Spiritual perspective. A reflective practice may also provide the impetus to change the GNP's perspectives on spirituality and spiritual care. Spiritual perspective is defined as having a certain spiritual view or outlook and seeing the relationship of various aspects to each other as a whole (Merriam-Webster Dictionary, 2009; Reed, 1987; Reed, 1991). The GNP's spiritual perspective might affect the ability to provide spiritual assessments and interventions in response to insights gained with pattern recognition through a reflective practice.

Conceptual Model. In this research, it is proposed that once the consciousness of the GNP has expanded and transcended through having a reflective practice and increasing the intrapersonal connection, gaining pattern recognition, knowledge, and insights can occur. The GNP will potentially be more effective in spiritual caregiving with this expanded consciousness. Expanding consciousness, or increasing the intrapersonal connection through self-reflection, is generally triggered by an encounter

with the environment, or an interpersonal connection. This expanded consciousness or increased intrapersonal connection will assist the GNP in supporting their clients' own spirituality or inner resources for health through the interpersonal relationship and pattern recognition, expanding consciousness, and transcending. Time will no longer appear as a barrier within GNP-client interactions at this point, nor will lack of knowledge. The proposed model includes this overall framework which is shown in Appendix E. This study will specifically look at characteristics of the GNP (including the GNPs spiritual perspectives), GNP spiritual assessments of clients, GNP use of spiritual interventions, and the relationship between the GNPs' spiritual perspectives and spiritual assessments and interventions. That portion of the conceptual framework is shown below (Figure 1).

Figure 1. Vincensi Conceptual Framework with Influencing Factors for Provision of Spiritual Care



Research in Spiritual Care

Spiritual care has been researched using a variety of quantitative research methods, which have primarily included descriptive, exploratory, cross-sectional, and correlation studies. In addition, qualitative methods were used to study this phenomenon with various phenomenological approaches and grounded theory. Four major topic areas

emerged from the literature review: (1) attitudes, beliefs, and perceptions of those providing spiritual care; (2) attitudes, beliefs, and perception of those receiving spiritual care; (3) how spiritual care was learned by providers; and (4) perceived barriers to providing spiritual care.

Attitudes, Beliefs, and Perceptions of Those Providing Spiritual Care

Research has demonstrated that health care providers' attitudes, beliefs, and perceptions of spirituality affect the ability to provide spiritual care. Health care providers' spirituality, spiritual perspectives and practices can affect attitudes and beliefs towards the provision of spiritual care (Ellis, Vinson & Ewigman, 1999; Kociszewski, 2004; Taylor, Highfield & Amenta, 1994). Increased spiritual self awareness, positive attitudes and beliefs toward spirituality, and the development of an individual spiritual practice, have been linked to increased ability and comfort in providing spiritual care (Vance, 2000).

In the research, beliefs and values of physicians toward spirituality and religion provide insights as to the spiritual care offered to clients in a physician-client encounter (Luckhaupt, et al., 2005). In the limited research literature on NPs and spiritual care, NPs often use spirituality and religiosity interchangeably as do physicians. In addition, NPs believe spiritual care is important but rarely provide it (Stranahan, 2001; Hubbell, et al., 2006). Nurses and NPs focused on spiritual assessments and interventions, whereas physicians were concerned with spiritual assessments and referrals for such care.

Staff nurses. Research consistently demonstrates that nurses' spiritual well-being, attitudes, beliefs, and perceptions affect their ability to provide spiritual care (Stranahan, 2001; Taylor, Highfield, & Amenta, 1999; Vance, 2001). The intrapersonal

relationship the nurse has with her/himself affects the ability to develop the interpersonal relationship needed to provide spiritual care. These two relationships are identified as vital to spirituality and spiritual care in the conceptual literature (Reed, 1991). The depth of the intrapersonal relationship is found to be especially important to the provision of spiritual care in the staff nurse literature (Taylor, Highfield, & Amenta, 1994).

Spiritual self awareness, positive attitudes and beliefs toward spirituality, and the development of an individual spirituality were found by Vance (2000) to be associated with an increased ability and comfort in providing spiritual care. In this correlation study, direct RN caregivers (n=173) were randomly selected from critical care, medical-surgical, women's health, and behavioral health units in a community hospital. Spiritual well-being was operationalized using the Spiritual Well-Being (SWB) scale (Paloutzian & Ellison, 1982) and spiritual involvement and beliefs with the Spiritual Involvement and Beliefs Scale (SIBS) (Daaleman, & Frey, 2004; Hatch, Burg, Naberhus, & Hellnick, 1998) (Appendix F). Findings indicated only 34.6% of the nurses provided spiritual care. Nurses who work in behavioral health provide more spiritual care, and nurses working in women's health provide the least amount of spiritual care, with those working in ICU and medical-surgical falling in the middle. There was no discussion as to why the different specialties provided more or less spiritual care, but there is a noted difference in length of stay in each area (Finkelstein, Harper, & Rosenthal, 1998; Harrison, Brady & Rowan, 2004). Because of the shortened length of stay in obstetrics units, there is potentially less time to develop a relationship with the client, a concept established as important in the provision of spiritual care (Reed, 1992).

Taylor et al. (1994) attempted to determine the best predictor to provide spiritual care in hospice (*n*=181) and oncology (*n*=638) nurses. Hospice and oncology nurses differed in a number of response areas, however findings indicated that the best predictor of perspectives on and perceived ability to provide spiritual care was the nurses' personal spirituality ($r = 0.47$). Additionally, a relationship was found between positively valuing spirituality and spiritual care to an increased frequency, ability, and comfort in providing such care (Appendix F). This study supports that nurses' attitudes or beliefs towards spirituality and spiritual care can influence their perceptions of spirituality and their ability to provide spiritual care, thus potentially affecting whether spiritual care is provided to patients.

Using a phenomenological heuristic approach with 15 hospice nurses, Carroll (2001) tried to understand how the meaning of spirituality affected the nurses' ability to provide spiritual care. The data revealed six themes demonstrating how hospice nurses view spirituality in their practice: interconnectedness to self, God, others and the Universe with being in the world; recognizing and assessing spiritual needs of others, and self; use of empathy and a trusting relationship; spiritual care as a multifaceted phenomenon; seeking out others to assist the patient and self; recognizing when to let the patient be (through use of presence); and fostering the search for meaning. All of the following themes have been identified in the concept literature related to spirituality: connection and relationship (Goldberg, 1998; Reed 1992); empathy and trust (Goldberg, 1998); multifaceted phenomenon (Tanyi, 2002); use of presence (DeLaune, 2006; Henderson, 2006); and search for meaning (Puchalski, 2002; Solomon & Hunter, 2002).

Only the attribute of “seeking out others to assist self” was a newly identified attribute of spirituality.

Nurse practitioners. Stranahan (2001) was interested in correlating NPs’ personal perceptions and attitudes about spirituality to the spiritual care interventions they utilized in practice. The survey included all licensed primary care nurse practitioners in the state of Indiana (*n*=269; response rate = 40%) to measure self-reported spirituality using Reed’s Spiritual Perspectives Scale (SPS) (1987) (perceptions on certain spiritual beliefs and values, and individual practice of spiritually related activities), and spiritual engagement using a modified Oncology Nurse Spiritual Care Perspective Scale (ONSCPS) (Taylor, Highfield, & Amenta,1994) which included two subscales: spiritual care interventions (Part 1) and attitudes toward providing spiritual care (Part 2). Participants were also asked to answer two other questions: how spiritual and how religious they perceived themselves. No reliability or validity testing was reported in this study; however, information on the psychometrics of the SPS and the ONSPCS tools can be found in Appendix F.

The majority of participants in Stranahan’s study indicated they were very spiritual (74%) and 59% rated themselves as very religious. Although Pearson product-moment correlation found no significant relationship between the SPS tool and participants’ self-reported spirituality, there were no specific data provided. However there were moderately significant correlations between the SPS and how religious participants perceived themselves ($r = .433$, $p < .001$) and frequency with which they attended religious services ($r = .649$, $p < .001$). This is important to note because the SPS tool allowed for participants to respond to items according to their individual definition

and meaning of spirituality. Although definitions for spirituality and religiosity were developed by Stranahan for the study, these definitions were not shared with the participants. In addition, the most frequently identified spiritual care interventions practiced were praying privately with a patient, referral to clergy, and talking with patients about a spiritual or religious topic (Part 1, modified ONSCPS). These interventions have been identified in the literature as responses to religious needs (Gillman, Gable-Rodriguez, Sutherland & Whitacre, 1996).

There were also high mean scores of 3 or above on a 5-point Likert scale found on Part 2 of the modified ONSCPS. Seven of these 13 items indicated a favorable attitude toward providing spiritual care. The greater the perceived spirituality of the NP, the more likely they were to have a positive attitude towards spiritual care, believe NPs should include spiritual care in their practice, and have provided spiritual care at some point in the past (Part 1, modified ONSCPS). When asked the frequency of providing spiritual care however, 57% indicated they rarely or never provided spiritual care, and 45% indicated their ability to provide this care was weak or limited (modified ONSCPS). Based on these findings it is difficult to conclude whether attitude toward spirituality and spiritual care affect spiritual care since it is not clear how the concepts of spirituality and spiritual care were defined from religious and religious care by participants. In addition, the spiritual care interventions provided support for religious care as opposed to providing or assisting another in finding connections, and searching for meaning and purpose in life as found in the spirituality and spiritual care literature previously discussed. Additional research is needed to clarify this difference between spiritual care and religious care.

Hubbell, Woodard, Barksdale-Brown, and Parker (2006), also studied spiritual care provided by NPs in a descriptive study of 100 NPs (return rate 65%) working in a federally designated nonmetropolitan area of North Carolina using systematic sampling. The tool used was an adapted Oncology Nurse Spiritual Care Perspective Scale called the Nurse Practitioner Spiritual Care Perspective Survey (NPSCPS) (Hubbell, Woodard, Barksdale-Brown, & Parker, 2006). Participants in this study believed spiritual care was important to nursing and should be provided as part of a holistic approach to client care. However, 73% of the sample rarely or occasionally provided spiritual care interventions. Many identified the belief that the work place was not the environment to provide such care, especially in the setting of a medically underserved federally funded clinic in which the study took place.

A social exchange theory was used by Donohue (2003) to explore and understand the special relationship of NPs and clients in primary care within the context of a resource exchange perspective. Social exchange theory involves relationships and services provided, similar to the interpersonal relationship and environment of HEC and the spiritual care literature. This descriptive study explored clients' expectations regarding resources to be exchanged within the visit prior to their clinic visit with the NP, what resources where actually exchanged, and the congruence between expectations and actual resources exchanged. There was congruence between a client's expectations and the resources received, with the longer the duration of the NP-client relationship, the more resources the client expected and perceived as received from the NP.

Donahue also found it necessary to add resources to the original social exchange theoretical categories of service, love, goods, and products to include the

multidimensionality of client expectations of a supportive, caring, relationship with the NP. Again, the emphasis was on caring, supporting, and a relationship. See Appendix G for comparison of concepts between Social Exchange Theory and nursing spiritual care.

Physicians. Knowing the beliefs and values of physicians toward spirituality and religion might also provide insight as to how physicians provide spiritual care. Residents in pediatric, internal medicine, family practice, and pediatric/internal medicine (n = 207) were studied by Luckhaupt, et al. (2005) to determine primary care residents' personal beliefs about spirituality and religion and the impact of these beliefs on what is offered to patients regarding spiritual or religious care.

This descriptive study measured resident characteristics that affect religion and spirituality within the patient visit. Variables and measurement tools used included the Functional Assessment of Chronic Illness Therapy – Spiritual Well-Being Scale (FACIT-SpEx) to measure spiritual well-being, the Duke Religious Index (DRI) to measure organized personal religious activity, the Brief RCOPE to measure positive and negative personal religious coping, and the ten-item Center for Epidemiologic Studies-Depression Scale (CESD-10) to measure depression levels. These instruments were adapted or used without any discussion of reliability or validity testing with the sample. This lack of discussion was a limitation of the study.

The results indicated that physicians' belief as to their role in spirituality and religion in client visits were affected by residency program and race. Family practice residents agreed physicians should play a role in patients' spiritual and religious lives (74%; p = .004) and be aware of patient's spiritual and religious beliefs (96%; p = .004). Race also appeared to influence the physicians' belief as to their role in spiritual and

religious care (56% African-American residents; 17% Asian; 27% White; 17% other; p = .038). Findings also indicated that residents' personal spiritual and religious beliefs and practices affected their perceptions of integrating religious and spiritual care into their medical practice.

Overall, 104 (46%) participants felt they should play a role in the clients religious or spiritual lives. This finding was associated with a greater frequency of participation in organized religious involvement (DRI) ($p < .0001$) and higher levels of spiritual well-being (FACIT-SpEx) ($p < .0001$) and religious coping (Brief RCOPE) ($p < .0001$) of the resident physicians. In this case personal spiritual and religious practices as well as coping styles of resident physicians are associated with their beliefs about integrating spiritual care into client care. Type of primary care residency program as well as race of the participants also appeared to be associated with the role of the physician in the religious or spiritual care of the client.

Family physician residents' beliefs, attitudes, and practices toward spiritual and clinical care were studied by Olson, et al. (2006). This phenomenological study explored family physicians' beliefs, attitudes, and practice regarding integration of spirituality into their practice. A purposive sample of 17 third-year family medicine residents from a southwest medical school participated in this study. Four main themes emerged as important in providing spiritual care: spiritual assessment in clinical practice; connecting spirituality and medicine; barriers to personal practice of spirituality; and strengths of integrating spirituality in medicine. This study provided a description of how spirituality and spiritual care can be integrated into medical practice. In addition, it highlighted the

physicians' belief that development of their own spirituality increased their ability to be sensitive to the spiritual needs of others.

Multidisciplinary teams. Multidisciplinary teams provide unique approaches to client care in a variety of settings with spiritual care approached most often in the psychiatric multidisciplinary setting. Using a focus group approach to understand attitudes and experiences, Greasley, Chiu and Gartland (2001) attempted to clarify the concepts of spirituality, spirituality and health, and the provision of spiritual care within the context of mental health care. Nine focus groups of 4 to 6 participants were recruited from the following: recipients of care, staff, and care providers at an acute mental health service hospital in the United Kingdom (UK). Each focus group included inpatients, outpatients, managers, pastoral care, or direct caregivers of nurses, psychiatrists, and psychologists or counselors. Findings indicated that spirituality included ideas of God, religion, and metaphysical beliefs. In addition, meaning and purpose of life, personal well-being, inner peace, hope, and interpersonal values that included love, caring and compassion in the provision of spiritual care were viewed as important. Spirituality and religiosity were seen as distinct and unique concepts. All groups identified the need for a trusting relationship when addressing spiritual concerns.

Mental health professionals' perception of the importance of spiritual care may be influenced by their professional and personal backgrounds. El-Nimr, Green, and Salib (2004) conducted an exploratory study of general practitioners (GPs) (n = 60), psychiatrists (n = 8) and psychiatric nurses (n = 30) who worked at a mental health hospital in the UK to examine the impact of the participants' personal and cultural background on their views of providing spiritual care (n=98, 66% response rate). This

survey, developed by the researchers, used a Likert scale to measure attitudes about spirituality, the spiritual care needs of mental health patients, whether spiritual care is important, and how much previous spiritual care training participants had in the past. Reliability and validity of the tool were not discussed.

Findings indicated nurses felt most strongly that spiritual care was important (52%) compared to GPs (29%) and psychiatrists (33%). More nurses (22%) had received some form of spiritual care education greatly contrasting with the GPs (2%) and the psychiatrists (8%). More respondents born outside of the UK (59%) felt strongly that humans were both body and spirit and that mental health patients' spiritual needs were different than the non-mental health patient, indicating that culture may impact the professional's views of spirituality and spiritual care. Limitations of the study include lack of generalizability, since participants were volunteers from one site, and the absence of any validity and reliability discussion of the survey tool. Cultural beliefs, education, and type of health care provider influence these providers' values and beliefs which affect the provision of spiritual care to mental health clients in this study.

Health care providers vary in how they perceive spirituality and their role in providing spiritual care in patient encounters. Perceptions, attitudes and beliefs vary but included a need for connection to self, others, and Supreme Being/God. In addition, there were findings in the research to support a connection between personal spirituality and attitude toward spiritual caregiving. Links in the provider research were also found between religion and spirituality, which may add to the confusion found in the literature in defining spirituality and spiritual care in terms of religiosity. Characteristics of the provider including culture, race, type of provider, and practice setting, also impacted

attitudes, beliefs, and perceptions about integrating spiritual care into patient care.

Physicians are uncertain as to their role in the provision of spiritual or religious care and multidisciplinary teams are influenced by the various education and attitudes of their members. Nurse practitioners believe spiritual care is important in their practice but rarely provide this type of care. In primary care, NPs have opportunities to build long-term relationships over time with clients and develop connections essential in providing spiritual care and supporting individual client spirituality. Spirituality has been identified as a resource for health, and by supporting this resource through spiritual care, NPs could potentially improve the health of their clients.

Attitudes, Beliefs, and Perceptions of Those Receiving Spiritual Care

Clients present spiritual care needs to those who they believe can or should provide spiritual care. In addition, client attitudes and beliefs related to spirituality may differ by cultural group, age, gender, and chronic disease progression (Conner & Eller, 2004). Client perception as to what constitutes spiritual care often differs from those of health care providers (Conner & Eller, 2004; MacLean, Susi, Phifer, Schultz, Bynum, Franco, Cykert, 2003; Ross, 1994).

African-American patients. Conner and Eller (2004) compared spiritual beliefs and values (using Reed's SPS), spiritual needs with a single item question using a 6-point Likert response, and perceived health status (based on how many disease processes or medical diagnoses the individual was managing) among a convenience sample of 44 African-Americans (AA) recruited from three churches. Participants also completed two open-ended questions following the spiritual needs item, identifying "those spiritual needs" and "what the nurse could do" to meet those needs if the participant was

hospitalized. Findings indicated significant differences existed between spiritual values and health status, with spiritual values increasing as health status decreased ($p = 0.001$).

Those above the median age of 57 rated higher in spiritual perspective ($p = 0.04$) and spiritual values ($p = 0.04$). Open-ended questions were also included in the study to allow for exploration of desired nursing interventions. These desired interventions were clustered into Reed’s (1992) three themes of connection to self (music, peace/quiet, hope), others (presence of others, support, witnessing), and God (prayer, bible reading, communication with God). This study demonstrates that within the AA community, spirituality increases with age and illness, and that AAs want spiritual care from nurses.

Male elderly patients. In the United Kingdom, Ross (1997) conducted semi-structured interviews with 10 elderly male patients admitted to a medical observation unit to explore clients’ perceptions of their spiritual needs. Participants identified two important themes in meeting spiritual needs, which included a continuing search for meaning, and making sense out of life’s events. Participants did not identify nurses as having provided any spiritual care and nurses were not considered as possible spiritual care givers. This brings into question the role of the nurse in the area of spiritual care with men and perceived expectations of spiritual care between nurses and male clients, particularly in the UK.

Patients with chronic illness. Other studies looked at the process of finding the meaning of spirituality by patients who have chronic diseases. Using the Glaserian method of grounded theory, Walton (2002) studied patients on hemodialysis to reveal the process of finding meaning of spirituality for these patients, and the effect of spirituality on their lives and health. Participants (n=11) were from a rural outpatient-

based hemodialysis unit. The findings revealed that spirituality is a life-giving force and a process of finding balance in life, which was nurtured by connection with others, God, and the environment. Everyday life on dialysis made finding a balance important and occurred in a process of four phases: confronting mortality, reframing, adjusting to dialysis, and facing the challenge. Categories of spirituality included faith, presence of God and others (being with), receiving (life from dialysis), and giving back (born of the process of introspection and reflection). In addition, the categories and the process of this beginning theory supported the findings in the literature that spirituality provides support for coping and promoting health.

For patients, spirituality is affected by increasing age, increasing severity of disease, and culture. Spiritual care is desired by older adults, African-American cultures, and as disease processes worsen. Spirituality is a process that promotes connection to others, self, and God while supporting health. Nurses are not always considered spiritual caregivers by male patients, an idea not always congruent with how nurses perceive their role. Spiritual care interventions vary but frequently promote ways to find meaning, purpose, and connections in life.

Perceived Barriers in Providing Spiritual Care

Both nurses and physicians identified lack of education and lack of time as a barrier in providing spiritual care (Ellis, et al., 1999; Hubbell, et al., 2006; MacLean, et al., 2003; Olson, et al., 2006; Sellers & Haag, 1990; Stranahan, 2001; Taylor, 2003). In addition, nurses also identified a lack of experience as a barrier, and physicians identified conflict as to what their role was in the provision of spiritual care. Frequently, the provision of spiritual care was treated as a separate procedure needing a separate

block of time, rather than being part of a spiritual practice incorporated into the entire process of interaction (Hubbell, et al., 2006; MacLean, et al., 2003; Stranahan, 2001; Wacholtz & Pargament, 2005). Spiritual care has been identified as being important to health but is not generally taught in nursing programs or medical schools (Olson, et al., 2006; Sellers & Haag, 1990)

Barriers to providing spiritual care in nursing. The literature repeatedly identified barriers to spiritual caregiving for nurses. These barriers were limited to only a few but have been identified as significant in the provision of spiritual caregiving by nurses.

Barriers in nursing education. Nurses have identified a lack of education in spiritual caregiving in their undergraduate as well as graduate programs (Sellers & Haag, 1998; Stranahan, 2001). In addition, those who are drawn to certain areas of nursing which focus on spiritual caregiving such as parish nursing or hospice care, often seek out informal ways to learn to provide spiritual care (Sellers & Haag, 1998). Lack of knowledge in spiritual caregiving was an identified barrier to providing spiritual care by nurses.

Nurse practitioners. Nurses have identified a lack of formal education in their basic and graduate nursing programs as a barrier to providing spiritual care. Maddox (2001) was interested in finding an assessment tool for nurse practitioner students to assess the spiritual needs of elderly patients, as students were found lacking in ability to assess or provide spiritual care while in their master's program. This descriptive exploratory study of 18 students found students lacking knowledge on the use of a specific spiritual assessment protocol. With further discussion as a focus group, students

identified feeling ill-prepared to perform a spiritual assessment and provide spiritual care. Providing in-class assignments and case studies related to spirituality and spiritual care greatly improved the students' clinical insights. With an increase in knowledge, students subjectively identified an increased confidence in providing spiritual care, which translated into increased spiritual self-awareness and improved abilities to provide such care.

Hospice, oncology, and parish nurses. Several studies highlight that lack of education or inadequate education on spiritual care in basic nursing programs hinders the provision of spiritual care by nurses (Highfield, Taylor, & Amenta, 2000; Maddox, 2001). Identifying that nurses did not believe they had enough education to provide spiritual care, Sellers and Haag (1998) explored how nurses learned about spiritual care interventions by identifying other educational sources besides nurses' basic nursing programs. A convenience sample (n = 224) was recruited from the Midwest and consisted of hospice (15%), oncology (12%), and parish nurses (57%).

Using a survey tool developed by the researchers, participants were asked to identify, describe, and rank in order of frequency specific nursing interventions they used to enhance the spirituality of patients and families. The participants were then asked to designate how they learned about the identified interventions. There was no discussion of reliability of this tool. Content validity was determined by a panel of experts. Ninety-five nursing interventions were repeatedly identified by 179 of the participants, with the ten most frequently used as follows: referral to spiritual advisor/minister, prayer, active listening, therapeutic communication, acceptance and respect, instilling hope, clarifying

patient's spiritual values and experiences through a spiritual history, presence, touch, and community resource referrals.

Nurses learned about these interventions through continuing education (65%), clinical experiences (63%), and reviewing the nursing literature or from nursing colleagues (39%). Only 45% had any education in spirituality and spiritual caregiving in their basic nursing program, with almost one-third feeling this education was inadequate. This study supported the perception that there is a lack of or inadequate education on spiritual care in nursing programs, and those who needed such knowledge sought it in other ways.

Hospice and oncology nurses. A descriptive secondary survey with oncology and hospice nurses by Highfield, et al. (2000) revealed a lack of education in spirituality and spiritual caregiving as a barrier to providing spiritual care. Six questions were analyzed from the Oncology Nurses Spiritual Care Perspective Scale (ONSCPS) that addressed frequency, ability and comfort in providing spiritual care, training/education and adequacy of education in spiritual care, and the influence of people living with terminal illness on the nurses' spirituality. This survey of oncology and hospice nurses (n = 181 and 645 respectively) indicated that hospice nurses had more education in spirituality, but the majority of participants from both groups felt they were inadequately prepared (52%).

Barriers in nursing experience. Lack of education in spiritual care influences the confidence and ability of the nurse in providing spiritual care in practice, thus limiting experience (Kociszewski, 2004; Maddox, 2001). In addition, nurses need to understand and experience their own spirituality in order to be sensitive to the spiritual needs of others (Carroll, 2001). The Highfield, et al. (2000) study presented in the previous

paragraph found that 96% of oncology and hospice nurses in the sample indicated patients had positively influenced their spirituality, with 66% indicating patients had significantly influenced them. The ONSCPS tool, which is scored on a 5-point Likert scale, was used in this study. Content analysis of the comments section included the nurses' recovery of their own spiritual past and discovery of new beliefs while uncovering patient needs. The findings support that nurse experience and nurse-client interactions can impact the spiritual caregiving of the nurse by providing the nurse with positive influences and experience in this domain.

Barriers to providing spiritual care in medicine. Lack of education, time, and spiritual well-being are described in the physician literature as barriers to the provision of spiritual care. The following section will describe the research literature regarding these identified barriers for physicians.

***Lack of time, education, and spiritual well-being*.** The medical literature described physician ability to discuss spiritual care issues with patients as being moderated by the physician's spiritual well-being, which has been identified as a barrier to providing this type of care. In addition, lack of time in the physician-client visit, as well as limited education provided on spiritual caregiving in medical school curriculum, have also been identified as impediments in the provision of spiritual care by physicians.

Family physicians were surveyed by Ellis, et al. (1999) to explore the physicians' spiritual well-being, perceived barriers to discussing spiritual issues with clients, and how often spiritual issues were actually discussed with clients. A random sample (n = 231) was selected from the list of board-certified Missouri family practice physicians

who practiced in the community (n=108), were on staff as faculty (n=43), or were resident physicians (n=80).

The participants completed the Spiritual Well-Being scale (SWB) which assesses both religious and existential well-being (Appendix F). Mean existential scores were higher than religiosity scores, with 96% of the participants viewing physician spiritual well-being as an important component of physician health and ability to discuss spiritual concerns with clients. However, 86% of the participants believed spiritual issues of patients should be referred to a chaplain or the patient's spiritual leader, with only 44% of physicians reporting frequent referral rates. ANOVA revealed the frequency of discussing spiritual care issues with clients did not differ significantly between the community and faculty physicians; however, both groups discussed spiritual issues more frequently than resident physicians (p = .005). Lack of time (71%), lack of education on how to take a spiritual assessment (59%), difficulty in identifying clients who desired attention to spiritual concerns (56%), and physicians' concerns about personal religious beliefs being projected onto the clients (53%) were the identified barriers to the provision of spiritual care during a client visit or encounter.

A limitation of the study was the lack of reliability and validity data of the revised SWB scale. Because participants were either practicing in the community, on staff as faculty, or resident physicians, the results may be more generalizable to family physicians within various levels of experience, practice settings, and age. This study supports lack of time as a main perceived barrier to the provision of spiritual care to clients by physicians.

Other studies indicate that client visits with physicians have a fixed time and a medical problem focus. Clients and physicians are reluctant to give up time from medical issues to discuss spiritual issues, making this an either-or situation (Maclean, et al., 2003). Teaching physicians how to make their practice a spiritual practice and weave spiritual care throughout their everyday encounters with clients might help to decrease the perception of lack of time. This would require a shift in their paradigm from viewing spiritual care as an additional billable item or procedure to an integrated way of providing health care in a holistic manner. This paradigm shift would also be applicable to other health care providers.

Barriers to providing spiritual care with multidisciplinary teams: lack of education and skills. Multidisciplinary health care teams have been found to be effective in providing a holistic approach to patient care in specialty areas (El-Nimr, et al., 2004). Many of these teams include nurses, physicians, chaplains, therapists, and even patients or their families in some cases. In relationship to spiritual care, these teams provide multiple perspectives and skill levels. This section will discuss barriers to providing spiritual care as identified by those involved with multidisciplinary teams, including lack of education and need for increased skill in spiritual caregiving.

In a psychiatric, multidisciplinary setting, Greasley, et al. (2001) identified barriers to the provision of spiritual care while trying to clarify the issue of spiritual care from the perspective of psychiatric patients, nurses, psychiatrists, and therapists. Details of this study are described previously in the multidisciplinary section: Attitudes, Beliefs, and Perceptions of Those Providing Spiritual Care. Professional and client focus groups identified a distinct need for further education and training of staff and caregivers in

order to be more attuned and adept at providing spiritual care. This is consistent with one of the barriers identified in the literature by physicians and nurses.

Details of the study by El-Nimr, et al. (2004) are also described in the section: Attitudes, Beliefs, and Perceptions of Those Providing Spiritual Care, with lack of education again identified as a barrier. In a survey, nurses, general practitioners, and psychiatrists who worked with mental health patients in a psychiatric facility were asked about factors which impacted spiritual caregiving. An important finding was the difference in spiritual caregiving education, where 20% of nurses, 2% of general practitioners, and 8% of psychiatrists had received some form of spiritual care training in the past. Nurses identified spiritual caregiving as being very important, followed by general practitioners and psychiatrists. However, the psychiatrists believed they should be the primary ones to evaluate and decide whether or what type of spiritual care was to be given to patients in this setting.

These studies have identified perceived barriers to the provision of spiritual care which include lack of time, lack of education, and lack of experience of the provider. Also, research suggests that the development of a personal spirituality and improved spiritual well-being allows for the provider to be more sensitive to clients' spiritual needs. Clients have also been identified as influencing the spirituality of the providers (Highfield, et al., 2000). There is a lack of provider education on spiritual care in both nursing and physician education, and a recognized limitation of time to address spiritual care needs of clients by health care providers (El-Nimr, et al., 2004; Greasley, et al., 2001). Graduate NP education has expectations of providing care to the whole person but lacks specific curricula regarding spiritual care as part of these expectations.

Students also do not enter their graduate programs with significant knowledge on providing spiritual care (Maddox, 2001).

Research indicates that most health care providers do not provide spiritual care. Clients want spiritual care provided within their visits or encounters with health care providers. Perceptions of spirituality, spiritual care, and who should provide this care differ among providers as well as cultural groups of clients. Barriers in providing spiritual care include lack of education, experience, and time. There was little discussion found in the literature, however, on how to overcome these barriers.

Gaps in the Literature

The literature supports the phenomenon that spiritual care can assist clients in improving aspects of their health. In addition, as one ages and chronic disease processes worsen, the desire by clients for the provision of spiritual care from their health care providers increases (Conner & Eller, 2004). The literature also supports the belief that spiritual care should be a part of nursing care (Stranahan, 2001). However, there are distinct gaps in the literature between the professional belief that spiritual care is part of the nursing role, the professional standards that support such care, curricular attention to spiritual care in nursing education, and the provision of such care. This is particularly true about GNPs, as they serve the population that desires spiritual care most from their health care providers.

Education

Specific barriers to providing spiritual care by nurses have been identified as lack of education, lack of time, and lack of experience. No studies to date have assessed specifically what lack of education entails with regard to NPs in general and GNPs in

particular. Since graduate educational standards are broad with regard to spiritual care, it is difficult to ascertain what is lacking in graduate education on spiritual care. There is the possibility that the perceived lack of education may actually be lack of personal spiritual self awareness and self-connection, as this increases sensitivity to other's spiritual needs. Further research could include exploring and describing areas to establish baselines for where current practice is and educational needs might exist for GNPs. Such areas could include the ability of GNPs to recognize client cues and behaviors indicating a spiritual need, and whether GNPs are likely to further assess this cue or behavior. Establishing how the GNP learned to recognize this particular cue or behavior as an indicator of a spiritual care need might also assist in guiding educational programs of GNPs. Experimental designs could include methods to assist the GNP to increase the intrapersonal relationship to expand consciousness, gain insights, and transcend. This would allow for knowledge acquisition and would improve the ability to provide spiritual care as well as enhance the intrapersonal and the interpersonal relationships while supporting transcendence.

Time

Evident in the literature is the perception among health care providers that providing spiritual care to clients requires more time. Nothing has been documented to support this perception in the research. In practice, GNPs are evaluated based on a productivity formula. In primary care, this typically means seeing higher numbers of clients within less time. Not all clients will require spiritual care however. Those that do are perceived as requiring more time for the visit unless there is a way GNPs can view their practice as a spiritual practice. In this way, spiritual care is interwoven throughout

the visit. Spiritual care is not seen as a separate procedure or an additional task in this situation and should require no additional time. There is the potential therefore to change the health care providers’ perceptions or validate their perceptions.

Using Newman’s Theory of HEC (2000, 2008) as a base, further research might assist the GNP to recognize patterns of relating within the interpersonal relationship by identifying cues and behaviors of clients requiring spiritual care. Using a reflective practice to gain knowledge on interactions with the environment could provide insights on how to assess and provide spiritual care (Burkhart & Hogan, 2008). This may support the actual provision of spiritual care within a specific timeframe, thereby providing a sense of expanded time based on insights and skill acquisition through pattern recognition. This is important because lack of time is identified as the second barrier in both the nursing and physician literature (Maclean, et al., 2003; Stranahan, 2001).

Summary

There is little research in the literature on spiritual care with the GNP population. Most research centers on staff nurses and physicians, and is not grounded in the GNP role. Little is known about how GNPs define, perceive, or implement spiritual care, or define or perceive spirituality. It is unknown if GNPs can identify client cues when spiritual care is needed, or what type of spiritual care interventions GNPs provide. The GNPs’ own spiritual care memories, past spiritual care encounters, education, spiritual perspectives, and personal spiritual well-being may influence this ability to identify cues, assess the spiritual needs of clients, and provide spiritual care, however this has not been studied (Burkhart & Hogan, 2008; Reed, 1986; Reed, 2008; Sellers & Haag1998).

More research is needed to describe the present practice of GNPs in relationship to the assessment of spiritual care needs of clients, provision of spiritual care interventions, and the GNPs' own spiritual perspectives. Spiritual perspectives may affect the ability to provide spiritual care and can possibly be altered with an increasing intrapersonal relationship. Understanding the relationship between GNPs' spiritual perspective and ability to assess the need for and to provide spiritual care will also help guide GNP education in this area.

CHAPTER THREE

METHODS

Purpose

Research has indicated that older adults and those with chronic diseases desire spiritual care from their health care providers. Promoting spiritual care has the potential to improve the health of clients. Geriatric nurse practitioners (GNPs) are in a position to provide such care to the older adult population they serve. More research is needed to further understand the dimensions of spirituality and spiritual care among GNPs and the population they serve.

The purpose of this descriptive study is to gain a better understanding of the association between GNP practice and the spiritual perspectives of the GNPs. This understanding may help inform GNP educational initiatives to include holistic care (AACN 1995, 2006; AACN/HGNI, 2004; NONPF, 2002) or reflective practice (NONPF, 2006) for GNPs within the recommended competencies. Providing holistic care is found within the recommended competencies for GNP education. Holistic care within a nursing framework includes care of the mind-body-spirit (Watson, 2008).

Although spiritual care is viewed as valuable, GNPs have few opportunities to develop abilities to provide such care within their graduate education. Those interested in providing spiritual care often pursue such education outside of academic programs (Highfield, et al., 2000; Sellers & Haag, 1998; Stranahan, 2001). It is therefore important

to understand the present spiritual perspectives of GNPs in practice, and the relationship between these perspectives and the frequency of conducting spiritual assessment a spiritual care interventions. This understanding will help direct educational offerings in spiritual care for GNPs.

Research Design

This cross-sectional, descriptive, survey design investigates practicing GNPs' spiritual perspectives. Also measured were the frequency of GNPs assessing for spiritual care needs and providing specific spiritual care nursing interventions. Investigation was also undertaken to determine whether there was a relationship between the GNPs spiritual perspectives and the frequency of nursing assessment of needs and provision of spiritual care interventions. This design addressed gaps in the literature describing the integration of spiritual care into GNP practice and the influence of individual spiritual perspectives on this care.

Sample

The sample was a stratified randomized sample taken from a listing of nationally certified GNPs who are members of the American Academy of Nurse Practitioners (AANP). The AANP, with approximately 125,000 members who hold various types of national certifications as NPs, has a research sampling program that allows for qualified researchers to apply for sampling of its NP members. If requested, sampling could be stratified by type of certification and geographic location, which would allow for narrowing of the sample to certified GNPs throughout the United States. This practice specialty was chosen because the client population served by GNPs is most likely to have progressive chronic diseases and increasing age, potentially requiring spiritual care.

Spirituality becomes more important as one ages based on adult social and psychological lifespan theories (Reed, 2008; Tornstarn, 2003). Those excluded from the sample were GNPs who no longer practiced, and NPs who indicated certification in other specialties such as adult or family, who were working in a geriatric setting. A power analysis indicated the need for 82 participants with $\alpha = 0.05$, an effect size of 0.30 (moderate), and a power of 0.80 (Appendix H).

Variables and Instrumentation

Variables included in this research were related to characteristics of the GNP (demographic variables and GNP spiritual perspectives), and GNP practice (GNP assessment of a spiritual care need and GNP spiritual care interventions).These variables were conceptually defined in Chapter 2. Each variable is operationally defined in the following sections. Demographic variables included gender; age; race/ethnicity; religious affiliation; years in practice as an RN prior to GNP certification; years in practice as a GNP; type of NP education; spiritual care education in undergraduate and graduate curriculum; and whether further spiritual care education was sought beyond the academic environment.

Demographic Variables

The literature suggest that spirituality is associated with certain demographic variables, including age, gender, race/ethnicity, and religious affiliations (Berry, 2005; Conner & Eller, 2004; Reed, 1991; Tornstrom, 2003). In addition, the literature suggests that spiritual care may be associated with years in practice, formal educational level, and specialized education in spirituality. These variables were operationalized using a demographic survey created by the researcher, as shown in Appendix J (survey packet).

Year born, gender, and race/ethnicity categories were based on the AANP membership application categories. Religious affiliation categories were based upon categories used by the PEW Research Center. Years in practice as an RN and at the advanced practice level of a GNP were also requested. This was to determine if there were differences in the assessment and provision of spiritual care based on length of practice in either role, as well as if any relationships existed between the number of years in practice as a GNP and individual items in the tools. Assessing educational levels of GNPs was used to determine if differences existed between or within groups, as well as whether relationships were present with certain variables. Finally, information on spiritual care education, whether received during formal undergraduate or graduate education, or informally obtained, were collected. Information on spiritual care education provided some insight into the perception of lack of education on such care in nursing programs at various levels, and allowed for establishment of differences between or within groups or identification of relationships between education levels and specific items or variables.

Spiritual Perspectives of Nurse Practitioners

This section will present conceptual as well as operationalization of the variable spiritual perspectives. Psychometrics of the tool used will also be discussed. Research using the Spiritual Perspective Scale (SPS) found that women, older adults, and more seriously ill adults scored significantly higher on the SPS than men, younger adults, and well adults (Dailey & Steward, 2007; Gray, 2006; Jesse & Reed, 2004; Thomas, Burton, Quinn-Griffin, & Fitzpatrick, 2010; Tuck, McCain & Elswick, 2001).

Conceptual definition of spiritual perspectives. One's spiritual perspective is influenced by development of self-awareness, life events, and interaction with the world around us, and results in how one views the interconnectedness of the world and self (Gray, 2006). Developing one's spiritual perspective might promote a heightened sensitivity to others' spiritual concerns and an elevated consciousness regarding spirituality, which could be potentially helpful in the assessment process (Olson, et al., 2006; Newman, 2000).

Operational definition of spiritual perspectives. Spiritual perspective for this research is operationalized using the Spiritual Perspectives Scale (SPS) by Reed (1991) (Reed, personal communication July 29, 2009) (Table 1). The SPS has three sections: two quantitative subscales and one qualitative subscale. The first subscale measures the extent that spirituality permeates the individual's life (perspectives, items 1-5).The second subscale measures spiritually related interactions one is engaged in regularly based on the participant's understanding of spirituality (interactions or behaviors, items 6-10). The third subscale is the qualitative portion. This section asks participants to provide their definition of spirituality and any other additional comments they believe the researcher should know.

The quantitative portion consists of a total of 10 items scored using a 6-point Likert scale to measure overall spiritual perspectives. Scoring ranges from 1.00 (not at all or strongly disagree) to 6.00 (about once a day or strongly agree). Calculating the mean across all items provides a score which ranges from 1 to 6 (Gray, 2006; Reed, 2008). Scoring and summing across items and using the arithmetic mean, or using ordinal data as interval data, more accurately captures the true variability of each score and improves

Table 1. Reed's Spiritual Perspective Scale

Introduction and Directions: In general, spirituality refers to an awareness of one's inner self and a sense of connection to a higher being, nature, others, or to some purpose greater than oneself. I am interested in your responses to the questions below about spirituality as it may relate to your life. There are no right or wrong answers. Answer each question to the best of your ability by marking an "X" in the space above that group of words that best describes you.

1. In talking with your family or friends, how often do you mention spiritual matters?

___________/___________/____________/___________/___________/___________

Not at all / Less than once a year / About once a year / About once a month / About once a week / About once a day

2. How often do you share with others the problems and joys of living according to your spiritual beliefs?

___________/___________/____________/___________/___________/___________

Not at all / Less than once a year / About once a year / About once a month / About once a week / About once a day

3. How often do you read spiritually-related material?

___________/___________/____________/___________/___________/___________

Not at all / Less than once a year / About once a year / About once a month / About once a week / About once a day

4. How often do you engage in private prayer or meditation?

___________/___________/____________/___________/___________/___________

Not at all / Less than once a year / About once a year / About once a month / About once a week / About once a day

Directions: Indicate the degree to which you agree or disagree with the following statements by marking an "X" in the space above the words that best describe you.

5. Forgiveness is an important part of my spirituality.

___________/___________/____________/___________/___________/___________

Strongly Disagree / Disagree / Disagree more than agree / Agree more than disagree / Agree / Strongly Agree

6. I seek spiritual guidance in making decisions in my everyday life.

___________/___________/____________/___________/___________/___________

Strongly Disagree / Disagree / Disagree more than agree / Agree more than disagree / Agree / Strongly Agree

7. My spirituality is a significant part of my life.

___________/___________/____________/___________/___________/___________

Strongly Disagree / Disagree / Disagree more than agree / Agree more than disagree / Agree / Strongly Agree

8. I frequently feel very close to God or a "higher power" in prayer, during public worship, or at important moments in my daily life.

___________/___________/____________/___________/___________/___________

Strongly Disagree / Disagree / Disagree more than agree / Agree more than disagree / Agree / Strongly Agree

9. My spiritual views have had an influence upon my life.

___________/___________/____________/___________/___________/___________

Strongly Disagree / Disagree / Disagree more than agree / Agree more than disagree / Agree / Strongly Agree

10. My spirituality is especially important to me because it answers many questions about the meaning of life.

___________/___________/____________/___________/___________/___________

Strongly Disagree / Disagree / Disagree more than agree / Agree more than disagree / Agree / Strongly Agree

Table 1. Reed's Spiritual Perspective Scale (continued)

If possible, please describe how you define spirituality on the back of this page, or provide any other comments you feel are important for the researcher to know about.

the statistical power (N. Tintle, November 19, 2010, personal communication).The use of ordinal data as interval data is supported in the literature and is the scoring method identified by the author (Armstrong, 1981; Granberg-Rademacker, 2010; Reed, 2008).

Psychometrics of the Spiritual Perspectives Scale. Cronbach's alpha coefficient ranged from 0.93 to 0.95 in patient populations, with test-retest reliability ranging from 0.57 to 0.68 for the entire tool (Reed, 2008). Subscales coefficients were 0.84 for perspectives and 0.60 for behaviors. Reed (2008) reported the Cronbach alpha coefficient at 0.90 for the entire tool. Inter-item correlations were greater than 0.40 during instrument development with no redundancy, which also supported internal consistency (Gray, 2006; P. Reed, personal communication, October 22, 2010). Construct validity for the SPS tool was supported by the known-groups technique in which certain groups scored in a fashion that would be theoretically predicted if the instrument measured spiritual perspectives (P. Reed, personal communication, October 22, 2010).

Spiritual Care Nursing Assessments

This section will present conceptual as well as operational definitions of the variables. Discussion of the development of a tool based on concept analysis of the literature will be discussed. The psychometrics of the tool will be presented and include face and content validity as well as internal consistency.

Conceptual definition of spiritual care nursing assessments. Spiritual care

nursing assessments include gathering verbal and non-verbal data on clients' spiritual care needs by various methods. Accurate assessments are important for the implementation of appropriate nursing interventions (Scherb & Weydt, 2009).

Operational definition of spiritual care nursing assessments. There were no specific tools found in the literature for use with GNPs for assessing clients' spiritual care needs. Therefore, spiritual care nursing assessment was operationalized by a tool developed by the researcher called the Vincensi Spiritual Assessment Tool (VSAT) based on content analysis of the nursing and psychiatry literature related to spirituality, oncology, cultural, and geriatric care. Phenomenological, conceptual, and quantitative articles provided support for the development of each item.

The VSAT tool is divided into four parts. Part I is a general indicator item and measures the participant's own perceived ability to recognize when clients need spiritual care. This item is measured on a 5-item Likert scale from never to always (1=never, 5=always). Part II contains patient indicator items measuring a need for spiritual care and consists of 15 items measured on a 5-item Likert scale from never to always (1=never, 5=always). These items asked participants the frequency they were able to determine a client's need for spiritual care when certain client cues and behaviors were present. Part III presented formal and frequently used spiritual assessment tools found in the literature to assess spiritual care needs of clients (FACIT-Sp, [Cella, Tulsky, Gray, Sarafian, Linn, Bono, Siberman, et al., 1993], FICA [Pulcalski & Romer, 2000], SIWB [Daaleman & Frey, 2005] and Other). Participants were asked to identify if and how often they used any of the tools, also scoring on a 5-item Likert scale from never to always (1=never, 5=always). The final question in Part IV was an open-ended question which allowed the

participants to write in any other information that they might want to share with the researcher (Table 2).

Psychometrics of Vincensi Spiritual Assessment Tool (VSAT). Psychometric testing of this tool included content analysis of the literature for item development and creation of the initial tool, and face and content validity testing. Items were initially developed based on the literature. The referenced items per subscale are listed in Table 2.

Content validity for this tool was done using Lawshe's method (1975). Four NPs educated at the PhD level who were national experts on spirituality in nursing, as well as 2 masters prepared NPs who were educated and practicing part time as parish nurses, agreed to be content experts. All were practicing part time or full time as nurse practitioners (ANP, FNP certifications) in addition to their roles as educators, researchers, or parish nurses, and all had expertise in spiritual care demonstrated through published research on spiritual care in nursing or their parish nurse education and ministry.

The Lawshe method asks the subject matter experts (SMEs) to rate each item on the tool as to whether the skill or knowledge measured by this item is "essential" "useful, but not essential" or "not necessary". If an item had greater than 50% agreement by the expert raters as being "essential", then it had some content validity.

The content validity ratio or CVR that was used was: $CVR = (n_e – N/2) / (N/2)$. The n_e = number of SME panelists indicating an item is essential, and N = total number of SME panelists. This formula yields a range from +1 to -1 where positive values indicate more "essential" ratings. The mean CVR across items may be used to indicate content validity. Five to seven panelists are recommended to assure a minimum value of 0.99 that agreement is unlikely due to chance (Rungtusanatham, 1998). The original tools

Table 2. Referenced Vincensi Spiritual Assessment Tool (VSAT)

Item	1	2	3	4	5
I. Please circle the following statement which best describes your NP practice?					
1. I am able to recognize when my clients are in need of spiritual care.	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
II. Using the following indicators from clients, please circle the answer which best describes your ability in each statement to determine clients' needs for spiritual care? I am able to determine a client's need for spiritual care when they:					
2. Demonstrate difficulty coping with certain health concerns or diagnosis. (Taylor, Amenta, & Highfield, 1995)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
3. Display a sense of helplessness. (Carroll, 2001; Taylor, et al., 1995)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
4. Cry during their visit. (Carroll, 2001; Taylor, et al., 1995)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
5. Appear to have lost meaning or purpose in life. (Carroll, 2001; Taylor, et al., 1995)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
6. Appear to have become disconnected from relationships. (Narayanasamy, 2004; Narayanasamy, Clissett, Parumal, Thompson, Annasamy, & Edge, 2004; Newlin, Knafl, & Melkus, 2002; Shaw, 2005; Tanyi, 2002; Stranahan, 2001)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
7. No longer appear comfortable with accepting love from others. (Carroll, 2001; Taylor, et al., 1995)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
8. Are having difficulties forgiving. (Carroll, 2001; Taylor, et al., 1995; Narayanasamy, Clissett, et al., 2004)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
9. Are grieving over various losses, including health losses. (Carroll, 2001; Taylor, et al., 1995; Narayanasamy, Clissett, et al., 2004 ; Newlin, et al., 2002; Wallace, & O'Shea, E. 2007)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
10. Verbalize fear or anxiety related to health concerns. (Carroll, 2001; Taylor, et al., 1995)	1 Never	2 Rarely	3 Sometimes	4 Often	5 Always

Table 2. Referenced Vincensi Spiritual Assessment Tool (VSAT) (continued)

11. Express life has no meaning or purpose now. (Carroll, 2001; Taylor, et al., 1995; Narayanasamy, Clissett, et al., 2004; Wallace, & O'Shea, E. 2007) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always
12. Display, verbalize, or express anger related to health. (Carroll, 2001; Taylor, et al., 1995) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always
13. Tell you they no longer are involved with spiritually or religiously related activities or rituals which have brought them peace, comfort, or a sense of connection in the past. (Carroll, 2001; Taylor, et al., 1995) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always
14. Mention directly they are interested in talking about their spiritual needs with someone. 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always
15. Display a sense of hopelessness. (Carroll, 2001; Taylor, et al., 1995) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always
16. Are having difficulties being forgiven. (Carroll, 2001; Taylor, et al., 1995; Narayanasamy, Clissett, et al., 2004) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always
III. I use one of the following spiritual assessment tools to assess the spiritual needs of my clients: **FACIT-Sp** (Functional Assessment of Chronic Illness Therapy- Spiritual well-being scale) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always **FICA** (**F**aith/Spirituality, **I**mportance, belong to a faith **C**ommunity, how should health care provider **A**ddress concerns) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always **SIWB** (Spiritual Index of Well-being) 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always **Other** ____ 1 Never — 2 Rarely — 3 Sometimes — 4 Often — 5 Always
IV. Is there any other information you would like to share?

sent to each SME before revisions can be found in Table 3. The CVR equations had values between -1.00 to +1.00. A CVR $\geq$ 0.00 in the essential column on any item meant 50% or more of the SMEs agreed the type of importance of the item to the construct was "essential". Comments were also requested and considered when revising the tools.

Based on these findings, six items were eliminated. Four items with negative scores in the essential column were eliminated (items 2, 4, 10, 12), as well as two that had a score of 0.00 for both columns of "essential" and "useful but not essential". This indicated 50% of the SMEs were split between the two choices for each item (items 7, 8). The latter two deletions were also based on further input from the experts that indicated possible contextual issues for the items. Appendix J presents the complete content validity scoring and SME comments on the VSAT.

The measurement system for the items was revised based on content expert opinion. Each item needed to be measured as to the likelihood of recognizing the spiritual need and then, if recognized, the likelihood of further assessing this spiritual need. Therefore, each item was measured in two ways, as shown in the final tool (Table 4). The division of the tool into two dimensions of first identifying the cues and behaviors of spiritual care needs of clients followed by how likely the participant was to follow up and probe further about this need, was inspired by a comment from one of the SMEs:

> In my experience, the key to being able to provide adequate spiritual care lies in the level of spiritual well-being that is experienced by the **care giver**. Thus, internal (intrapersonal) analysis is very important for (in our case) nurses who are working on doing accurate spiritual assessments of patients. Unless the nurse is comfortable with his/her inner sense of spiritual well-being, the exercise of assessment of a patient's state is pretty much doomed to superficial platitudes or well-meaning but often ineffectual referrals rather than becoming an integral part of the care provided.

Table 3. Content Validity Summary of Vincensi Spiritual Care Assessment Tool (VSAT)

Items	Responses CVR Scores ( ) NA = no answer		
Displayed, verbalized, or expressed need for spiritual care	Essential	Useful, but not Essential	Not Essential
1. How often if ever, do you believe you are able to recognize when your patients are in need of spiritual care?	3 (0.00)	NA	NA
2.Demonstrate difficulty coping with certain health concerns or diagnosis	2 (-0.34)	4 (+0.34)	-
3.Displays a sense of helplessness	3 (+0.34)	2 (-0.34)	NA
4.Cry during their visit	2 (-0.34)	2 (-0.34)	1 (-0.66)
5.Appear to have lost meaning and purpose in life	6 (+1.00)	-	-
6.Appear to have become disconnected from relationships	4 (+0.34)	2 (-0.34)	-
7.No longer appears comfortable with accepting love from others	3 (0.00)	3 (0.00)	-
8.Are having difficulties forgiving	3 (0.00)	3 (0.00)	-
9.Are grieving over various losses including health losses	4 (+0.34)	1 (-0.66)	1 (-0.66)
10.Verbalize anxiety related to health concerns	2 (-0.34)	4 (+0.34)	-
11.Expresses life has no meaning or purpose now	6 (+1.00)	-	-
12.Display, verbalize or express anger related to health	1 (-0.66)	5 (+0.66)	-
13.Tell you they no longer are involved with spiritually or religiously related activities or rituals which have brought them peace, comfort, or a sense of connection in the past	6 (+1.00)	-	-
14.Mention directly they are interested in talking about their spiritual needs with someone	6 (+1.00)	-	-
15.Display a sense of hopelessness	6 (+1.00)	-	-
16.Are having difficulties being forgiven	5 (+0.66)	1 (-0.66)	-

Referrals are one way nurses can provide spiritual care, but such care is not directly provided by the GNP. The question arose as to how to assess the spiritual needs of clients beyond simply recognizing patterns of cues and behaviors, and how to make the assessment "an integral part of the care provided" or integrating the interpersonal relationship during the assessment phase. In order to do this, there was a need to differentiate between recognizing the cues and behaviors without further probing, or recognizing cues and behaviors while probing further into spiritual care needs in order to complete an adequate spiritual care assessment. This would be based on a deeper connection within the interpersonal relationship between GNP and client, thus integrating the proposed model upon which this research is based. Because of this, two dimensions of each of the final questions were added to include the following: how likely would you recognize this cue or behavior as an indicator of a client's need for spiritual care; and, if a patient displayed this cue or behavior, how likely would you further assess spiritual care needs?

Once the final tool was revised, face validity was assessed with two practicing ANPs and two practicing FNPs reviewing the tool. They were asked to determine whether the tool was well designed and usable for the intended sample. Feedback comments indicated the tool was easy to read, survey items were easily understood, and there was little question as to the intent of each item. Some editorial changes were recommended and adapted regarding wording and set-up for easy reading and flow. The final tool can be found in Table 4.

Spiritual Care Nursing Interventions.

This section will present conceptual as well as operational definitions of

the variables. Discussion of the development of a tool based on concept analysis of the literature will be discussed. The psychometrics of the tool will be presented and include face and content validity testing.

Conceptual definition of spiritual care nursing interventions. Spiritual care nursing interventions are focused on enabling clients to tap into inner resources to meet life's challenges and gain meaning, purpose, and insights into their health. Although the word "intervention" as it is used in nursing primarily implies doing (action) rather than being (state), it is important to understand that spiritual care often involves both (Mayer, 1992; E. Taylor, personal communication, August 19, 2009).

Operational definition of spiritual care nursing interventions. The literature did not contain any specific tools to describe spiritual care nursing interventions used by GNPs. Therefore, spiritual care nursing interventions were operationalized with a tool developed by the researcher called the Vincensi Spiritual Care Interventions Tool (VSCIT), based on a content analysis of the literature. The VSCIT was developed from the nursing literature including parish nursing, reflective practice literature, and the spirituality nursing literature. Phenomenological, conceptual, and quantitative articles also provided support for the development of each item.

The final tool consisted of three subscales. Part I is interventions generated by GNPs and consists of ten items scored on a 5-item Likert scale from never to always (1=never, 5 = always). These items asked the frequency the GNP initiated a particular spiritual care intervention. Part II contains five items in which clients initiate or request spiritual care interventions. The GNP assists or follows through on providing these interventions with the permission of the client. This portion also measures

Table 4. Vincensi Spiritual Assessment Tool (VSAT)

Displayed, verbalized, or expressed patient behavior	How likely would you recognize this behavior as an indicator of a client's need for spiritual care?	If a patient displayed this behavior, how likely would you further assess spiritual care needs?
1. Appears to have lost meaning or purpose in life.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
2. Displays a sense of helplessness.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
3. Is having difficulties accepting forgiveness.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
4. Displays a sense of hopelessness.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
5. Appears to have become disconnected from relationships.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
6. Is grieving over various losses, including health losses.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
7. Expresses that life has no meaning or purpose now.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
8. Tells you they no longer are involved with spiritually or religiously related activities or rituals which have brought them peace, comfort, or a sense of connection in the past.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 Never Sometimes Always
9. Mentions directly they are interested in talking about their spiritual needs with someone.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always

Table 4. (continued) Vincensi Spiritual Assessment Tool (VSAT)

II. Please circle the answer in the statement which best describes your nurse practitioner practice.

10. In general, how often, if ever, do you believe you are able to recognize when your clients are in need of spiritual care

1	2	3	4	5	N/A
Never		Sometimes		Always	

III. There are formal tools available to use to assess spiritual care needs of patients. Please answer the following questions related to your practice as a NP working with geriatric patients.

11. Have you ever used a tool or rating scale to assess a patient's spiritual needs?
Yes______ No________

If Yes, please check which of the following ones:

_____ **FACIT-Sp** (Functional Assessment of Chronic Illness Therapy-Spiritual well-being scale) (Cella, et al.)
_____ **FICA** (**F**aith/Spirituality, **I**mportance of faith/spirituality, belong to a faith **C**ommunity, how should heath care provider **A**ddress concerns) (Puchalski & Romer)
_____ **SIWB** (Spirituality Index of Well-being) (Daaleman & Frey)
_____ **SWB** (Spiritual Well-being scale) (Paloutziain & Ellison)
_____ **SPS** (Spiritual Perspective Scale) (Reed)
_____ **Other**(list)____

IV. Is there any other information you would like to share with the researcher

frequency on a 5-item Likert scale from never to always (1=never, 5=always). Part III is an open-ended question encouraging participants to share anything else they believe is important regarding spiritual care in their practice.

Psychometrics of Vincensi Spiritual Care Interventions Tool. Psychometric testing of this tool included content analysis of the literature for item development and creation of the initial tool, as well as face and content validity testing. Items were initially developed based on the literature. The referenced items per subscale are listed in Table 5.

Content validity for this tool was done using Lawshe's (1975) method as previously described for the VSAT. The same six SMEs used for the VSAT also provided validation of content for the VSCIT. This included four NPs educated at the PhD level who were national experts on spirituality in nursing, as well as two masters prepared NPs who were educated and practicing part time as parish nurses, who agreed to be content experts. All were practicing part time or full time as nurse practitioners (ANP, FNP certifications) in addition to their roles as educators, researchers, or parish nurses, and all had expertise in spiritual care demonstrated through published research on spiritual care in nursing or their parish nurse education and ministry.

The CVR formula was used to obtain the ratio for each item as well as tool, based on SME input and feedback. Again, each was asked to identify if the item was "essential", "useful, but not essential," or "not essential," along with any comments. Table 6 summarizes this feedback and provides the CVR of each item. The CVR for the entire tool was 0.73. All items were 0.00 or above. The SMEs were split on item 3 between "essential" and "useful but not essential". Active listening had been identified as a spiritual care intervention in the literature (Taylor, 2008; Watson, 2008); however, several SMEs felt this was part of NP practice in general. This question was reconfigured to deal more with spiritual care concerns.

Other feedback suggested changing wording to focus more on NP interventions, for example, using the word "encourage" instead of "listened." It was also highly recommended to add a question that dealt with healing or working on interpersonal relationships, as this was included in the VSAT and would be appropriate for a GNP-specific SCI, even though the two tools are not tied to each other. Certain items were

Table 5. Referenced Vincensi Spiritual Care Interventions Tool (VSCIT)

Do these statements describe the type of spiritual care intervention you integrate into your NP practice in the Gerontological environment?
1. I have listened to a client talk about their spiritual concerns. (Conner, & Eller, 2004; Solari-Twadell, 2002; Taylor, 2008; Taylor, 2009) 1 Never – 2 Rarely – 3 Sometimes – 4 Frequent – 5 Always
2. I have listened to a client talk about their recent spiritual insights as related to health and chronic disease. (Conner, & Eller, 2004; Newman, 2008; Taylor, 2008; Taylor, 2009) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always
3. I have actively listened to clients tell their story. (Conner, & Eller, 2004; Lee, 2005; Noveletsky-Rosentahl, & Solomon, 2005; Solari-Twadell, 2002; Taylor, 2008; Wallace, & O'Shea, 2007; Taylor, 2009) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always
4. I have encouraged clients to talk about their grieving as it relates to their health, chronic disease, and spiritual well-being. (Taylor, 2008) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always
5. I use touch appropriately as spiritual needs arise with clients. (Solari-Twadell, 2002; Taylor, 2008) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always
6. I have discussed clients' spiritual care needs with colleagues. (Taylor, 2008; Taylor, 2009) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always
7. I have documented spiritual care I provided in clients' charts. (Stranahan, 2001; Taylor, 2008; Taylor, 2009) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always
8. I have encouraged clients to talk about what gives their life meaning and purpose in the midst of chronic disease. (Conner, & Eller, 2004; Lee, 2005; Taylor, 2008; Taylor, 2009) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always
9. I have encouraged clients to talk about how chronic disease affects their relationship to God or whatever they determine is their Transcendent truth or reality. (Conner, & Eller, 2004; Taylor, 2008; Taylor, 2009) 1 Never – 2 Rarely – 3 Sometimes – 4 Often – 5 Always

Table 5. Referenced Vincensi Spiritual Care Interventions Tool (VSCIT) (continued)

10. I have offered to pray with a client. (Conner, & Eller, 2004; Stranahan, 2001; Taylor, 2008; Taylor, 2009)				
1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
11. I have arranged for a visit or made a referral to clients' clergy or spiritual mentors. (Conner, & Eller, 2004; Taylor, 2008; Taylor, 2009; Wallace, & O'Shea, 2007)				
1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
12. I have encouraged a client to talk about coping at the spiritual level. (Solari-Twadell, 2002; Taylor, 2008; Taylor, 2009)				
1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
13. I have provided support for clients' spiritual practices. (Conner, & Eller, 2004; Lee, 2005; Solari-Twadell, 2002; Taylor, 2008; Taylor, 2009; Wallace, & O'Shea, 2007)				
1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
14. I have discussed with clients potential spiritual resources to help meet their needs in the community or institution setting. (Solari-Twadell, 2002; Taylor, 2008; Taylor, 2009)				
1 Never	2 Rarely	3 Sometimes	4 Often	5 Always
15. Please share any thing else you believe is important regarding spiritual care interventions in Gerontological NP practice.				

identified as too wordy which interfered with making the content of the question clear. The recommendations for changes were incorporated into the final tool. Also based on content expert opinion, the final tool was divided into two parts: one initiated by the GNP and one initiated by the clients. Appendix J contains the content validity final results and the SMEs' comments.

Face validity was conducted in the same manner as the VSAT tool, using the same two ANPs and two FNPs for feedback after content validity was completed. Table 7 contains the completed tool after both content and face validity were completed. The face validity feedback was similar to the previous tool (VSAT) with no content or structural

changes needed. Editorial changes were incorporated to make the items clearer and flow more easily for the reader.

Data Collection and Management

Data collections for both the general survey as well as the development of the two tools are discussed in this section. This included content and face validity for the VSAT as well as the VSCIT.

Content and Face Validity Experts

Data were collected for content and face validity using the same method for both the VSAT and the VSCIT tools. As described in the previous section, the original VSAT and VSCIT tools used a survey format with each item followed by "useful" "useful but not essential" and "not essential" choices, plus a column for comments on each item. Four of the six SMEs were identified through the literature and national nursing publications. The other two were known regionally through parish nurse and nurse practitioner networks. They all were initially approached through electronic mail which provided an introduction of the researcher and how the individual was identified as a potential SME, a brief description of the research itself, and a request for their assistance in providing content validity for the 2 tools being developed. All agreed to participate and were supportive. A consent letter (Appendix I) and the survey (Appendix J) were sent electronically to each SME and were returned within 3 weeks. A $10 gift card was included in appreciation of their time.

Once changes were made to the original tool based on the CVR of each of the items as well as narrative input from the SMEs, the final tools were sent to four NPs (two

Table 6. Content Validity Summary of Vincensi Spiritual Care Interventions Tool (VSCIT)

Items	Responses with CVR Scores ( )	
	Essential	Useful but Not Essential
I have listened to a client talk about their spiritual concerns.	xxxxxx (+1.00)	-
I have listened to a client talk about their recent spiritual insights as related to health and chronic disease.	xxxxx (+0.67)	x (+0.33)
I have actively listened to clients tell their story.	xxx (0)	xxx (0)
I have encouraged clients to talk about what gives their life meaning and purpose in the midst of chronic disease.	xxxxxx (+1.00)	-
I have encouraged clients to talk about how chronic disease affects their relationship to God or whatever they determine is their Transcendent truth or reality.	xxxxxx (+1.00)	-
I have documented spiritual care I provided in clients' charts.	xxxxx (+0.67)	x (+0.33)
I have discussed clients' spiritual care needs with colleagues.	xxxxx (+0.67)	x (+0.33)
I use touch appropriately as spiritual needs arise with clients.	xxxx (+0.34)	x (-0.67)
I have encouraged clients' to talk about their grieving as it relates to their health, chronic disease, and spiritual well-being. (*only 5 responded*)	xxxx (+0.60)	x (-0.60)
I have discussed with clients potential spiritual resources to help meet their needs in the community or institution setting.	xxxxxx (+1.00)	-
I have provided support for clients' spiritual practices.	xxxxx (+0.67)	x (+0.34)
I have arranged for a visit or made a referral to clients' clergy or spiritual mentors.	xxxxxx (+1.00)	-
I have offered to pray with a client.	xxxxx (+0.67)	x (+0.33)
I have encouraged a client to talk about coping at the spiritual level.	xxxxxx (+1.00)	-

Table 7. Vincensi Spiritual Care Interventions Tool (VSCIT)

Item	Response
1. I have encouraged clients to talk about their spiritual concerns.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
2. I have encouraged clients to talk about their recent spiritual insights as related to health and chronic disease.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
3. I have encouraged clients to talk about their spiritual difficulties of living with chronic disease.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
4. I have encouraged clients to talk about what gives their life meaning and purpose in the midst of chronic disease.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
5. I have encouraged clients to think about ways to heal relationships in which they are experiencing dissonance.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
6. I have encouraged clients to talk about how chronic disease affects their relationship with God or a Higher Power.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
7. I have documented the spiritual care I provided in clients' charts.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
8. I have discussed a client's spiritual care needs with other health care providers as it impacts the client's health.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
9. I use touch appropriately as spiritual needs arise with clients.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
10. I have encouraged clients' to talk about their grieving as it relates to their health, chronic disease, and spiritual well-being.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A
II. Upon request from clients I have done the following:	
11. In the primary care setting, I have discussed with clients potential spiritual resources in the community to help meet their spiritual care needs.	1 Never 2 Rarely 3 Sometimes 4 Frequent 5 Always N/A

Table 7. Vincensi Spiritual Care Interventions Tool (VSCIT) (continued)

Item	1 Never	2 Rarely	3 Sometimes	4 Frequent	5 Always	N/A
12. I have provided support for clients' spiritual practices.	1 Never	2 Rarely	3 Sometimes	4 Frequent	5 Always	N/A
13. I have arranged for a visit or made a referral to clients' clergy or spiritual mentors.	1 Never	2 Rarely	3 Sometimes	4 Frequent	5 Always	N/A
14. I have offered to pray with clients.	1 Never	2 Rarely	3 Sometimes	4 Frequent	5 Always	N/A
15. I have encouraged clients to cope using spiritual practices or spirituality.	1 Never	2 Rarely	3 Sometimes	4 Frequent	5 Always	N/A

III. Please share anything else you believe is important regarding spiritual care interventions in nurse practitioner practice.

ANPs, and two FNPs) to evaluate for face validity. These individuals were practicing fulltime in their specialty areas and were identified through a local nurse practitioner network. Face validity was completed within a week of the individuals receiving the tools through the mail.

Pilot Study and Research Protocol

Initially, survey packages were mailed to 50 participants as a pilot study. This survey package included the recruitment and information letters, and the survey package itself which consisted of the SPS tool, the VSAT and VSCIT, and the demographic information sheet (Appendix K). This pilot study was done in order to discover any concerns that might emerge related to the method of survey delivery, the surveys themselves, or other problems that might warrant changes prior to the larger mailing.

Two weeks prior to this initial survey mailing, postcards were sent alerting participants to the survey mailing and asking for their participation in the study. Of the initial 50 surveys mailed, 33 (66%) were returned within two weeks. With reminder post cards an additional five more were received, bringing the total return rate of the pilot

study to 76% within one month after the initial mailing.

The responses and the surveys themselves were scrutinized for potential problems, for example, of patterns that might demonstrate difficulty or confusion in understanding questions, potential reluctance to answer certain questions, or any comments that might have been written by participants beyond what was already part of the survey. There were no identified problems or additional comments found with this pilot group. The additional 250 introduction post-cards were then mailed, followed by the survey packages within two weeks of the postcard mailings.

General Survey

A survey method was used to collect data from the sample via mailings. Initially a post-card was sent announcing the study, with the survey sent within a few weeks after this postcard. A $10 gift card was included as an incentive with the mailed survey packet that included a cover letter, an informed consent letter, the survey, a demographic sheet, and a stamped return envelope. Please see Appendix K for a copy of the survey packet. Follow-up reminder postcards were mailed to those who had not responded in 2 weeks after the initial survey mailing.

Data were coded to assure anonymity and confidentiality. Entry of data was performed by the researcher into a password protected Excel spreadsheet initially. Data were cleaned before being transferred to Statistical Package for Social Sciences (SPSS) software package for analysis. The first stage of data cleaning was to visually inspect for any empty cells for data entered on returned surveys. If any were found, the survey was pulled and the appropriate numerical entry was placed in the cell on the spreadsheet.

Next, only those surveys (*n*= 133) that had completed data and met inclusion criteria were transferred to SPSS since the Excel spreadsheet contained all 300 participants in order to track returns and follow up.

Paper surveys were kept in a locked fireproof file cabinet with the key available to the researcher only. Surveys will be destroyed seven years after the completion of this study. The file cabinet is kept in the locked home office area of the researcher.

Ethical Concerns

Internal Review Board (IRB) approval was obtained through Loyola University Health System IRB before beginning the study and IRB procedures were followed. The study posed little to no potential risks or discomfort to participants. Participation was voluntary with no direct or indirect benefits present to the participants. Confidentiality of the SMEs and NPs participating in the content and face validity testing was ensured by locking returned information in the file cabinet to which only the researcher had access to the key, or using a password-protected computer program. Confidentiality and anonymity of survey participants was maintained throughout the study. Participants were assigned a number which was used to preserve anonymity in the data analysis. Confidentiality was addressed with all returned surveys being locked in a file cabinet for which only the researcher had the key. This file cabinet was kept in the locked home office of the researcher. The surveys will be destroyed seven years after the completion of the study. Consent to participate was implied with the return of the survey. No ethical problems or concerns arose during this research.

Data Analysis

Data analysis methods will be presented for each research question.

Research Question 1: What are the spiritual perspectives of GNPs?

The SPS tool was used to answer this question. This tool measures both spiritual perspectives as well as behaviors. Descriptive statistics of each subscale (perspective, behaviors) was done using frequency and percents as well as measuring the arithmetic mean.

1 a. Do spiritual perspectives differ from or correlate with any of the following demographic data: gender; age; race/ethnicity; religious affiliation; years in practice as an RN prior to GNP certification; years in practice as a GNP; type of NP education; spiritual care education in undergraduate and graduate curriculum; whether further spiritual care education was sought beyond the academic environment?

This question was answered looking at the differences between spiritual perspectives of the GNPs and the demographic information collected on the demographic data collection tool using ANOVA and independent *t*-tests. For age, participants were divided into two groups: ≥50 and under 50. The average age of an RN in the US is 47 years (Minority Nurse, 2010), and the average age of the participants was 52 years old. Therefore, 50 was chosen as the division indicator to evaluate whether spiritual perspectives differed by age.

1 b. How do GNPs define spirituality?

The last question of the SPS tool was open ended and allowed for participants

to define spirituality using their own terminology. This qualitative portion was mapped using Krippendorf's (2003) technique for content analysis. The participants' direct quotes were first broken down into individual data and mapped into meaning units. These meaning units were then grouped into categories that were related or similar. The categories were then mapped into two themes 1.) themes that mapped into the research definition, or 2.) themes that did not map into the research definition.

Research Question 2: How do GNPs integrate spiritual assessments into their practice?

2 a. What client cues or behaviors do GNPs recognize as a potential need for spiritual care?

This was answered by content analysis of the literature. Since no tool was found specifically for use with the GNP population, a tool was developed from this content analysis of the literature. Content analysis is presented in table format in the Spiritual Care Nursing Assessment section (Table 2) and is the foundation for items included in a tool to measure spiritual assessment called the Vincensi Spiritual Assessment Tool. This tool measures the frequency of how likely the GNP would recognize specific patterns in cues and behaviors of clients as an indicator of a spiritual care need.

2 b. What are the content and face validity and internal consistency of the VSAT?

Content validity was done with the previous six SMEs of four NPs educated at the PhD level who were national experts on spirituality in nursing, as well as two masters prepared NPs who were educated and practicing part time as parish nurses. All were

practicing part time or full time as nurse practitioners (ANP, FNP certifications) in addition to their roles as educators, researchers, or parish nurses, and all had expertise in spiritual care demonstrated through published research on spiritual care in nursing or their parish nurse education and ministry.

Lawshe's method was used to obtain the CVR to determine which items were supported (1975). The tool was modified based on the SMEs' scoring using Lawshe's CVR method, as well as the SMEs' narrative input. Face validity was completed with four practicing NPs as previously discussed with two practicing ANPs and two practicing FNPs reviewing the tool. At this point, content and face validity were completed. The tool was scored using the arithmetic mean for the entire tool, as well as each subscale of cues and behaviors and for further assessing cues and behaviors. Scoring and summing across items and using the arithmetic mean, or using ordinal data as interval data, more accurately captures the true variability of each score and improves the statistical power (N. Tintle, personal communication, November 19, 2010). The use of ordinal data as interval data is supported in the literature (Armstrong, 1998; Granberg-Rademacker, 2010).

To help establish reliability and internal consistency, Cronbach's alpha and inter-item correlations were utilized. This would help determine internal consistency of the items and support the scales of the tool.

2 c. How likely would GNPs recognize client cues and behaviors as an indicator of a need for spiritual care?

This question was answered by frequency distributions and use of

descriptive statistics. In addition, differences using *t*-tests and one-way ANOVA, as well as correlations using Pierson-*r*, were examined based on the demographic data.

2 d. How likely do GNPs further assess for spiritual care needs once a cue and behavior has been identified?

This question was answered by frequency distributions and use of descriptive statistics. In addition differences using *t*-tests and one-way ANOVA, as well as correlations using Pierson-*r*, were examined based on the demographic data.

2 e. How often, if ever, do GNPs believe they are able to recognize when clients need spiritual care?

This question was a general indicator question in the tool. This assisted in understanding if congruency existed between the GNPs' belief in their knowledge on recognizing the cues and behaviors indicating a need for spiritual care, and the reality of recognizing and identifying such indicators on the survey. This question was answered with descriptive statistics and again, *t*-test, ANOVA, and Pierson-*r* to analyze data based on demographic information.

2 f. What are the specific tools used by GNPs to evaluate clients' spiritual care needs?

Simple descriptive statistics of frequency and percent were used to indicate which of the identified tools GNPs used in their practice.

2g. What other information did GNPs want to share about spiritual care?

This was an open ended-question which allowed participants to share information about spiritual care in GNP practice.

Research Question 3: How do GNPs integrate Spiritual Care Interventions into their practice?

3 a. What specific spiritual care interventions do GNPs utilize?

This was initially answered by content analysis of the literature on spiritual care. Since no tool was found specifically for use with the GNP population, a tool was developed to measure spiritual care interventions. Items for this tool were derived from this content analysis. This tool measures the frequency of how likely the GNP would use a particular spiritual care intervention based on this content analysis.

3 b. What are the content and face validity measurements and internal consistency of the VSCIT?

Content validity for this tool was completed using the same methods as with the VSAT, using the same six SMEs. The tool was modified based on the SMEs' scoring using Lawshe's CVR method, as well as the SMEs' narrative input. Face validity was completed with the same four NPs as with the previous tool who indicated little change was needed, again predominately editorial. The tool was scored using the arithmetic mean for the entire tool. Once more, the literature supports the use of ordinal data as interval data (Armstrong, 1998; Granberg-Rademacker, 2010). Scoring and summing across items and using the arithmetic mean, more accurately captures the true variability of each score and improves the statistical power (N. Tintle, personal communication, November 19, 2010). The reliability co-efficient used was the Cronbach's alpha and inter-item correlations which provided data on internal consistency and support for the scaling system.

3 c. How frequently do GNPs initiate specific spiritual care interventions to clients?

This question was answered by use of frequency distributions and descriptive statistics. In addition, *t*-test, one-way ANOVA, and Pierson-*r* were considered based on the demographic variables.

3 d. How frequently do GNPs provide specific client-requested spiritual care interventions?

This question was answered by use of frequency distributions and descriptive statistics. In addition, *t*-test, one-way ANOVA, and Pierson-*r* were considered based on the demographic variables.

3e. What other information did GNPs want to share about spiritual care interventions?

This was an open-ended question that allowed participants to share other information regarding spiritual care interventions in GNP practice.

Research Question 4: What is the relationship between the spiritual perspectives of GNPs and the degree to which GNPs integrate spiritual assessments and spiritual care interventions provided to geriatric clients in their practice?

With the information gathered from the first three questions, it was possible to answer this fourth research question.

4 a. What is the relationship between the spiritual perspectives of GNPs and the frequency of recognizing the client cues and behaviors indicating a need for spiritual care?

To answer this question, a correlation using Pierson-*r* was calculated between the SPS perspectives subscale (items 1-5) and the VSAT cues and behaviors subscale.

4 b. What is the relationship between the spiritual perspectives of GNPs and the frequency of further assessing a need for spiritual care once clients' cues and behaviors indicating such a need have been recognized?

Again, a correlation was calculated using a Pierson-*r* with the perspectives subscale of the SPS tool (items 1-5) and the VSAT further assessing subscale to answer this question.

4 c. What is the relationship between the spiritual perspectives of GNPs and the frequency of initiation of GNP-specific spiritual care interventions provided to clients?

Pierson-*r* was calculated with the perspectives subscale of the SPS tool and the VSCIT subscale of GNP initiated interventions, items 1 through 10.

4 d. What is the relationship between the spiritual perspectives of GNPs and the frequency of GNP follow-through on client-initiated requests of specific spiritual care interventions?

Pierson-*r* was calculated with the perspectives subscale of the SPS tool and the VSCIT subscale of client-initiated requests, items 11 through 15.

Summary

Methods integrate psychometric, descriptive, and qualitative methods to answer the research questions. Two tools needed to be developed to measure spiritual care assessments and spiritual care interventions. Descriptive data were collected using the

two tools, the Spiritual Perspectives Scale, and a demographic data collection tool. Krippendorf's (2003) method of content analysis compared GNP definition of spirituality with the author's definition of spirituality. The findings are presented in Chapter 4.

CHAPTER FOUR

RESULTS

This chapter presents the results of the study: Spiritual Care in Advanced Practice Nursing. A summary of the sample and sample characteristics will be presented, followed by the results of the research questions. The remaining portion of the chapter will present reliability and validity data of the three different tools utilized in this study.

Survey Response

The initial return rate of the 300 surveys mailed was 190 (64%) with an additional 5 surveys returned undeliverable. Follow up-reminder post-cards elicited 11 more responses for a total of 201 returns (67%) over a two month period. Thirty nine (13%) of these surveys were eliminated as participants had crossed out Gerontologial Nurse Practitioner (GNP) on the demographic sheet and written in Adult (ANP) or Family Nurse Practitioner (FNP). This was related to questions on years in practice as a GNP or presently practicing as a GNP. Most of these participants made notations explaining they were certified as an ANP or FNP but were working in geriatric settings. Although adult and family nurse practitioner programs do include geriatric components in their education programs, these individuals did not meet the inclusion criterion of being certified as a GNP to participate in this study as described in Chapter 3. Another 29 (9%) were also eliminated because participants indicated they were no longer working as GNPs and therefore did not meet inclusion criteria. The final number of participants and thus

surveys that met inclusion criteria was 133 (44%).

Data Cleaning and Data Entry

As each survey was returned, data were entered into a Microsoft Excel spreadsheet. Once data collection was completed and data were entered into the spreadsheet, visual inspection of the spreadsheet was done to assure there were no empty cells or cells that had unusual data not congruent with the column name (such as a single digit in the year born column). In the case of an error or empty cell, the original paper survey was pulled and the data entered on this participant was rechecked, with re-entry and correction performed as needed. At this point data of those who met the inclusion criteria of currently employed and certification as GNPs were transferred to another spreadsheet.

All returned surveys were locked in a file cabinet in the researcher's home office. A separate data file was kept for everyone who requested summary information at the completion of the study (n = 80; 27%), whether they met inclusion criteria or not. The initial password-protected excel spreadsheet contained the names of all 300 participants which facilitated tracking for follow-up with a reminder post-card for unreturned surveys. Data of those who met inclusion criteria were then transferred to Statistical Package for Social Sciences (SPSS) 17.0 for analysis.

Sample and Sample Characteristics

The average age of the final 133 participants was 52 years, ranging from 28 to 82 years of age, with 60.9% age 50 or older. The majority of participants were female, Caucasian, Christian, Master's prepared, were working full time, and had worked an average of 13.27 years as an RN before becoming a GNP. Only a third of the participants had received education in either their undergraduate or graduate nursing programs

Table 8. Demographic Information of the Sample

Gender:	Frequency	Percent	Mean
Male	8	6.0	-
Female	125	94.0	-
Age	-	-	52 years
50 and older	81	60.9	(*sd*=10.14)
Race/Ethnicity:			
Hispanic	5	3.8	-
Non-Hispanic	5	3.8	-
Black/African American	1	0.8	-
Asian	8	6.0	-
Caucasian	111	83.5	-
Other	2	1.5	-
American Indian/ Alaskan Native	1	0.8	-
Religious Affiliation:			
Evangelical	11	8.3	-
Catholic	51	38.3	-
Orthodox	3	2.3	-
Other Christian	32	24.1	-
Unaffiliated	8	6.0	-
Mormon	1	0.8	-
Jewish	1	0.8	-
Jehovah's Witness	1	0.8	-
None	6	4.5	-
Other	14	10.5	-
More than one identified	1	0.8	-
African-American/Black Churches	1	0.8	-
Missing	3	2.3	-
Years in practice as an RN prior to GNP certification	-	-	13.27 years (*sd*=8.82)
Years in practice as a GNP	-	-	10.42 years (*sd*=7.96)
GNP Education:			
Masters	95	71.4	-
Post Master's certificate	25	18.8	-
DNP	7	5.3	-
Other	4	3.0	-
Missing	2	1.5	-
Undergraduate education provide spiritual care education: Missing	1	0.8	-
Yes	46	34.6	-
No	86	64.7	-

Table 8. Demographic Information of the Sample (continued)

	Frequency	Percent	Mean
Graduate education provide spiritual care education:			
Yes	45	33.8	-
No	86	64.7	-
Not Applicable	1	0.8	-
Missing	1	0.8	-
Have you sought out education in spirituality/spiritual care beyond undergraduate and graduate education:			
Yes	39	29.3	-
No	92	69.2	-
Missing	2	1.6	-
Working:			
Full time	95	71.4	-
Part time	38	28.6	-

regarding spirituality and spiritual caregiving, or had sought out such education on their own. See Table 8 for details on demographic information of the sample.

Data Analysis Results

Question 1: What are the spiritual perspectives of GNPs?

The SPS tool (Reed, 2008), with a Cronbach's alpha for this study of 0.87 (items 1-5), 0.95 (items 6-10), and 0.95 (items 1-10), was used to answer this question. On a scale of 1 to 6 for spiritual perspectives, GNPs have a moderate mean score of 4.73 (about once a month [4] to about once a week [5]; agree more than disagree [4] to agree [5]). Spiritual perspectives are an important part of their lives. On an individual basis, several items also scored above average means as indicated in Table 9, with a high percent of participants choosing once a week/ once a day for the perspective item 4, and agree/strongly agree for perspective item 5. Spiritual behaviors (items 6 through 10)

had a mean score of 4.86, also indicating high moderate spiritual behaviors are present in the participants' lives. The overall mean score of this tool was 4.82.

Table 9. SPS Items with Above Average Means

		Sample Mean	Percent
Spiritual Perspective	4. How often do you engage in private prayer or meditation: about once a week / once a day	5.18	79%
	5. Forgiveness is an important part of my spirituality: agree / strongly agree	5.41	87%
Spiritual Behavior	7. My spirituality is a significant part of my life: agree / strongly agree	5.04	72%
	9. My spiritual views have had an influence upon my life: agree / strongly agree	5.29	81%

1 a. Do spiritual perspectives differ from or correlate with any of the following demographic data: gender; age; race/ethnicity; religious affiliation; years in practice as an RN prior to GNP certification; years in practice as a GNP; type of NP education; spiritual care education in undergraduate and graduate curriculum; and whether further spiritual care education was sought beyond the academic environment.

A one-way ANOVA was computed and compared the differences of several of the demographic variables with the spiritual perspectives mean. There were no significant differences found between spiritual perspectives and years in practice as an RN prior to certification as a GNP and years in practice as a GNP. There was a significant difference found between religious affiliation (F = 3.432; p = .000) and spiritual perspectives, as well as ethnicity/race (F = 3.565; p = .003) and spiritual perspectives. Because both variables had at least one group with fewer than two cases, post hoc tests were unable to be performed. These results support the literature that indicates both ethnicity and

religious affiliation can influence individual spirituality and spiritual perspectives. Independent *t*-tests were also conducted. No significant differences in spiritual perspectives were found based on gender, age, undergraduate, and graduate education, or other education sought on spiritual caregiving. There was not a significant correlation between spiritual perspectives and age.

1 b. How do GNPs define spirituality?

The final question, "If possible, please describe how you define spirituality or provide any other comments you feel are important for the researcher to know about," was analyzed using Krippendorff's (2003) method of content analysis. Only 32 participants (24%) responded in any manner to this question. Early mapping of the direct quotes into data meaning units was done first. Data meaning units were then compared to the research definition and further mapped into themes based on the definition (Appendix M) as well as themes that were not based on this definition (Appendix N). This was done to evaluate if the GNPs defined spirituality similar to the research definition and to identify what might also be missing in this definition that GNPs identified as important.

For those meaning units that mapped into the definition of spirituality used for this research, GNPs used descriptors that included reintegration of the mind body spirit into a whole to restore balance, harmony, and a sense of well-being (n = 7; 21.8%). Existential themes were present which included finding fulfillment and having a higher purpose in life (n= 2; 6.25%). Connections to God, a Higher Power, or Higher Being were emphasized by 25 respondents (78%) along with connections to self (n = 5; 15.6%), and to nature, others, and the world/environment around us (n= 8; 25%). Other data also included references to transcending time and space such as life after death, and a power

that was a non-measurable energy (*n*= 5; 15.6%). Spirituality was also referred to as holistic, involving the total picture, and making whole (healing). Thus if one ignored spirituality, one ignored health (*n* = 4; 12.5%). Finally, spirituality was personal, an individual right, and not religiously based (*n* = 2; 6.25%). Some expressed their spirituality through faith rituals (*n* = 8; 25%) while others did not (*n* = 2; 6.25%).

Themes that mapped into the definition of spirituality used for this research included the following:

- Spirituality supports the reintegration of body mind soul, restores balance, harmony, and a sense of well-being, and promotes a higher purpose and fulfillment in life through our connections to self, others/ nature/ the environment, and God/ Higher Power/ the Transcendent.
- Spirituality assists in transcending through non-measurable energy exchange facilitated by our connections.
- Spirituality is different from religiosity, is personally defined and individually practiced, with some expressing their spirituality through faith rituals while others may not.
- Spirituality is a holistic experience that promotes interconnectedness of all aspects of the individual to become a resource for health and healing.

The second theme above links with the conceptual model of transcending and expanding consciousness with energy exchanges that occur within relationships or our connections. Table 10 lists the meaning units from the data that mapped into the research definition and are grouped by similar significance or relationship. For those data and meaning units that did not map into the definition, GNPs presented a strong case of spirituality as a foundation for moral and ethical ways of thinking, acting, and being in the world with relationship to others and self (*n* = 12; 37.5%). Spirituality also assisted in providing for direct human needs such as love, comfort, joy, and a calming influence(*n* = 5;15.6%). Direct quotes and early mapping of the meaning units can be found in Appendix N.

The following are the two themes that emerged which did not map into the

Table 10. Content Analysis: Themes Mapping into the Research Definition

Condensed Meaning Units : Grouped by Similar Significance	Proposed Themes Based on Data Units and Research Definition
1. Harmony 2. Sense of well-being 3. Sense of well-being 4. Sense of well-being 5. Sense of well-being 6. Promoting reconnection of body mind spirit 7. Restores balance between body mind soul 8. Higher purpose in life 9. Fulfillment 10. Connection to a Higher Being 11. Connection to a Higher Being 12. Connection to a Higher Being 13. Connection to a Higher Being 14. Connection to a Higher Being 15. Connections to a Higher Being 16. Connections with a Higher Being 17. Connection to a Higher Being 18. Connection to a Higher Being 19. Connection to a Higher Being 20. Connection to a Higher Power 21. Connection to a Higher Power 22. Connection with a Higher Power 23. Connection to a Higher Power 24. Connection to a Higher Power 25. Presence of a Higher Power 26. Connection with God 27. Seeking connection to God 28. Connection with God 29. Connection with God 30. Connection with God 31. Connection to God 32. Connections to God 33. Connection to God 34. Connection to God 35. Connections with God/Higher Being/ the Transcendent	Spirituality supports the reintegration of body mind soul, restores balance, harmony, and a sense of well-being, and promotes a higher purpose and fulfillment in life through our connections to self, others/nature/the environment, and God/ Higher Power/the Transcendent.

Table 10. Content Analysis: Themes Mapping into the Research Definition (continued)

Condensed Meaning Units : Grouped by Similar Significance	Proposed Themes Based on Data Units and Research Definition
36. Connections to nature 37. Connection to nature 38. Connection to nature 39. Connection to others 40. Connections to others 41. Connections to others 42. Connections to the world/environment/others 43. Connection to the world/music/others 44. Connection to self 45. Connection to self 46. Connection to self 47. Connection to self 48. Connection to self 49. Non-measurable energy 50. Transcendence 51. Transcendence 52. Transcendence 53. Transcendence	Spirituality assists in transcending through non-measurable energy exchange facilitated by our connections.
54. Not religious 55. Individual 56. Spirituality is expressed through religion (faith in God) 57. Religious ritual (prayer) 58. Religious ritual (saying the rosary) 59. Religious ritual (prayer) 60. Religious ritual (prayer) 61. Religious ritual (prayer) 62. Religious ritual (prayer) 63. Religious ritual (prayer)	Spirituality is different from religiosity, is personally defined and individually practiced, with some expressing their spirituality through faith rituals while others may not.
64. Wholistic 65. Total picture 66. Resource for health 67. Making whole	Spirituality is a holistic experience that promotes interconnectedness of all aspects of the individual to become a resource for health and healing.

definition for spirituality used for this research:

- Spirituality provides guidance for moral and ethical ways of thinking, acting, and being in the world for the greater good of others and self.
- Spirituality helps meet specific human needs.

Meaning units grouped by similar significance which did not map into the research definition can be found in Table 11 along with the proposed themes.

Question 2: How do GNPs integrate spiritual assessments into their practice?

2 a. What client cues or behaviors do GNPs recognize as a potential need for spiritual care?

This was answered through content analysis of the literature from which the VSAT was developed. Content analysis indicated that spirituality integrated relationships with self, others, nature, or a Transcendent Being, with a search for meaning and purpose in life. Frequently the outcome of spirituality or a spiritual journey was to find hope, develop coping skills, to heal, or transcend one's situation. This assisted in providing inner resources that can be used for health. The final items on the VSAT are directed at trying to capture the above concepts and operationalize them in a manner that is measurable.

2 b. Describe content and face validity measurements and reliability measurements of a tool developed from content analysis of the literature to measure frequency of recognizing the client cues and behaviors indicating a need for spiritual care; and to measure frequency of further assessing for spiritual care needs of clients' based on identified cues and behaviors. Content and face validity have previously been discussed for this tool in Chapter 3 under instrumentation. Only those

Table 11. Content Analysis: Themes Which Did Not Map Into the Research Definition

Data Meaning Units Which Did Not Map Into Research Definition Grouped by Similar Significance	Proposed Themes Based on Data Which Did Not Map Into Research Definition
1. Moral and ethical beliefs as spiritual practice 2. Respect for human life, rights, needs 3. Moral living/acting for the greater good of others 4. Moral and ethical issues related to pain in life 5. Deep moral and ethical sense 6. Guide to how to treat others 7. Philosophical non-religious approach 8. Related to morals and ethics (goodness) 9. Guides actions 10. Doing good 11. Guides thought and action	Spirituality provides guidance for moral and ethical ways of thinking, acting, and being in the world for the greater good of others and self.
12. Meets human needs (love) 13. Human need (love) 14. Meets human needs (comforting) 15. Provides for a human need (calm) 16. Provides for a human need (joy)	Spirituality helps meet specific human needs.

items with a CVR of 0.00 using Lawshe's method were used, incorporating recommended changes from the 6 SMEs. The CVR of 0.00 indicated 50% of the SMEs agreed that the item was essential. This was an acceptable level based on the CVR method used. Face validity was accomplished with input from four practicing NPs, and editorial changes were completed before the final tool was used in the study. The tool was scored using the arithmetic mean for the entire tool and subscales. This allowed for the most accurate measurement of individual variability and is supported by the

literature (Armstrong, 1998; Granberg & Rademacker, 2010).

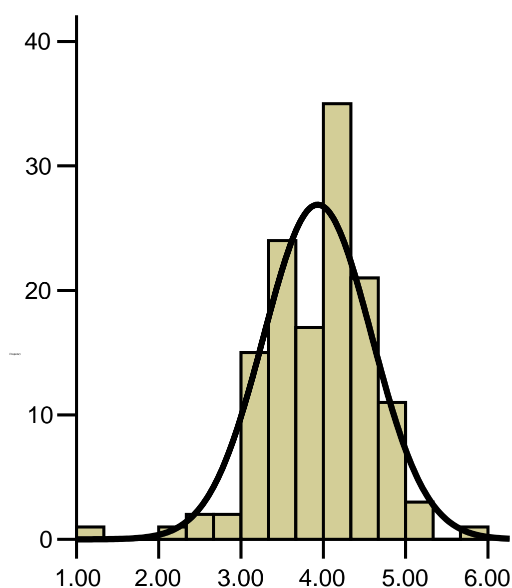
Cronbach's alpha was 0.89 for the VSAT cues and behaviors subscales. Inter-item correlations were all positive and indicated items 1 through 7 were moderately to highly correlated with scores ranging from 0.40 to 0.70 (Table 12). This supports the assumption that the items are measuring the same concept but not the same question (Munro, 2004). Item 8 (indicates they no longer are involved with spiritually or religiously related activities or rituals which have brought them peace, comfort, or a sense of connection in the past) and item 9 (mentions directly they are interested in talking about their spiritual needs with someone) had all but one score below 0.40, indicating they are measuring a different concept from items 1 through 7. If both items 8 and 9 were eliminated the reliability coefficient for this subscale would remain at 0.89. The reliability coefficient would decrease to 0.87 if either item 8 or 9 were eliminated. Elimination of these items would depend on how the subscale of further assessing would be affected. Figure 2 presents a histogram for the distribution of means of this subscale. The curve follows a normal distribution.

Cronbach's alpha for the subscale of further assessing a need once a cue or behavior had been recognized was $\alpha = 0.89$. Again, inter-item correlations for items 1 through 7 were moderate to high, ranging from 0.40 to 0.81. Item 8 had low moderate correlations and item 9 had mostly low correlations (Table 13). Eliminating item 9 alone would increase the reliability coefficient to 0.90, while eliminating both items 8 and 9 would improve the reliability coefficient to 0.91. Figure 3 is the histogram for the subscale of further assess. It has a slight negative skew indicating that once the cues and behaviors had identified a spiritual care need, there was more of a tendency for the

Table 12. Inter-item Correlation Matrix for Vincensi Spiritual Assessment Tool Cues and Behaviors

	SA1	SA2	SA3	SA4	SA5	SA6	SA7	SA8	SA9
SA1	1.000								
SA2	.705	1.000							
SA3	.403	.325	1.000						
SA4	.577	.665	.399	1.000					
SA5	.578	.620	.464	.643	1.000				
SA6	.437	.460	.340	.638	.599	1.000			
SA7	.488	.428	.470	.610	.623	.683	1.000		
SA8	.348	.157	.429	.222	.305	.191	.377	1.000	
SA 9	.177	.000	.310	.137	.166	.160	.390	.555	1.000

Figure 2. Vincensi Spiritual Assessment Tool (VSAT) Cues and Behaviors



participants to follow up by further assessing for spiritual care needs. The Cronbach's alpha for the entire tool was 0.93. A summary can be found in Table 14 of the various changes in the reliability coefficient with elimination of items 8 and 9 for the entire tool as well as the subscales.

Table 13. Inter-Item Correlation Matrix for Vincensi Spiritual Assessment Tool Further Assess

	SA1	SA2	SA3	SA4	SA5	SA6	SA7	SA8	SA9
SA1	1.000								
SA2	.810	1.000							
SA3	.500	.464	1.000						
SA4	.651	.712	.531	1.000					
SA5	.578	.576	.548	.680	1.000				
SA6	.435	.508	.477	.702	.632	1.000			
SA7	.502	.488	.507	.722	.672	.761	1.000		
SA8	.317	.270	.393	.314	.371	.389	.401	1.000	
SA9	.181	.081	.253	.227	.216	.284	.358	.425	1.000

Table 14. Cronbach's Alpha for the Vincensi Spiritual Assessment Tool Subscales and Items 8 & 9

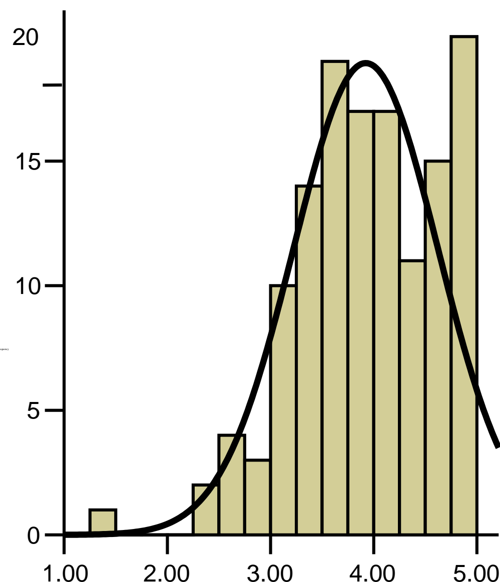
	Cues and Behaviors	Further Assess	Entire Tool
All items included	0.89	0.89	0.93
Eliminate item 8	0.87	0.90	0.92
Eliminate item 9	0.87	0.90	0.93
Eliminate both item 8 & 9	0.89	0.91	0.94

2 c. How likely would GNPs recognize clients' cues and behaviors as a indicators of a need for spiritual care?

Those GNP who never to rarely were able to identify specific cues and behaviors of clients that indicated a need for spiritual care were 4.5% while those who always were able to identify such cues and behaviors were 2.2%. The majority of participants fell between sometimes (42.10%) and often (50.4%). The overall mean for the subscale of cues and behaviors was 4.73. Mean scores based on the demographic variables can be found in Table 15.

One-way ANOVAs were conducted and indicated there were no significant differences based on religious affiliation, ethnicity/race, years in practice prior to GNP

Figure 3. Vincensi Spiritual Assessment Tool
(VSCIT) Subscale Further Assess



certification, years in practice as a GNP, or type of GNP education. Independent *t* – tests were also calculated to determine if there were significant differences between the means of this subscale based on gender, age, undergraduate and graduate curriculum providing education on spiritual care, or seeking out further education beyond academia in spirituality and spiritual care. A significant difference was found with the independent *t* –test calculated comparing the mean score of male and female participants regarding frequency of identifying specific cues and behaviors of clients' as indicators of a spiritual care need (t (131) = -2.727, p= .007). Females were more likely to have higher means (m = 3.96, sd = 0.59) than males (m = 3.33, sd = 1.17) in spiritual assessment.

A significant difference was also found comparing the mean scores of participants who sought out further education in spirituality and spiritual caregiving beyond their undergraduate and graduate education (t (129) = 2.259, p= <.05). The mean score of

Table 15. Descriptive Statistics of the Vincensi Spiritual Assessment Tool Subscale of Cues and Behaviors and Demographic Data

Category	N	Mean
Gender		
Male	8	3.33
Female	125	*3.96
Religious Affiliation		
Evangelical	11	3.95
Catholic	51	3.94
Orthodox	3	4.33
Other Christians	32	3.87
Unaffiliated	8	4.12
Mormon	1	4.40
Jewish	1	3.45
Jehovah's Witness	1	3.44
None	6	3.85
Other	14	3.79
More than one identified	1	4.11
African-American/ Black Churches	1	4.67
Race/Ethnicity		
Hispanic	5	3.75
non-Hispanic	5	3.96
Black/African-American	1	3.67
Asian	8	3.68
White	111	3.98
Other	2	2.95
American Indian/ Alaskan Native	1	3.55
Work		
Full time	95	3.94
Part time	38	3.91
GNP Education		
Masters	95	3.97
Post master certificate	25	3.92
DNP	7	3.31
Other	4	4.27

Spiritual Care Education	Mean (N) yes	Mean (N) no
In Undergraduate	4.12 (46)	3.90 (86)
In Graduate	*4.13 (45)	3.81 (86)
Sought out other	**4.12 (39)	3.85 (92)

Category	N	Mean
Age		
≥ 50 years	81	3.92
≤ 49 years	49	3.97

Years in Practice Prior to GNP Cert

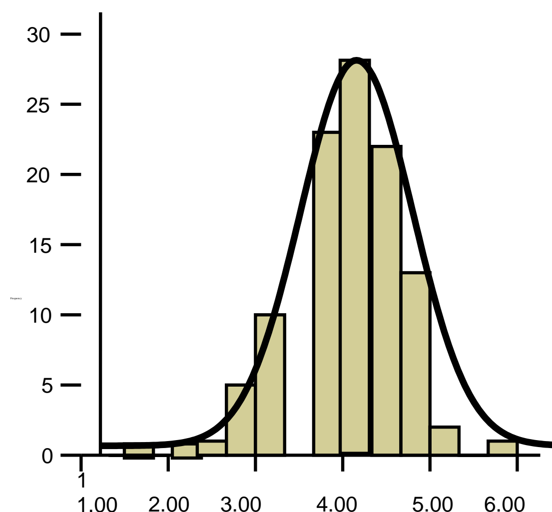
Yrs	N	Mean
1	1	4.56
1.5	1	4.40
2	5	3.20
3	3	4.10
4	11	3.74
5	12	4.03
6	6	4.53
7	7	3.82
8	7	4.06
9	2	4.22
10	9	3.81
11	6	4.09
12	4	4.05
13	5	3.36
14	3	3.90
15	3	4.03
16	3	3.96
17	2	4.44
18	4	3.66
19	3	3.70
20	8	3.78
22	5	4.04
23	4	3.63
24	1	4.50
25	5	4.20
26	2	4.05
28	2	4.22
30	6	4.03
31	1	4.89
38	1	2.55
41	1	4.44

Years in Practice as a GNP

Yrs	N	Mean
.00	1	3.77
1	6	4.04
2	10	3.81
3	7	3.97
4	7	4.05
5	10	3.90
6	7	3.74
7	3	3.77
8	4	3.91
9	7	4.12
10	18	4.02
11	7	4.15
12	3	4.73
13	8	3.62
14	6	4.09
15	8	3.83
16	2	4.17
17	2	3.94
18	1	3.23
19	3	4.18
21	1	4.67
22	1	4.22
23	1	3.44
24	1	2.45
25	2	4.39
29	1	3.33
30	1	1.22
32	2	3.33
34	1	3.67
53	1	4.22

* $p < 0.01$ ** $p < 0.05$

Figure 4. Vincensi Spiritual Assessment Tool Entire Tool Mean Scores



those who sought out further education on spiritual caregiving was significantly higher (*m* = 4.12, *sd* = .509) than the mean score of those who did not seek out such education (*m*= 3.84, *sd* = .698). Only 29.3 % of participants sought out further education in the area of spirituality and spiritual caregiving.

A third significant difference was found between participants who had received education on spiritual caregiving in their graduate nursing curriculum (t (129) = 2.633, p = .009). Those who received spiritual care education in graduate school had a significantly higher mean (*m* = 4.13, *sd* = .547) than those who had not (*m* = 3.81, *sd* = .689). Only 33.8% had received such education. Table 16 summarizes these findings. Figure 4 is the histogram for the entire VSAT tool representing a normal distribution.

2 d. How likely do GNPs further assess for spiritual care needs once a cue and behavior has been recognized?

Those who never to rarely further assessed clients' spiritual care needs once cues and behaviors were identified totaled 7.5% of the participants. Others who always

Table 16. Vincensi Spiritual Assessment Tool (VSAT) Cues and Behaviors: Significant *t*-test Scores for Differences Based on Demographic Variables

Variable and Categories	*t*-test	df	Sig. (2-tailed)	Mean	*SD*
Gender	-2.727	131	.007		
Male *n* = 8 (6%)				3.33	1.17
Female *n* = 125 (94%)				3.96	0.59
Graduate Education on Spiritual Care	2.633	129	.009		
Yes *n* = 45 (33.8%)				4.13	0.54
No *n* = 86 (66.2%)				3.81	0.68
Sought Out Further Education	2.259	129	.026		
Yes *n* = 39 (29.3%)				4.12	0.50
No *n* = 92 (70.7%)				3.84	0.69

followed up and probed further accounted for 8.3%. The majority of participants fell between sometimes (45.10%) and often (39.1%) in frequency of further assessing for spiritual care needs. The overall mean score for the subscale of further assessing spiritual care can be found in Table 17. The means for the subscale to further assess based on demographic variables can be found in Table 18. The overall mean for the entire VSAT was 4.82.

Table 17. Vincensi Spiritual Assessment Tool (VSAT) Subscales and Entire Tool Mean Scores

VSAT Cues and Behaviors	4.73
VSAT Further Assess	3.92
VSAT Total Overall Mean	4.82

A one-way ANOVA was conducted and indicated there were no significant differences based on religious affiliation, ethnicity/race, years in practice prior to GNP certification, years in practice as a GNP, or type of GNP education. Independent *t* – tests were also calculated to determine if there were significant differences between the means

of this subscale based on gender, age, working full or part time, whether undergraduate and graduate curriculum provided education on spiritual caregiving, and whether further education on spirituality and spiritual caregiving was sought. Significant differences were found with independent *t* – tests based on gender, whether graduate curriculum provided education on spiritual caregiving, and with participants who sought out further education in spirituality and spiritual caregiving beyond their undergraduate and graduate education.

With gender, the *t*-test results were significant (t (131) = -2.693, p = .008). The mean score of females (m = 3.96, sd = 0.66) was higher than the mean score of males (m = 3.29, sd = 0.97) as it related to further assessing clients' spiritual care needs. Graduate curriculum that offered spiritual care education made a significant difference for participants in frequency of further assessing identified cues and behaviors (t (129) = 3.098, p = .002), as those who had such education (33.8%) had higher mean scores (m = 4.17, sd = 0.70) than those who did not have such education (m = 3.78, sd = 0.66).

Finally, those who sought out further education on spiritual caregiving also had significantly (t (129) = 2.365, p = .020) higher mean scores to further assess the cues and behaviors (m = 4.14, sd = .63) than the mean scores of those who did not seek out such education (m= 3.83, sd = .71). Only 29.3 % of participants sought out further education in the area of spirituality and spiritual caregiving. Please see Table 19 for a summary of significant *t* – test results and means for this subscale.

2 e. How often, if ever, do GNPs believe they are able to recognize when clients need spiritual care?

Those who believed they are rarely able to recognize when clients needed

Table 18. Descriptive Statistics of the Vincensi Spiritual Assessment Tool (VSAT) Subscale of Further Assess and Demographic Variables

Category	N	Mean
Gender		
Male	8	3.33
Female	125	*3.97
Religious Affiliation		
Evangelical	11	3.94
Catholic	51	3.91
Orthodox	3	4.60
Other Christians	32	3.87
Unaffiliated	8	3.97
Mormon	1	3.44
Jewish	1	3.90
Jehovah's Witness	1	2.56
None	6	4.20
Other	14	3.82
More than one identified	1	4.11
African-American/ Black Churches	1	3.90
Race/Ethnicity		
Hispanic	5	4.04
non-Hispanic	5	3.74
Black/African-American	1	3.90
Asian	8	3.71
White	111	3.97
Other	2	2.61
American Indian/ Alaskan Native	1	3.67
Work		
Full time	95	3.93
Part time	38	3.91
GNP Education		
Masters	95	3.93
Post master certificate	25	3.97
DNP	7	3.31
Other	4	4.12

Spiritual Care Education	Mean (N) yes	Mean (N) no
In Undergraduate	4.01 (46)	3.89 (86)
In Graduate	* 4.13 (45)	3.82 (86)
Sought out other	**4.14 (39)	3.83 (92)

Category	N	Mean
Age		
≥ 50 years	81	3.92
≤ 49 years	49	3.97

Years in Practice Prior to GNP Cert

Yrs	N	Mean
1	1	4.57
1.5	1	4.40
2	5	3.47
3	3	4.40
4	11	3.60
5	12	3.71
6	6	4.03
7	7	3.90
8	7	4.15
9	2	4.27
10	9	3.91
11	6	4.07
12	4	3.73
13	5	4.15
14	3	3.60
15	3	4.10
16	3	3.70
17	2	4.38
18	4	3.69
19	3	3.85
20	8	3.91
22	5	3.89
23	4	3.52
24	1	5.00
25	5	4.28
26	2	4.50
28	2	4.00
30	6	4.20
31	1	4.67
38	1	2.44
41	1	4.22

Years in Practice as a GNP

Yrs	N	Mean
.00	1	4.56
1	6	3.86
2	10	3.73
3	7	3.63
4	7	4.04
5	10	3.75
6	7	3.81
7	3	3.92
8	4	4.21
9	7	4.14
10	18	3.97
11	7	3.90
12	3	4.69
13	8	3.84
14	6	3.95
15	8	3.81
16	2	4.19
17	2	4.33
18	1	4.78
19	3	4.37
21	1	5.00
22	1	3.67
23	1	3.78
24	1	3.11
25	2	4.05
29	1	3.11
30	1	1.33
32	2	3.44
34	1	3.67
53	1	4.67

* $p < 0.01$ ** $p < 0.05$

Table 19. Vincensi Spiritual Assessment Tool (VSAT) Further Assess Significant *t*-test Scores for Differences Based on Demographic Variables

Variable and Categories	*t*-test	df	Sig. (2-tailed)	Mean	*sd*
Gender	-2.693	131	.008		
Male *n* = 8 (6%)				3.29	0.97
Female *n* = 125 (94%)				3.96	0.66
Graduate Education on Spiritual Care	3.098	129	.002		
Yes *n* = 45 (33.8%)				4.17	0.70
No *n* = 86 (66.2%)				3.78	0.66
Sought Out Further Education	2.364	129	.020		
Yes *n* = 39 (29.3%)				4.14	0.63
No *n* = 92 (70.7%)				3.83	0.71

spiritual care were 3.8% while 9.8% believed they always were able to recognize when clients needed such care. Again, the majority of participants had means in the middle ranging from sometimes (31.6%) to often (54.9%). The overall mean for this item was *m* = 3.70 with a *sd* = 0.69. Table 20 has a summary of the descriptive statistics for this item. Figure 5 includes the histogram indicating a normal distribution.

Pearson-r correlations indicated a significant moderate relationship between the participants self-belief in their ability to recognize spiritual care needs in others and over-all assessing spiritual care needs of clients (*r* = .557, *p* = <0.001). There was also a significant moderate relationship between self-belief in ability to recognize a spiritual care need and the two subscales of recognizing cues and behaviors indicating such a need (*r* = .476, *p* = <0.001) as well as further assessing this need (*r* = .592, *p* = <0.001). One-way ANOVA tests were also conducted to answer this question. There were no significant differences found between the mean scores of frequency of GNPs belief in their ability to identify clients' spiritual care needs and GNP demographic data of religious affiliation, race/ethnicity, years as an RN prior to GNP certification,

Table 20. Descriptive Statistics of Item 10 on the Vincensi Spiritual Assessment Tool (VSAT): Belief in Ability to Recognize When Clients Need Spiritual Care

Category	N	Mean
Gender		
Male	8	3.12
Female	125	*3.74
Religious Affiliation		
Evangelical	11	3.64
Catholic	51	3.76
Orthodox	3	4.33
Other Christians	32	3.65
Unaffiliated	8	3.87
Mormon	1	3.00
Jewish	1	4.00
Jehovah's Witness	1	2.00
None	6	3.66
Other	14	3.57
More than one identified	1	3.00
African-American/ Black Churches	1	4.00
Race/Ethnicity		
Hispanic	5	4.04
non-Hispanic	5	3.20
Black/African-American	1	3.00
Asian	8	3.62
White	111	3.73
Other	2	3.50
American Indian Alaskan Native	1	3.00
Work		
Full time	95	3.71
Part time	38	3.68
GNP Education		
Masters	95	3.66
Post master certificate	25	3.80
DNP	7	3.57
Other	4	4.00

Spiritual Care Education	Mean (N) yes	Mean (N) no
In Undergraduate	3.82 (46)	3.62(86)
In Graduate	*3.93 (45)	3.58 (86)
Sought out other	3.87 (39)	3.64 (92)

Category	N	Mean
Age		
≥ 50 years	81	3.72
≤ 49 years	49	3.69

Years in Practice Prior to GNP Cert

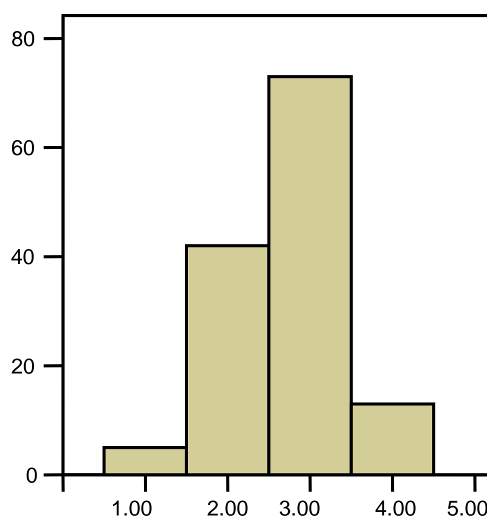
Yrs	N	Mean
1	1	3.00
1.5	1	3.00
2	5	3.60
3	3	3.66
4	11	3.27
5	12	4.00
6	6	3.83
7	7	3.85
8	7	4.00
9	2	3.50
10	9	3.55
11	6	3.66
12	4	3.50
13	5	4.00
14	3	3.33
15	3	3.66
16	3	3.33
17	2	5.00
18	4	3.25
19	3	3.00
20	8	4.00
22	5	4.00
23	4	3.25
24	1	4.00
25	5	3.80
26	2	4.00
28	2	4.00
30	6	3.83
31	1	4.00
38	1	3.00
41	1	4.00

Years in Practice as a GNP

Yrs	N	Mean
.00	1	4.00
1	6	3.50
2	10	3.30
3	7	3.28
4	7	3.42
5	10	3.60
6	7	3.85
7	3	3.00
8	4	4.00
9	7	3.57
10	18	3.72
11	7	4.42
12	3	4.33
13	8	4.00
14	6	3.66
15	8	3.62
16	2	4.50
17	2	3.50
18	1	4.00
19	3	4.00
21	1	4.00
22	1	4.00
23	1	3.00
24	1	3.00
25	2	4.00
29	1	4.00
30	1	3.00
32	2	4.00
34	1	3.00
53	1	4.00

* $p < 0.01$

Figure 5. Histogram for Vincensi Spiritual Assessment Tool(VSAT) Item 10: Belief in Ability to Recognize When Clients Need Spiritual Care



years as a GNP, and type of GNP education. Differences of mean scores were also compared using independent *t*- tests with no significant differences found between the means of those working full time or part time, having had spiritual care education in their undergraduate curriculum, seeking out further education in spiritual caregiving, and age.

Significant differences in mean scores (*t* (131) = -2.494, *p* = .01) were found between males (*m* = 3.12, *sd* = .640) and females (*m* = 3.74, *sd* = .682), with females having a higher mean score of belief in ability to recognize a clients' spiritual care need. With the provision of graduate education on spiritual caregiving, there were also significant differences (*t* (88.188) = 2.797, *p* = .006) between the mean scores of those who had received such education (*m* = 3.93, *sd* =. 687) and those who had not (*m* = 3.58, *sd* = .676) in their belief in their ability to recognize when clients needed spiritual care.

2 f. What are the specific tools used by GNPs to evaluate clients spiritual care needs?

Many participants indicated by writing additional comments that they were not aware of any formal tools available to help assess spiritual care needs of clients for use in practice. Only 6.1% used any formal tools to assess spiritual care needs of their clients. Other tools developed within institutions were done with a team that included social workers and clergy, or as an assignment in graduate school. Table 21 has a summary of percentages of the various tools utilized by the participants.

Table 21. Spiritual Assessment Tools Utilized by GNPs

FACIT	(Functional Assessment of Chronic Illness Therapy)	1.5%
FICA	(Faith, Importance, Community, Address Care)	2.3%
SIWB	(Spiritual Index of Well-being)	0.8%
SWBS	(Spiritual Well-being Scale)	0.0%
SPS	(Spiritual Perspective Scale)	0.0%
Other	(Developed within the institution)	1.5%

2 g. What other information did the participants want the researcher to know in the open-ended question?

This item provided an open-ended question allowing participants to supply more information if they desired. However, due to the unstructured nature of this question, the answers did not provide any additional information to the questions. Some examples of responses are listed below:

- The nursing homes that I go to have a chaplain(s) that are very involved in spirituality of the patients and so with the ‘spirit’ of the nursing home.
- The nursing homes have different church services.

Research Question 3: How do GNPs integrate spiritual care interventions (SCI) into their practice?

3 a. What specific Spiritual Care Interventions (SCIs) do GNPs utilize?

This was initially answered by content analysis of the literature. Since no tool was found specifically for use with the GNP population, a tool was developed from this content analysis. This tool measures the frequency of how often the participants provided specific SCI to clients. Again, the SCI items were based on the literature and included encouraging clients to talk about the following: their spiritual concerns; recent spiritual insights related to health and chronic disease; spiritual difficulties of living with chronic disease; what gives life meaning and purpose with chronic disease; healing dissonant relationships; how their relationship with God or a Higher Power is affected by chronic disease; and documentation and discussion with other health care professionals of clients' spiritual care needs. In addition participants were asked about the frequency of use of appropriate touch, discussion of grieving of losses as it relates to health, and offering specific interventions when requested by the client such as prayer or referrals.

3 b. Describe content and face validity measurements and reliability measurements of this tool developed from content analysis of the literature to measure the frequency of GNPs providing specific spiritual care interventions to their clients.

Content validity for this tool was done using the same methods as with the VSAT. The VSCIT was modified based on the SMEs' scoring using Lawshe's CVR method, as well as the SMEs' narrative input. Items with a CVR of +0.34 for the essential column and above were the items used, since lower scores for the rest of the items were below 0.00 and of negative values. The tool was scored using the arithmetic mean for the entire tool. Again the literature supports the use of ordinal data as interval data (Armstrong,

1998; Granberg & Rademacker, 2009). Appendix J contains the complete content validity chart for the VSCIT with the SMEs' comments. Based on the input of the SMEs, one item was eliminated, "I have actively listened to clients tell their story," as this was considered part of general practice and received a score of 0.00 meaning the SME's were split. Fifty percent agreed it was essential while 50% agreed this was important but not essential. The choice was made not to include this item based on other SME input that this was part of general nurse practitioner practice and not necessarily specific to spiritual care. Face validity was completed with the four NPs used for the VSAT tool. They indicated predominately editorial changes were needed, which were implemented. The reliability co-efficient used was the Cronbach's alpha which provided data on internal consistency. Interventions generated by the GNP, items 1 through 10, had a Cronbach's alpha of .89. Inter-item correlations were all positive and indicated the items were all moderately correlated. Item 9, use of appropriate touch, had low correlations however removal of this item would not affect the internal reliability. Table 22 provides the Inter-Item Correlation Matrix for this portion of the tool. A histogram can be found in Figure 6 representing a normal distribution of the mean score.

Interventions requested by clients, items 11 through 15, had a Cronbach's alpha of 0.92. Inter-item correlations were all positive and indicated the items were all moderately correlated. Item 14, use of prayer if clients requested, had lower correlations however, removal of this item would decrease the internal reliability (Table 24). A histogram can be found in Figure 7 representing a normal curve and distribution, with mean item scores of 3.3.

The Cronbach's alpha for the entire tool was 0.92. Inter-item correlations

Table 22. Inter-Item Correlation Matrix for Vincensi Spiritual Care Interventions Tool (VSCIT) GNP Generated Items 1-10

	SCI1	SCI2	SCI3	SCI4	SCI5	SCI6	SCI7	SCI8	SCI9	SCI 10
SCI 1 Talk about spiritual concerns	1.00									
SCI2 Talk about spiritual insights	.689	1.00								
SCI3 Talk about spiritual difficulties	.700	.735	1.00							
SCI4 Talk about what gives life meaning	.563	.507	.678	1.00						
SCI5 Think of ways to heal relationships	.380	.387	.402	.425	1.00					
SCI6 How chronic disease affects relationship with God	.585	.622	.712	.515	.589	1.00				
SCI7 Document spiritual care given	.416	.406	.443	.323	.392	.542	1.00			
SCI8 Discuss client spiritual concerns with other health care providers if appropriate	.365	.391	.403	.291	.360	.504	.632	1.00		
SCI9 Use touch	.379	.334	.324	.228	.245	.210	.388	.359	1.00	
SCI10 Talk of grieving r/t to health	.566	.474	.553	4.12	.349	.463	.356	.337	.450	1.00

Table 23. Inter-Item Correlation Matrix for Vincensi Spiritual Care Intervention Tool (VSCIT) Client Generated Items 11-15

SCI	Discussed community spiritual resources(11)	Provided support for clients' spiritual practices (12)	Arranged for visit or made referral to clergy or spiritual mentors(13)	Offered to pray with clients(14)	Encouraged to cope using spiritual practices (15)
11	1.00				
12	.532	1.00			
13	.475	.557	1.00		
14	.333	.349	.442	1.00	
15	.511	.503	.379	.590	1.00

were positive and high and indicated the majority of items were measuring the same concept but not the same question. Exceptions to this were items 9 and 5, and 9 and 6. Tables 24 and 25 have the Cronbach's alpha for both subscales if certain items were omitted.

3 c. How frequently do GNPs initiate specific-client centered spiritual care interventions?

Participants who initiated GNP-specific SCIs never to rarely included 31.1% while only 17.1% often and 0.8% always initiated specific SCIs. The majority of participants sometimes (48.9%) initiated specific SCIs. The overall mean for the subscale of GNP-initiated interventions was 3.28. Mean scores based on the demographic variables can be found in Table 26. There were no significant relationships found between GNP-initiated SCI and any demographic variables.

One-way ANOVAs were conducted and indicated there were no significant differences based on religious affiliation, ethnicity/race, years in practice prior to GNP

certification, years in practice as a GNP, or type of GNP education. Independent *t* –tests were also calculated to determine if there were significant differences between the means

Figure 6. Histogram of Vincensi Spiritual Care Intervention Tool GNP Initiated Interventions

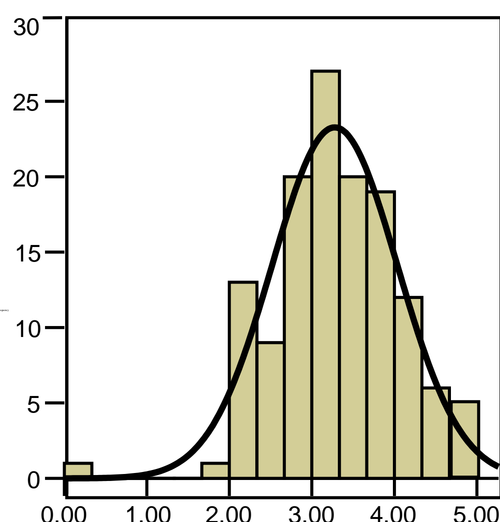


Table 24. Cronbach's Alpha if Item Deleted Vincensi Spiritual Care Intervention Tool: (VSCIT) Items 1-10

GNP Generated Interventions	Cronbach's Alpha if Item Deleted Sub-scale	Entire Tool
SCI 1 Talk about spiritual concerns	0.874	0.909
SCI2 Talk about spiritual insights	0.874	0.909
SCI3 Talk about spiritual difficulties	0.869	0.908
SCI4 Talk about what gives life meaning	0.881	0.913
SCI5 Think of ways to heal relationships	0.884	0.914
SCI6 How chronic disease affects relationship with God	0.865	0.905
SCI7 Document spiritual care given	0.881	0.911
SCI8 Discuss client spiritual concerns with other health care providers if appropriate	0.884	0.911
SCI9 Use touch appropriately	0.889	0.914
SCI10 Talk of grieving as it relates to health	0.881	0.912

Figure 7. Histogram Vincensi Spiritual Care Intervention Tool
GNP Generated Interventions

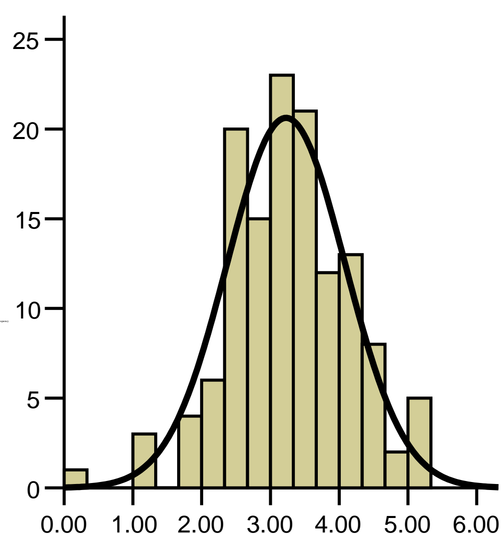


Table 25. Cronbach's Alpha if Item Deleted Vincensi Spiritual Care Intervention Tool: (VSCIT) Item 11-15

Client Generated Interventions	Cronbach's Alpha if Item Deleted Sub-scale	Entire Tool
SCI11 Discussed spiritual resources in the community	0.778	0.913
SCI12 Provided support for clients' spiritual practices	0.767	0.908
SCI13 Arranged for visits or referrals to clergy or spiritual mentors	0.775	0.913
SCI14 Offered to pray with clients	0.794	0.913
SCI15 Encouraged clients to cope using spiritual practices or spirituality	0.761	0.908

of this subscale based on gender, age, undergraduate and graduate curriculum providing education on spiritual care, or seeking out further education beyond graduate school in spirituality and spiritual caregiving.

A significant difference was found with the independent *t*-test calculated comparing the mean scores of those who had received education on spiritual caregiving in their graduate nursing curriculum (t (75.782) = 2.150, p = <.05). Those who had received spiritual care education in graduate curriculum had higher mean scores (m = 3.48; sd = .845) than those who had not received such education (m = 3.16; sd = .696). As mentioned previously, only 33.8% had received education in spiritual caregiving in their graduate curriculum. Another significant difference was found in comparing the mean scores of those who sought out further education in spirituality and spiritual caregiving beyond their undergraduate and graduate nursing education (t (78.193) = 4.069, p = <.001). Those who had sought out additional education had higher mean scores (m = 3.67; sd = .667) than those who had not (m = 3.13; sd = .732).

3 d. How frequently do GNPs provide specific-client requested spiritual care interventions?

Those who reported they never to rarely provided specific client-requested SCIs included 36.8% of the participants, while 17.3% often, and 3.8% always provided such care. The majority of participants sometimes (42.1%) provided specific client-requested SCIs. The overall mean score for the subscale of client-requested interventions was 3.23. Mean scores based on the demographic variables for this subscale can be found in Table 27. There were no significant relationships found between client-requested SCI provided by GNPs and any of the demographic variables.

Table 26. Descriptive Statistics of the Vincensi Spiritual Care Intervention Tool (VSCIT) Subscale of GNP Initiated Interventions

Category	N	Mean
Gender		
Male	8	2.87
Female	125	3.03
Religious Affiliation		
Evangelical	11	3.20
Catholic	51	3.32
Orthodox	3	3.52
Other Christians	32	3.14
Unaffiliated	8	3.13
Mormon	1	2.73
Jewish	1	3.93
Jehovah's Witness	1	2.13
None	6	3.34
Other	14	3.30
More than one identified	1	4.00
African-American/ Black Churches	1	2.80
Race/Ethnicity		
Hispanic	5	3.42
non-Hispanic	5	2.80
Black/African-American	1	2.40
Asian	8	3.27
White	111	3.29
Other	2	2.53
American Indian/ Alaskan Native	1	3.93
Work		
Full time	95	3.25
Part time	38	3.33
GNP Education		
Masters	95	3.22
Post master certificate	25	3.39
DNP	7	3.20
Other	4	3.73

Spiritual Care Education	Mean (N) yes	Mean (N) no
In Undergraduate	3.29 (46)	3.25 (86)
In Graduate	**3.47 (45)	3.16 (86)
Sought out other	***3.67 (39)	3.13 (92)

Category	N	Mean
Age		
≥ 50 years	81	3.32
≤ 49 years	49	3.17

Years in Practice Prior to GNP Cert

Yrs	N	Mean
1	1	3.33
1.5	1	3.50
2	5	2.76
3	3	4.13
4	11	2.79
5	12	3.28
6	6	3.34
7	7	2.86
8	7	3.66
9	2	3.30
10	9	3.43
11	6	3.34
12	4	3.00
13	5	3.58
14	3	2.97
15	3	3.60
16	3	2.84
17	2	4.05
18	4	3.28
19	3	3.37
20	8	3.29
22	5	3.38
23	4	2.73
24	1	2.90
25	5	3.50
26	2	3.45
28	2	3.10
30	6	3.84
31	1	3.80
38	1	2.10
41	1	3.80

Years in Practice as a GNP

Yrs	N	Mean
.00	1	3.40
1	6	2.98
2	10	2.87
3	7	3.04
4	7	3.30
5	10	3.06
6	7	3.50
7	3	3.00
8	4	3.65
9	7	3.16
10	18	3.19
11	7	3.67
12	3	4.13
13	8	3.18
14	6	3.26
15	8	3.20
16	2	4.45
17	2	3.70
18	1	2.50
19	3	3.80
21	1	4.00
22	1	3.80
23	1	4.00
24	1	2.90
25	2	3.35
29	1	2.70
30	1	2.00
32	2	3.25
34	1	3.50
53	1	3.50

*** $p < 0.001$ ** $p < 0.05$

One-way ANOVAs were conducted and indicated there were no significant differences based on religious affiliation, ethnicity/race, years in practice prior to GNP certification, years in practice as a GNP, or type of GNP education. Independent *t* – testswere also calculated to determine if there were significant differences between the means of this subscale based on gender, age, undergraduate and graduate curriculum providing education on spiritual care, or seeking out further education beyond graduate school in spirituality and spiritual caregiving. A significant difference was found in comparing the mean scores of those who sought out further education in spirituality and spiritual caregiving beyond their undergraduate and graduate nursing education (t (81.486) = 2.204, p <.05). Those who had sought out additional education on spiritual caregiving had higher mean scores (m = 3.48; sd = .754) than those who had not (m = 3.15; sd = .863). Again, only 29.3% of the participants had sought out further education in the area of spirituality and spiritual caregiving.

3e. What other information did GNPs want to share about spiritual care interventions?

This item provided an open-ended question allowing participants to supply more information if they desired. However, due to the unstructured nature of this question, the answers did not provide any additional information. Two examples of responses are listed below.

- I work with psychiatric patients who sometimes have religious delusions; so I must judiciously talk with some patients about spiritual issues. Thank you for this opportunity to address spirituality in my practice.
- Would like to incorporate more spirituality in my practice.

Table 27. Descriptive Statistics of the Vincensi Spiritual Care Intervention Tool (VSCIT) Subscale Client Requested Interventions

Category	N	Mean
Gender		
Male	8	2.93
Female	125	3.25
Religious Affiliation		
Evangelical	11	3.35
Catholic	51	3.28
Orthodox	3	3.80
Other Christians	32	2.99
Unaffiliated	8	3.41
Mormon	1	2.60
Jewish	1	4.20
Jehovah's Witness	1	2.00
None	6	3.02
Other	14	3.30
More than one identified	1	4.00
African-American/ Black Churches	1	2.60
Race/Ethnicity		
Hispanic	5	3.36
non-Hispanic	5	2.64
Black/African-American	1	3.00
Asian	8	3.13
White	111	3.27
Other	2	2.70
American Indian/ Alaskan Native	1	2.40
Work		
Full time	95	3.20
Part time	38	3.29
GNP Education		
Masters	95	3.22
Post master certificate	25	3.15
DNP	7	3.22
Other	4	3.70

Spiritual Care Education	Mean (N) yes	Mean (N) no
In Undergraduate	3.22 (46)	3.22 (86)
In Graduate	3.37 (45)	3.14 (86)
Sought out other	**3.48 (39)	3.15 (92)

Category	N	Mean
Age		
≥ 50 years	81	3.21
≤ 49 years	49	3.26

Years in Practice Prior to GNP Cert

Yrs	N	Mean
1	1	3.60
1.5	1	3.00
2	5	2.88
3	3	4.47
4	11	2.63
5	12	3.35
6	6	3.55
7	7	3.04
8	7	3.45
9	2	3.30
10	9	3.20
11	6	3.23
12	4	3.57
13	5	3.76
14	3	3.27
15	3	4.47
16	3	2.53
17	2	4.40
18	4	3.50
19	3	2.80
20	8	3.81
22	5	3.24
23	4	2.90
24	1	2.80
25	5	2.97
26	2	3.10
28	2	2.97
30	6	3.83
31	1	3.20
38	1	2.40
41	1	3.40

Years in Practice as a GNP

Yrs	N	Mean
.00	1	2.80
1	6	2.88
2	10	2.88
3	7	3.11
4	7	3.47
5	10	3.10
6	7	3.22
7	3	3.60
8	4	3.30
9	7	3.10
10	18	2.98
11	7	3.66
12	3	3.73
13	8	3.00
14	6	2.68
15	8	3.61
16	2	4.10
17	2	3.55
18	1	2.50
19	3	4.13
21	1	4.00
22	1	3.80
23	1	3.40
24	1	3.80
25	2	3.30
29	1	2.80
30	1	2.80
32	2	3.40
34	1	3.40
53	1	3.20

** $p < 0.05$

Research Question 4: What is the relationship between the spiritual perspectives of GNPs and the degree to which GNPs integrate spiritual assessments and spiritual care interventions provided to geriatric clients in their practice?

This question was answered correlating the perspectives subscale of the SPS tool (items 1-5) with each subscale of the VSAT (cues and behaviors; further assess) and the VSCIT (GNP-generated; client-initiated) tools.

4a. What is the relationship between the spiritual perspectives of GNPs and the frequency of recognizing the client cues and behaviors indicating a need for spiritual care?

A Pearson correlation was calculated examining the relationship between participants' spiritual perspectives and frequency of recognizing client cues and behaviors indicating a need for spiritual care. A very weak correlation that was not significant was found (r =.157, $p > .05$). This study does not support a relationship between the spiritual perspectives of GNPs and frequency of recognizing clients' cues and behaviors indicating a need for spiritual care.

However, there were weak but significant relationships ($p < .05$) found between the spiritual perspectives and individual items of recognizing cues and behaviors. This included identifying clients who: appear to have lost meaning or purpose in life (r = .183); display a sense of helplessness (r = .247), and hopelessness (r = .196); express life has no meaning or purpose now (r = .181;); and tell you they are no longer involved with spiritually or religiously related activities or rituals which brought peace, comfort, and a sense of connection in the past (r = .196).

4b. What is the relationship between the spiritual perspectives of GNPs and the frequency of further assessing a need for spiritual care once clients' cues and behaviors indicating such needs have been recognized?

A Pearson correlation was calculated examining the relationship between participants' spiritual perspectives and the frequency of further assessing a need for spiritual care once client cues and behaviors indicating such a need have been recognized. A very weak correlation that was not significant was found (r =.098, p > .05). This study does not support a relationship between the spiritual perspectives of GNPs and frequency of further assessing a need for spiritual care once client cues and behaviors indicating such a need have been recognized. In addition, no relationships were found between spiritual perspectives and any of the individual items of further assessing the cues and behaviors of the spiritual care needs.

4 c. What is the relationship between the spiritual perspectives of GNPs and the frequency of initiation of GNP-specific client centered spiritual care interventions?

A Pearson correlation was calculated examining the relationship between participants' spiritual perspectives and frequency of initiation of GNP-specific spiritual care interventions provided to clients. A very weak correlation that was not significant was found (r =.144, p > .05). This study does not support a relationship between the spiritual perspectives of GNPs and frequency of initiation of GNP-specific spiritual care interventions provided to clients.

There were however weak but significant relationships found between spiritual perspectives and encouraging clients to talk about their spiritual difficulties of living with

chronic disease (*r*=.203; $p < .05$); how chronic disease affects their relationship with God or a Higher Power ($r = .206$; $p < .05$); and using touch appropriately as a spiritual need arises ($r = .278$; $p = .001$)

4 d. What is the relationship between the spiritual perspectives of GNPs and the frequency of GNP follow through on client-initiated requests of specific spiritual care interventions?

A Pearson correlation was calculated examining the relationship between participants' spiritual perspectives and the frequency of GNP follow-through on client-initiated requests of specific spiritual care interventions. A weak significant positive correlation was found ($r = .203$, $p = <.05$) between the two variables. When clients initiate a specific appeal, GNPs will potentially follow through with providing the spiritual care intervention requested by the client. In addition, a moderate significant relationship was found between spiritual perspectives and the following individual items: offering to pray with clients ($r = .401$; $p < .001$) and encouraging clients to cope using spiritual practices or spirituality (r=.303; $p < .001$).

The research questions were answered by descriptive and correlation statistics and by comparing means. The next chapter will provide discussion of the results as they relate to GNP spiritual perspectives, spiritual assessments, and spiritual interventions related to practice and education. Potential implications for future research and education will also be discussed.

CHAPTER FIVE

DISCUSSION AND CONCLUSIONS

This chapter will summarize and integrate the results of each of the research questions in Chapter 4 and provide an explanation of the findings. Limitations and strengths will be discussed. Validity and reliability of the two tools developed by the researcher will also be discussed regarding further recommendations and areas of concern. Correlation of the findings to the literature, whether knowledge gaps have been resolved, and recommendations for potential research will also be addressed in this chapter with each research question. Implications for GNP practice, education, and further research, along with recommendations and conclusions will summarize this research.

Limitations

This study has limitations related to the sample and subsequent generalizability, limitations of survey research, and limited reliability and validity testing of the new tools.

Generalizability Related to the Sample

Since participation was voluntary, it is possible that only those who valued spiritual care or spirituality completed the survey. This limited the responses and insight from those who might not value such care or phenomena. Additionally, the participants were offered a $10 gift card incentive. The incentive could have compelled the return of completed surveys from some participants who might not have otherwise responded.

Another limitation was the different entry levels of GNP education. Although most had master's degrees or post-master's certificates, some held clinical doctorates (DNP) as the entry level to GNP practice. Still others had not attended graduate school at all but held a certificate as a GNP. All took the same national certification exam and held the same state license no matter the academic degree or diploma. It is uncertain how the varying education levels might affect knowledge of spiritual care and participants' responses.

The majority of the sample was Caucasian, of the Christian faith, and worked full time, limiting a non-Caucasian and non-Christian perspective. In addition, the participants were only practicing GNPs, limiting generalizability to other advanced practice nurses (APNs) and those GNPs not presently employed. Other APNs would include NPs in other specialty areas, clinical nurse specialists (CNS), certified nurse midwives (CNM), or certified registered nurse anesthetists (CRNA). In addition the sample was 94% female. Data including differences based on gender were interpreted cautiously with this lack of proportional participation from males. However, this percentage mirrored the present male-female ratio (92.6% female) found in general nursing today in the US (Minority Nurse Statistics, 2010).

Survey Research

Since this research used a survey method, a potential limitation was the self-report nature of surveys. Self-reported data may be inaccurate with potential for under- or over-reporting (Chong-ho, 2009). An assumption was made that the participants were as accurate as possible in reporting data.

Reliability and Validity of VSAT and VSCIT

The VSAT and VSCIT were new tools developed specifically for use with this research. This could add to the limitations of the study since no reliability testing of the tools had previously occurred. Content and face validity were done prior to the use of both survey tools by participants. Content validity was effective in limiting the items to those specific to the constructs that each individual tool was attempting to measure. Cronbach's alpha was used for measuring internal consistency of the new tools and was consistently high for all subscales.

Although the internal reliability scores were high for both tools and their subscales, it is recommended eliminating items 8 and 9 for the VSAT tool with further reliability testing of the tool. The inter-item correlations do not support retaining these last two items as they appear to measure another construct or diverge from measuring the same construct that items 1 through 7 measure. Eliminating items 8 and 9 from the tool increases the Cronbach's alpha from 0.93 to 0.94 for the entire tool; from 0.87 to 0.89 for the subscale of cues and behaviors; and from 0.89 to 0.91 for the subscale of further assessing.

The VSCIT also had good internal reliability scores for both subscales. The inter-item correlations were minimal, however, between item 9 and items 4, 5, 6. Elimination of item 9 would slightly lower the internal reliability score and further testing is recommended. The reliability score would decrease for the entire tool from 0.92 to 0.91, and for the GNP-initiated intervention subscale from 0.89 to 0.88 if item 9 were

eliminated. The recommendation is to retain all of the VSCIT items for use in continued reliability testing of the tool.

Strengths

A major strength of this study was the large geographic representation in the sample which included a stratified randomized sample of GNPs across the United States. There was also significant diversity in age as well as years experience as a GNP among the participants. At 44%, the return rate was also good for survey research. In addition, the SPS tool has been in use for many years, with past validity and reliability testing providing support for measuring the spiritual perspectives and behaviors of a variety of participants which have included nurses, young and elderly adults, male, female, and those who are well and chronically ill.

The next sections will discuss the findings specific to each research question. The discussions will include whether the findings supported the literature, answered the question, or revealed if gaps still existed or new themes emerged.

The Spiritual Perspectives of GNPs

The results indicated GNPs have moderate spiritual perspectives overall. These spiritual perspectives are influenced by religious affiliation and ethnicity/race, which supports the literature (Conner & Eller, 2003; El-Nimr, et al., 2004; Luckhaupt, et al., 2005; Newlin, et al., 2002). Various differences were found in this study between gender, religious affiliation, GNP education on spiritual care in graduate school or outside of the academic setting, and spiritual perspectives. The literature supported these findings (Maddox, 2001). A major finding was the increased frequency of spiritual caregiving by GNPs who had received education in such care, either in graduate school or outside of

academic settings. This indirectly supports what the literature states: that lack of education is a barrier to providing spiritual care (El-Nimr, et al., 2004; Stranahan, 2001).

An item on the SPS tool having a very high mean score was the frequency of engaging in prayer or meditation. Participants reported engaging in prayer or meditation about once a week (18.8%) to once a day (58.6%). Both prayer and meditation are ways to connect to self, the world around us, and to a Transcendent Being/God/Higher Power; however, prayer is associated more with religion as discussed in Chapter 2. Religion and spirituality were defined as different but not mutually exclusive in the literature, for this study, as well as by the GNP participants (Berry, 2005; Buck, 2006; Govier, 2000). Spirituality is the individual's journey and is defined by the individual whereas religion is the communal journey where beliefs, values, sacred text, and even sacred space are held in common by a community (Gill, 2005; Leininger & McFarland, 2002; National Health Service in Scotland, 2008; Sawatzky & Pesut, 2005)

It is of interest to note that a significant moderate relationship existed between GNPs' spiritual perspectives of prayer and meditation, and client-requested interventions on the VSCIT subscale of offering to pray with a client. Here is an example of GNPs highly valuing prayer in their own spiritual perspective and being more likely to provide the same SCI to clients when requested. This aligns with the affective domain of learning and would fit with the development of a reflective practice as suggested in the conceptual model for this research and within the NONPF (2006) curriculum standards (Appendix L).

Religion and Culture

Spiritual perspectives of GNPs were also influenced by religious

affiliation and race/ethnicity. Although spirituality was defined as an individual journey in Chapter 2, this journey is influenced by many things including life experiences, past religious experiences and values, and cultural and ethnic heritage and connections. The research findings support what is discussed in the literature as well as in Chapter 2 of this paper regarding the influences of such experiences on the formation of the individual's spirituality.

Religion. Significant differences were found between religious affiliation and spiritual perspectives and are an interesting finding of this research. Religious affiliation or background may influence spirituality and spiritual perspectives as discussed in Luckhaupt et al., (2005), where personal spiritual and religious practices influenced resident physicians' beliefs of integrating spiritual care into practice. Such affiliation may have assisted in bringing the individual to a certain point in their worldview, and may or may not continue to be an important part of forming one's spiritual perspectives at the present and into the future.

The opposite may also be true when one has difficulty seeing the interconnections to the whole (Buck, 2006). This is where affiliation with a faith or religious community may help change or develop one's spiritual perspectives. With affiliation to a faith community, connections may develop to others, self, or a Transcendent Being/God. Those who may be searching for a way to heighten their spiritual perspectives may seek this through religious affiliation (Springer, et al., 2003). Although by definition for this study, as well as described by the GNP participants, religion and spirituality are different but are not mutually exclusive. Thus affiliation with a faith community may promote the

further development of one's spiritual perspectives, but varies with the individual and the religious affiliation.

Culture. The influence of culture or ethnicity on spirituality and spiritual care is also supported in the literature and the research findings. One's worldview and spiritual perspectives are closely tied to one's cultural or ethnic heritage. Conner and Eller (2004) discuss that older African-American adults continue to expect spiritual care from health care providers when hospitalized, but Ross (1997) identified the opposite in older Caucasian males.

Although this present study was limited to predominantly Caucasian Christian participants, the majority of cultures view and interpret the world through their own specific lens (Pesut, 2003; Pesut, 2005). This would also include spiritual perspectives and warrants further research to include a more diverse sample.

How GNPs Describe Spirituality

Geriatric nurse practitioners' definition of spirituality is consistent with the definition based on the literature and used in this research. Words such as harmony, peace, holistic, restoring balance, and reintegration of body mind and spirit were used and are the same as those found in the conceptual literature (Buck, 2006; Friedemann, et al., 2002; Gaskamp, et al., 2006; Henderson, 2006; Malinski, 2002; McEwan, 2004; McManus, 2006; Narayanasamy, 2004; Narayanasamy, et al., 2004; Newlin, et al., 2002; Puchalski, et al., 2006; Sawatzky & Pesut, 2005; Tanyi, 2002; Tuck, 2004).

References to various types of connections were numerous and important. These types of connections included the intrapersonal, interpersonal, and Transcendent connections. These types of connections correspond to the types of connections Reed

(1991, 2008) incorporates into the SPS tool. In addition, transcendence provided a link to the conceptual model while religious practices were viewed as ways to express spirituality, even though spirituality was identified as a different phenomenon from religiosity (Berry, 2005; Govier, 2000; Newman, 2008).

Two new themes emerged that were not part of the research definition or found in the literature. The first theme involved ethical and moral ways of thinking, acting, and being in the world for the greater good of others and self. This provided a different philosophical slant to spirituality from the existential approach of finding meaning, purpose, and fulfillment in life and health which was introduced in the conceptual portion of this paper in Chapter 2 (Burkhart, 2001; Martsolf & Mickley, 1998; Post, et al., 2000) Finding meaning and purpose in life and health most certainly differs in focusing more on the individual self versus the world and others. However, increasing spiritual self-awareness by incorporating existential processes into self-reflection and education can promote sensitivity to others' spiritual care needs as suggested earlier in Chapter 2 (Burkhart & Hogan, 2008; Olson, et al., 2006). Being and acting in the world for the greater good of others and self would involve interactions with the external environment. This is also part of the interpersonal relationship previously discussed in this paper, and is included in the conceptual framework of this research. Spiritual care has been identified as occurring within the interpersonal relationship for this study. Approaching spirituality from this different philosophical perspective of ethics and morals, linking it to something that promotes the greater good for others and self, is a consideration for further research.

The second theme that emerged which did not map into the research definition indicated that spirituality met specific human needs such as love, comfort, and joy. The

literature did not specifically address this aspect of spirituality, however many of these needs are met within the relationships and connections to self, others and the world around us, and the Transcendent, as discussed earlier in Chapter 2. Providing spiritual care may also help meet or facilitate meeting human needs as identified by Goldberg (1998), through our connections with others which allows for empathy, compassion, giving hope, love, and healing.

Integration of Spiritual Assessments into GNP Practice

Integration of spiritual assessments into GNP practice was addressed first with pattern recognition by GNPs of cues and behaviors exhibited by clients indicating a spiritual care need. Probing and further assessing the spiritual care need once cues and behaviors were identified provided further insight into GNPs' integration of spiritual assessments into practice, but in more depth.

From the spirituality and spiritual care literature several concepts were identified as specific cues and behaviors indicating a spiritual care need, which included meaning and purpose in life, helplessness and hopelessness, forgiveness, relationships, grieving over losses, and religious and spiritual activities (Chao, Chen, & Yen, 2002; Newlin, et al. 2002; Reed, 1992). With the assistance of expert input, the content validity process identified the following as being the most important client indicators of a need for spiritual care: appears and expresses loss of meaning or purpose in life; a sense of helplessness; difficulty accepting forgiveness; having a sense of hopelessness; dissonance with important relationships; grief over losses, including loss of health; disconnection from past religious activities or rituals that used to bring peace, comfort, or a sense of connection in the past; and clients specifically stating they are interested in talking about

their spiritual needs. Looking at individual items on the SPS tool, forgiveness was a major part of the GNPs' spiritual perspectives, supporting what Newlin et al. (2002) discussed regarding the reparative processes of spirituality, as well as what was indicated by expert input.

Client Cues and Behaviors

Recognizing patterns is the first step in assessing clients' needs for spiritual care. In general, more than half of the GNP participants in this study were often (50.4%) able to recognize patterns of cues and behaviors of clients that indicated a need for spiritual care.

Gender. The overall mean scores indicated a significant difference between male (m = 3.33) and female (m = 3.96) participants' frequency in identifying specific cues and behaviors of clients. The sample for this research (94% female) closely mirrored the ratio of females represented in nursing in the United States today (92.6%) (Minority Nurse Statistics, 2010).

Men and women experience life differently based on a number of variables related to gender issues. Because of the limitation of low male participation in this research, as well as limited numbers of men found in nursing in general, it cannot be assumed that the spiritual perspectives of male participants in this study were lower than females. The literature indicates women tend to have higher spirituality scores and also scored higher on the SPS tool than men (Reed, 1991; Reed, personal communication, October 22, 2010). Women more frequently identified cues and behaviors of those in need of spiritual care in this study, thus supporting the literature. Further research is needed to better understand the relationship between gender, spiritual perspectives, and

identifying clients' cues and behaviors as part of integrating spiritual assessment into the practice of GNPs, with increased numbers of male GNP participants.

Education. The participants were asked to identify whether they had received spiritual care education in their undergraduate or graduate programs, and whether they had sought such education beyond their degree programs. Undergraduate education was not found to be a significant variable in this study. For those whose curriculum in graduate education included spiritual care, as well as those seeking further education on such a topic beyond the academic setting, there was a significant difference in the frequency of GNPs identifying clients' cues and behaviors. This would suggest that such education might increase GNPs pattern recognition of spiritual care needs.

Unfortunately, only close to 30% in each group (graduate and outside of academia) had received such education. This is consistent with what is found in the general NP and nursing literature on those receiving education on spiritual care and spirituality (Sellers & Haag, 1998; Stranahan, 2001). This also supports one of the primary purposes of this research: to describe whether the inclusion of spiritual care curriculum in GNP education, or continuing education offerings to practicing GNPs, would make a difference in the frequency of the provision of spiritual care provided to clients. The findings support graduate and continuing education in spiritual caregiving as a significant factor in increasing the recognition of cues and behaviors indicating spiritual care needs in clients.

There is a question however that must also be considered based on the fact that one has increased in age between undergraduate and graduate programs and beyond; however, increased age was not a significant variable in this study. Conner and Eller

(2004) as well as aging and developmental theories (Tornstam, 2003) support the increasing importance of spirituality as one ages, as well as the increasing importance of the provision of spiritual care by health care providers. Different life experiences, levels of expertise, and maturing spirituality for those who sought out education in post-academic settings, or perhaps intentionally sought out graduate education which included spiritual care curriculum, could be important variables of interest for future research.

Further Follow-Up Assessment of Spiritual Care Needs

The choice to address whether GNPs further assessed clients' spiritual care needs once such a need had been discovered was based on comments from the SMEs involved in the content validity process. The variables assessed within the items did not change from the previous ones of identifying the cues and behaviors. Rather, the second part of each question moved the interpersonal relationship beyond pattern recognition to a deeper level of the relationship. This deeper relationship is aligned with Newman's (2008) theory and the conceptual framework developed for this research. The literature supports that increased personal spiritual awareness and increased sensitivity to others' spiritual needs was predominantly obtained through reflection on personal experience, or through the intrapersonal connection (Olson, et al., 2009). It would appear that those who have heightened spiritual self-awareness or evolved consciousness in this area will generally be more comfortable in further assessing and more deeply probing clients' spiritual needs within the interpersonal relationship.

Gender. Females exhibited an increased frequency in further assessing client's spiritual care needs than males. As discussed previously, there was limited male participation in this study. Both genders also interpret their life experiences differently

based on gender issues which are beyond the scope of this paper (Klemke et al., 1998). Thus these results need to be interpreted cautiously, as previously mentioned, with the ratio of male to female in this study mirroring ratios found nationwide in nursing in general. Further study is recommended with increased male participation. Again, gender and advanced education were implicated in this study in improving GNPs' ability to further assess the spiritual care needs of clients once the cue and behavior pattern had been discovered.

Education. Education on spiritual care does influence the frequency of further assessing clients' needs for spiritual care as found in this study. This education was at the graduate level and also independently sought outside of the academic settings, however, only about a third in each group had received such education. Education on spiritual care whether at the graduate level or outside of the academic setting, was supported by this study as increasing the assessment of clients' spiritual care needs by GNPs beyond pattern recognition of cues and behaviors to a deeper level of further assessing. This study's findings also support the findings of Stranahan (2001) and Sellers and Haag (1998) regarding lack of education as a barrier to the provision of spiritual care by NPs and nurses

Belief in Ability to Recognize Spiritual Care Needs in Others

Geriatric nurse practitioners who believe they can recognize the cues and behaviors of those who need spiritual care have increased frequency in actually recognizing those patterns, but not in moving to a deeper level of further assessing clients' specific needs. Fifty-four percent often believed they recognized when clients needed spiritual care which is consistent with 50.4% of GNPs who often identified

specific cues and behaviors indicating a spiritual care need. However, only 39.1% often further assessed client's spiritual care needs and only 17% often provided any spiritual care interventions as found in this research.

Being female and having education on spiritual care in graduate school also made a difference in improving recognition of the patterns of cues and behaviors, but not in further assessing the spiritual care needs. Adequately assessing the need assists in providing the appropriate intervention, whether this is a referral or providing other specific spiritual care interventions.

These study results support the findings in the literature. The literature supports females are more spiritual than males which may influence their ability to recognize spiritual care needs in others (Reed, 1991). Lack of education on spiritual care is cited as a barrier to the provision of spiritual care by health care providers in the literature (Highfield, et al., 2000). This study's results also indicated undergraduate education was not a significant variable for GNPs and their belief in their ability to recognize patterns of cues and behaviors. Graduate education and non-academic education on spiritual care however, had a significant impact on frequency of recognition of cues and behaviors and the GNPs' belief in their ability to recognize these patterns.

Specific Tools Used by GNPs to evaluate Clients Spiritual Care Needs

Participants had little knowledge of tools available to assist in assessing and evaluating spiritual care needs of clients as evidenced by the research findings. Many provided feedback that they would like to or were planning on utilizing the tools within their practice which were identified on the VSAT. A few participants indicated internal tools had been developed by a team of chaplains and social workers in their workplace, or

was an assignment in graduate school. Nursing was a missing participant in the development phase of the tools in the institution setting, and only periodically used the tools. From this information it can be assumed that GNPs have had little exposure or education on methods and tools available for use in their practice to assist in evaluating clients for spiritual care concerns, and are missing as part of the team to develop such tools. This again provides support regarding the lack of education as a barrier to the provision of spiritual care found in the literature and presents a continuing gap between practice and education (Stranahan, 2001).

Integrating Spiritual Care Interventions into GNP Practice

From the literature several concepts were identified regarding specific spiritual care interventions provided by nurses in particular or requested by clients. Subject matter experts also assisted in narrowing the concepts to specific items that reflected the practice of advanced practice nurses. Those interventions that were GNP generated included: (1) encouraging clients to talk about their spiritual concerns, recent spiritual insights related to health and chronic disease, spiritual difficulties of living with chronic disease, how chronic disease affects their relationship with God or a Higher Power, grieving as it relates to health, and what gives their life meaning and purpose (Conner & Eller, 2004; Lee, 2005; Newman, 2008; Solari-Twadell, 2002; Taylor, 2008); (2) thinking about ways to heal dissonant relationships (Conner & Eller, 2004); (3) documenting spiritual care interventions provided (Stranahan, 2001); (4) discussing client's spiritual care needs with other health care providers related to the client's health needs; and (5) using touch appropriately (Solari-Twadell, 2002).

Those spiritual care interventions generated from the client included: discussing potential spiritual resources in the community to meet needs (Solari-Twadell, 2002); providing support for client's spiritual practices (Conner, & Eller, 2004; Lee, 2005; Solari-Twadell, 2002; Taylor, 2008; Wallace, & O'Shea, 2007); arranging for a visit from, or a referral to, clergy or spiritual mentors (Conner, & Eller, 2004; Taylor, 2008; Wallace, & O'Shea, 2007); offering to pray with clients (Conner, & Eller, 2004; Stranahan, 2001; Taylor, 2008); and encouraging clients to cope using spiritual practices or spirituality (Solari-Twadell, 2002; Taylor, 2008).

Spiritual care interventions generated by GNPs were not often implemented (17.1%) in spite of 29.3% to 34.5% of GNPs receiving some form of education in spiritual caregiving at some point in their careers. Only 17.3% of GNPs often provided client requested spiritual care interventions in spite of graduate education standards stating the client's own spiritual, religious, and cultural preferences should be included in the GNPs plan of care (AACN, 2006; NONPF, 2002; NONPF, 2006) (Appendix L). This next section discusses the research findings on GNPs and client-generated spiritual care interventions and their implications.

Geriatric Nurse Practitioner Generated Spiritual Care Interventions

Ten items were included in this portion of the tool as identified above. Whereas slightly over 50% of the participants often identified patterns of cues and behaviors indicating a need for spiritual care as previously discussed, only 17.1% often initiated any specific spiritual care interventions.

Education. There is a distinct gap between the frequency of often identifying patterns of cues and behaviors with providing GNP-generated SCI. The primary findings

point to education as a means to improve GNP generated SCIs. Graduate education as well as education outside of the academic setting on spiritual care significantly influenced the ability to provide GNP generated SCIs to clients. This supports what is found in the literature regarding the lack of education on spiritual care as a barrier to providing such care to clients by nurses in general and GNPs in particular (Maddox, 2001; Sellers & Haag, 1998).

Geriatric Nurse Practitioner Provision of Client-Requested Spiritual Care Interventions

Geriatric nurse practitioners who often provided specific client-requested SCIs were limited (17.3%) compared to the percent that had received education on spiritual caregiving in some manner (29.3% to 34.6%), and further assessed these patterns (39.1%). The findings indicate a limited alignment between the educational standards to incorporate the client's own religious or spiritual perspectives into a plan of care, and actual practice (AACN, 2006; NONPF, 2002; NONPF, 2006) (Appendix L). This study however, indicated further education beyond graduate school on spiritual caregiving significantly increased GNPs' frequency of providing client requested interventions. This provides support for the literature that lack of education on spiritual caregiving is a barrier to the provision of spiritual care by GNPs (Stranahan, 2001).

Conceptual Model with Influencing Variables

The concept of interconnectedness to the whole, as found in the definition of spirituality by the GNPs and for this research, supports Newman's theory (2000) and the conceptual model for this research (Appendix E). Connection to the whole would include the GNP and client as open energy fields interacting with the environment and within a

relationship. This interaction includes the client and GNP as parts of a whole with regard to health, expanding consciousness, and transcending, through an interpersonal relationship and connectedness with each other and the environment. This was found in the themes of this study in defining spirituality.

The 5 variables found within this study that influence the GNPs integration of spiritual care can be added to the conceptual model. Gender, religious affiliation and experiences, and culture influence the GNP's intrapersonal self and worldview. Expanding consciousness through spiritual care education in graduate GNP curricula as well as continuing education for practicing GNPs provides skills for spiritual assessment and interventions. Combining expanded consciousness with the intrapersonal connection allows for the GNP to transcend to a higher level of consciousness. This higher level of consciousness will assist the GNP with the interpersonal connection needed to address the clients' chaos in heath through spiritual assessments and interventions by the GNP.

Fig. 8 Vincensi's Expanded Conceptual Framework with Influencing Variables

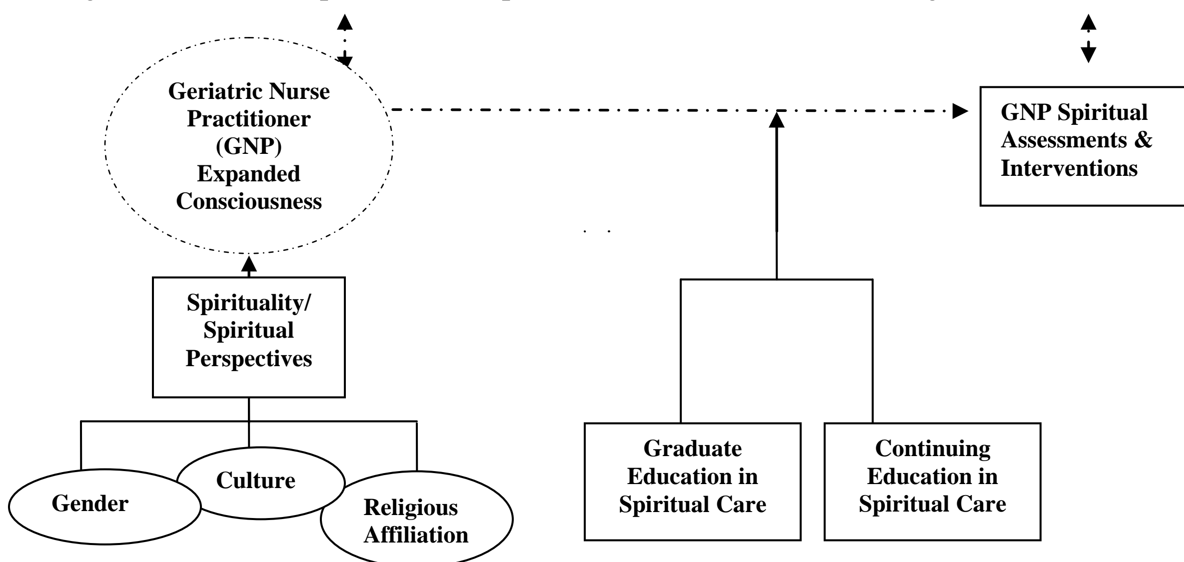


Figure 8 shows the expansion of the conceptual model with the added variables

which this study supports as influencing the spirituality and spiritual care provided by GNPs. The GNP is surrounded by a broken line which indicates continuous interaction with the environment and others. Spirituality/spiritual perspective is influenced by gender, culture, and religious affiliation. Gender is intrinsic to the individual and is shown to have some influence on spirituality. This is being interpreted with caution since the majority of participants were female. Culture and religious affiliation are part of the interpersonal interaction that transpires between the GNP and the environment where there is constant energy exchange occurring. Although these variables are originally extrinsic to the GNP, they expand consciousnesses, eventually becoming part of the individual or the intrapersonal connection. They are used as the GNP's internal resources for the provision of spiritual care. In addition, graduate and continuing education on spiritual care provides knowledge, skills, and expands consciousness of the GNP to implement spiritual care assessments and interventions within GNP practice. The influence of these five variables assists the GNP in expanding consciousness within the intrapersonal relationship and recognizing patterns in the intrapersonal and interpersonal relationships. This will promote further progression of both the GNP, and eventually the client, to higher levels of consciousness, transcending, and health as indicated in the original model in Appendix E.

The Relationship of Geriatric Nurse Practitioners' Spiritual Perspectives and Integration of Spiritual Assessments and Spiritual Care Interventions into Practice

The literature indicated one's individual spiritual perspectives can affect how one acts and behaves as well as how one views the interconnectedness of the world (Reed, 1991). This study found no relationship between GNPs' spiritual perspectives and the

frequency in which patterns of cues and behaviors of spiritual care needs were identified or further assessed, or the frequency with which GNP-generated SCIs were provided. The only subscale where a significant but weak correlation was found was with GNP provided client-requested SCIs. This would follow the standards for graduate education which promote the incorporation of the client's own religious or spiritual beliefs into practice and the plan of care, but with a weak relationship, one questions a gap between practice and education (AACN, 2006; NONPF, 2002; NONPF, 2006) (Appendix L).

It would not be necessary in such cases for the GNP to consider themselves spiritual or have a more in-depth relationship with the client to fulfill client-requested interventions. At times, facilitating a client request may be all that is needed and could be provided without regard to relationship status with the client or the GNP's spiritual perspective. Often however, GNPs are the first to encounter clients' sharing of spiritual concerns that may require more immediate and sensitive in-depth responses and evaluation, allowing for adequate interventions and follow-up.

Spiritual Perspectives and Individual Spiritual Assessment Items

Cues and Behaviors. In this study, spiritual perspectives of GNPs have a relationship to specific individual cue and behavior items, and none to further assessing items. There was a weak but significant relationship found between spiritual perspectives of GNPs and the frequency of identifying clients who appear to have lost meaning or purpose in life, and who express that life has no meaning or purpose. Losing meaning and purpose in life may indicate spiritual distress for some individuals as discussed in Chapter 2. Finding meaning and purpose in life was also identified in the literature as a major attribute of spirituality and as part of an existential perspective of spirituality

(Burkhart, 2001; Goldberg, 1998; Martsolf & Mickley, 1998; Post, et al., 2000; Ross, 1994). However, these existential aspects were never identified in the quotes and themes of the GNPs to define spirituality. Another philosophical perspective of ethics and morals was introduced in the findings as a theme which did not map into the research definition of spirituality but warrants further investigation in the literature.

Additional significant but weak correlations existed between spiritual perspectives and increased frequency of identifying a pattern of clients displaying a sense of hopelessness as well as helplessness. A pattern of hope is supported in the literature as part of the reparative process of spirituality and an outcome of spiritual caregiving regarding the development of hope (Newlin, et al., 2002). Helplessness was identified in the literature as the experience of no longer feeling connected to others or a Higher Power (Carroll, 2001; Gaskamp, et al., 2006; Taylor, et al., 1995). Having hope and being comforted when distressed, such as when one is feeling helpless, are human needs which were also identified in the study findings as a theme that did not map into the research definition of spirituality. Although discussed in Chapter 2, meeting human needs should be further investigated as part of the definition of spirituality.

Spiritual Perspectives and Individual Spiritual Care Interventions Items

GNP-Generated Interventions. Although overall there was no significant relationship between the subscales of spiritual perspectives of GNPs and the provision of GNP-initiated spiritual care interventions, spiritual perspectives did have a weak but significant relationship to increased frequency of encouraging clients to talk about living with chronic disease and the spiritual difficulties this presented. In addition, increased spiritual perspectives also increased the frequency of encouraging clients to discuss the

effect chronic disease had on the clients' own relationship with God or a Higher Power, as well as the appropriate use of touch by GNPs when spiritual needs arose. This supports Reed's (1991) and Narayanasamy's (2004) discussions of spirituality and spiritual care as a connection to God or a Higher Power, as well as to self and others in developing relationships at different levels (intrapersonal, interpersonal, and Transcendent levels).

Client-Initiated Requests. Two client-initiated items had moderate but significant relationships to the spiritual perspectives of GNPs. These included the GNP offering to pray with the client and encouraging coping through the client's use of spiritual practices or spirituality. The use of spirituality to help cope with health concerns is well documented by Narayanasamy (2004), Taylor et al., (1995), and Tanyi (2002), and the findings of this research study. Chapter 2 discusses prayer however as a part of religious ritual (Gilman, et al., 1996). By definition, GNPs identified spirituality as different from religion in this study. Prayer can be part of both religious and spiritual ritual, two concepts which are defined differently but may not be mutually exclusive as previously discussed. However, graduate education standards (AACN, 2006; NONPF, 2002, 2006; AACN/JHF 2004) stress the incorporation of the client's own religious, cultural, and spiritual beliefs and practices into a plan of care.

Implications for Research

There are implications for areas of future research based on the research findings of this study. One area is to increase male participation, as well as cultural and religious diversity. This would assist in better understanding the spiritual perspectives of male

GNPs and how their spiritual perspectives differ from their female colleagues, as well as other cultural and religious perspectives on spirituality and spiritual care.

Another area for continuing research includes refining the VSAT and the VSCIT instruments. This would include implementing some of the recommendations suggested earlier on the VSAT to improve the internal consistency; and to maintain all items on the VSCIT instrument while continuing to test for internal consistency or homogeneity and stability across time.

A final area for further research includes reviewing the literature to follow up on the two new themes that emerged which did not map into the research definition. This would include reviewing the literature from the philosophical perspective of basing spirituality on moral and ethical ways of thinking, being, and doing in the world, and fulfilling specific human needs through spirituality.

Implications for Education

The research findings supported education on spirituality and spiritual caregiving at the graduate level and outside of academic settings, and meant a higher frequency of spiritual care was provided by GNPs to clients. There is a need to more fully implement the graduate educational standards into the curriculum beyond incorporating the client's own religious beliefs and spirituality into a plan of care. In addition one needs to first connect to self (intrapersonal connection) before connecting to and assisting others (interpersonal connection). This would include increasing the graduate student's or GNPs spiritual self awareness through various methods to expand consciousness and transcend. Centering on the affective domain, where values and personal insights are part of the learning process of expanding consciousness, is one educational focus suggested within

this research and found within the NONPF (2002, 2006) standards. Various pedagogies and models for education need to be developed.

Implications for Practice

The potential to improve clients' health is presented in the literature by supporting their spirituality with the provision of spiritual care (Boland, 2005; Daaleman & Frey, 2004; Singleton, 2002; Springer, et al., 2003). This may have implications for health care costs, mortality, and morbidity in the future especially if spiritual care can be integrated into GNP practice. Although advanced practice nursing standards include some form of incorporating spiritual care into practice, a gap between what is taught, the standards of care, and what is happening in the practice environment is apparent. There may be other reasons why spiritual care is not integrated into GNP practice regularly, which need to be considered. Specific models of graduate nursing education need to be developed to include spiritual care.

If the conceptual model is used in regards to spiritual care in practice, time will expand as one's consciousness expands. With this in mind, it is possible that some barriers in the practice environments to providing spiritual care will diminish and decrease the gap between practice standards, education, and GNP practice.

Conclusions

Both the literature review and the research study advance nursing knowledge. The literature review provided subject matter on the connection between health and spirituality and spiritual care. This information was used for content analysis for tool development. Lack of tools to evaluate the integration of spiritual assessment and spiritual care interventions into GNP practice were identified as a gap in this research. As

a result, two new tools were developed and tested in this study. Both were found to have good internal consistency after content validity testing was completed. However, to continue to improve them, since they are in the early stage of development, more work is needed to further develop and test the tools. Consideration in adapting the tools for other NP specialties would be important as no tools are presently available to adequately assess integration of spiritual care into any NP specialty practices.

In addition, a conceptual model was derived from the spirituality and spiritual care literature and synthesized with Newman's Theory of Health as Evolving Consciousness to provide a unique framework. This framework helped to suggest relationships and support connections. Development of the intrapersonal and interpersonal relationships is stressed in this model in order for both the client and GNP to expand consciousness and transcend to higher levels of insight and knowledge. Although graduate education was consistently supported as improving the frequency of providing spiritual care in this study, gaining knowledge outside of academic settings was also identified as an educational source to improve frequency of spiritual care. As part of this education, increasing one's spiritual self awareness is recommended as it is supported in the literature as improving sensitivity to others need for spiritual care. Expanding the consciousness of the GNP is also part of the larger conceptual framework developed for this study. It is recommended as one means to promote transcendence through deepening intrapersonal and interpersonal relationships to improve spiritual care in GNP practice.

Knowing how to expand consciousness is something the GNP student can take with them into the practice setting for continued transcending. In addition, improving

spiritual care integration into GNP practice was identified as starting with graduate curriculum and continuing education programs for practicing GNPs. This educational initiative needs to be seriously considered to improve care, which was supported by this study.

Lastly, GNPs defined spirituality much the same as it was defined for this research study. In addition, two new themes were discovered which need to be further explored as they have significant implications as to how spirituality is defined and operationalized. The new themes indicated spirituality fulfilled human needs and proposed a moral and ethical way of being, doing, and perceiving the world. This was not found in the literature, although existential perspectives were discovered in the literature but not included in the two new themes that were mapped. Linking spirituality to morals, ethics, and philosophy, as well as to fulfilling specific human needs, is a new path for further exploration.

APPENDIX A

RESEARCH DATABASES

Research Databases

Database	Search Parameters	Total Articles
CINAHL (Nursing)	Nurse, Spirituality, Advanced Practice Nurse, Spiritual Care, Holistic Nursing, Hospice	1. Spirituality and: a. Nurse /Nursing 2,000 b. Advanced Practice Nurse 15 c. Holistic nursing 8 d. Research 1,500 2. Nurse with: a. Spiritual Care 0
Medline (Medicine)	Nurse, Advanced Practice Nurse, Spirituality, Physician, Hospice	Spirituality and: a. Nurse 7 b. Physician 30 c. Advanced Practice Nurse 2
Sociological Abstracts (Social Work)	Spirituality	1. Spirituality 10
PsychInfo (Psychology)	Spirituality, Nursing, Advanced Practice Nurse, Healing	1. Spirituality 100 2. Spirituality with: a. Advanced Practice Nurse 0 b. Nursing 0 c. Healing 10
ALTA (Religion/Pastoral Care)	Nurse, Nursing, Spirituality, Health, Research	1. Nursing, Spirituality or Health 0 2. Spirituality & Research 15

APPENDIX B

ATTRIBUTE GRIDS OF SPIRITUALITY (1992-2007) AND SPIRITUAL CARE (1994-2006) IN THE LITERATURE

Literature Source	Attributes of Spirituality in the Literature
Reed, P. (1992). Nursing	• Holistic • Human characteristic • Connectedness: intrapersonal (existential well-being), interpersonal, and transpersonal (components of connectedness: hope, generativity, inner-meaning, mystical experiences, religious behaviors) • Multidimensional concept: vertical and horizontal dimensions • Self-transcendence • Core components: hope in the face of illness; receiving and giving love; meaning and purpose in life
Ross, L. (1994) Nursing	• Meaning, purpose and fulfillment in life • Meaning in illness • Hope • Belief/faith in self, others, God
Goldberg, B. (1998) Nursing	• Connection through empathy, compassion, giving hope, love/self-giving, appropriate touch, healing • Vertical connection/relationship/dimension with God, the transcendent, Supreme Being, etc. • Horizontal connection/relationship/dimension with self, others, and the natural world • Relationship with others through presencing • Search for meaning • Spirituality: abstract noun vs. spirit: concrete noun • Cultural meanings: *Greek*, spirit is opposed to the physical reality (spiritual person is not interested in the material world or gain); *Hebrew*, spirit (*Ruah)* is within the body providing a life force with which to actively commit to a spiritual life. It is opposed to death and destruction and all that is negative about the law • Broader meaning than religion
Martsolf, D. Mickley, J. (1998) Nursing	• Meaning • Value • Transcendence • Connecting • Becoming

Literature Source	Attributes of Spirituality in the Literature
Post, S. Puchalski, C. Larson, D. (2000) Medicine	• Meaning and purpose in life • Faith in a higher being • Religious affiliation/spirituality in religious form
Pulchalski, C. Romer, A. (2000) Medicine	• Transcendence • Relationship with God, nature, art, music, family or community, others • Sense of meaning and purpose in life
Burkhart, L. (2001) Nursing	• Finding meaning and purpose in life • Universal concept that is personal (vs. religious concept /group) • Connection with self, others, art, music, literature, nature, or a supreme being/power
Burkhart, L. Solari-Twadell, A. (2001) Nursing	• Meaning and purpose in life • Broader concept than religion • Connectedness to self, others, art, music, literature, nature, or a supreme being/power, through the spirit. • Human characteristic (realist perspective) • Spiritual beings in a physical world equals human being (existential perspective)
Friedemann, ML. Mouch, J. Racey, T. (2002) Nursing	• Coherence, finding patterns of God and unity within • Individuation through connection with others and the world, expanding one's consciousness and sharpening perceptions to the rhythm and patterns of the surrounding universe • Transcending self • Spirituality connects humans with a universal order, and establishes harmony or congruence within
Malinski, V. (2002) Nursing	• Broader, inclusive term (vs. religion) • Unitive experience without boundaries • Direct experience of the sacred • Healing energy • Caring for others, self, the natural world and all that live within it • Spirituality is what an individual says it is to him/herself

Literature Source	Attributes of Spirituality in the Literature
Newlin, K. Knafl, K. Melkus, G. (2002) Nursing	• Higher being or power • Transcendence • External dimensions: interpersonal connections with God, others, or organizations • Consoling dimensions: liberating source of peace, compassion, love, protection, warmth and comfort • Transformative dimensions: source of healing, personal growth, liberation, strength, meaning, coping, hope, purpose, renewal and interpretation of experience • Outlying attributes: joy, fear, identity, celebration, fulfillment and abandonment
Puchalski, C. (2002) Medicine	• Meaning and purpose • Hope • Connection to God, others
Solomon, J. Hunter, J. (2002) Educational Leadership	• Meaning system in response to existential concerns • Connection to self, others, and things beyond self • Transcendence • Idiosyncratic, individual • Presencing
Tanyi, R. (2002) Nursing	• Transcendence • Unfolding mystery • Multidimensional concept • Connectedness to self, others and a supreme purpose or meaning or a higher power • Vertical and horizontal components • Relationships • Wholeness • Peace • Harmony • Individuality • Driving force in life • Inherent component of humans • Belief and faith • Inner strength
Connelly, R. Light, K. (2003), Religion and Health (Ethics)	• Brings significance, purpose and direction to life • Search for meaning, life, wholeness, healing and hope.

Literature Source	Attributes of Spirituality in the Literature
Musgrave, C. McFarlane, E. (2003) Nursing	• Drive to find meaning and purpose • Spiritual dimension is integral to health, well-being
Omen, D. Thoresen, C. (2003) Psychology of Religion	• Search for the sacred
Pesut, B. (2003) Nursing	• Connectedness, intrapersonal and interpersonal • Relationship to a higher being or God
Elkins, M. Cavendish R. (2004) Nursing	• Focuses on the sacred • Meaning in life • Spirituality can be considered complementary and alternative medicine for healing
Handzo, G. Koenig, H. (2004) Medicine	• Meaning, purpose in life • Relationship to the sacred or transcendent
Koenig, H. (2004) Medicine	• Individualistic and self-determined • Broader and more inclusive term (vs. religion) • Finding meaning in illness
McEwan, W. (2004) Nursing	• Enables us with an awareness of the meaning of life • Transcendence • Connecting, relationship development • Becoming • Inner self connection • Wholeness • Meaning of life • Harmony
Narayanasamy, A. (2004) Nursing	• Meaning and purpose • Essence of our being • Spirituality gives a sense of personhood and individuality • Inner source of power and energy • Connection to others and surroundings • Mysterious nature • Relationship with 'something other'/supreme • Source of wisdom, meaning and purpose • Holism • Love and harmonious relationships with others

Literature Source	Attributes of Spirituality in the Literature
Narayanasamy, A. Clissett, P. Parumal, R. Thompson, D. Annasamy, S. Edge, R. (2004) Nursing	• Holistic • Essence of being • What motivates and guides us to live a meaningful life • Interconnected • Human characteristic • Inner peace and strength derived from a relationship with a transcendent being or reality • Meaning and reason for existence
Tuck, I. (2004) Nursing	• Dimension of holism • Essence of the individual • Allows for meaning, peace, hope • Connectedness with self, others, nature and God or higher power • The force that integrates existence, wholeness and healing
Fawcett, T. Noble, A. (2004) Nursing	• Search for meaning and purpose • Transcendent • Different from religion
van Leeuwen, R. Cusveller, B. (2004) Nursing	• How one makes meaning out of life and finds purpose • Relationship to the transcendent, others, self
Gill, S. (2005) Palliative Care	• Differs from religion • Relationship, person centered • Implied way of volition • Transcendent • The core the integrates the whole person of mind, body and spirit
Hollins, S (2005) Nursing	• Person-centered • Given of human existence • Transcends the physical world • Meaning; deriving purpose in life • Shapes values and behaviors • Connecting: relationship with self, others, environment and higher power/God • Becoming, life unfolds to give a sense of who one is and how one knows; uses reflection and experience

Literature Source	Attributes of Spirituality in the Literature
McEwen, M. (2005) Nursing	• Individual's essence as a person • Relationships with others, self, nature, and an infinite being • Search for meaning, fulfillment and purpose in life • Vertical and horizontal dimensions • Integration and unification of mind, body, and spirit • A unique and dynamic process influenced by worldview, culture, development, experience • Universal and personal (vs. religion)
Shaw, J. (2005) Psychiatry	• Expansion of self • Transcendence • Connections to nature, others • An attempt to find a greater significance, being part of something larger than self • Spirituality is a reparative process for the self • Based on or part of human experience
Sawatzky, R. Pesut, B. (2005) Nursing	• Meaning and direction in life • Presencing • Transcendence • Relationships, connections to others and self • Intensely personal nature of spirituality • Holistic
van Loon, A. (2005) Nursing	• Breathes life and vitality into a person • Meaning and purpose in life
Speck, P. (2005) Nursing	• Vital essence of life • Helps to transcend circumstances and find new meaning and purpose • Dynamic and individual
Buck, H. (2006) Nursing	• Meaning or purpose (teleology, ultimate purpose) • Value or beliefs • Transcendence beyond the self • Connecting with self, nature, others, supreme being/God (with corporeal and non-corporeal) • Becoming, Integration of the parts into a whole • Intrinsically human experience • May or may not involve religious structures • Find meaning and purpose through connections

Literature Source	Attributes of Spirituality in the Literature
DeLaune, S. (2006) Nursing	• Multidimensional • Universal • Ecumenical • Spontaneous • Affective • Connection to self, others. and a higher power • Meaning and purpose in life • State of being
Gaskamp, C. Sutter, R. Meraviglia, M. (2006) Nursing	• Connectedness with self, others, nature or God • Integration of the whole • Meaning and purpose in life
Henderson, M. (2006) Medicine	• Refers to the essence which brings meaning, courage and hope • Seeking • Integral to the whole person
Hodge, D. (2006) Social Work	• Broader construct than religion
McBrien, B (2006) Nursing	• Belief and faith in a higher power • Inner strength and peace when accepting a situation and reaching a state of congruency • Connectedness with self, others, God/higher power and the environment which leads to a deeper meaning in life
McManus, J. (2006) Nursing	• Holistic • A search for the sacred
Pesut, B. (2006) Nursing	• Universal dimension of person • One dimension of a multidimensional person • Transcendence of consciousness of time and space • Connectedness • Meaning and purpose • Individually defined by nurse and patient: humanist, theist, monistic approaches

Literature Source	Attributes of Spirituality in the Literature
Puchalski, C. Lunsford, B. Harris, M. Miller, T. (2006) Multidisciplinary (physician, nursing, social work and clergy)	• Sense of transcendence (vertical relationship with the divine/holy/sacred) • Relation aspects with others (horizontal relationships) • Transcendental or existential way to live life fully • Search for ultimate meaning in the context of religious values, beliefs, and practices • Holistic • Meaning and purpose in life
Reynolds, D. (2006) Nursing	• Not synonymous with religion • Ascribes meaning to the experience of illness • Connectedness • Transcendence • Meaning • Purpose • Potential source of empowerment
Sinclair, S. Pereira, J. Raffin, S. (2006) Palliative Care	• Personal • Life-giving • Being (God) • Relationship • Transcendent • Not synonymous with religion • Focus on meaning
Smith, A. (2006) Nursing	• Seeking meaning • Experiencing transcendence • Connectedness to others, self, and beyond self • Universal phenomenon • Abstract and multidimensional concept with vertical and horizontal components • An internal reserve to assist with resiliency in time of need
Tyler, I. Raynor, J. (2006) Nursing and Natural Sciences	• Holistically conceived • Quality of being • Consists of insights, beliefs, values, attitudes, emotions and behavior • Informed by the lived experience • Defined by the individual • Not the same as religion • Dimension of health • Intimate connection of body, mind, and spirit

Literature Source	Attributes of Spirituality in the Literature
Como, M. (2007) Nursing	• Not synonymous with religion • Essence of person while seeking meaning and purpose in life • Life-giving • Experiencing connectedness or transcendence to that which is beyond the self • Universal phenomenon as all seek meaning and acceptance in their lives through relationships with self, others, and the sacred • An aspect of health
Tinley, S. Kinney, A. (2007) Nursing	• Affirmation of life in relations to self, community, environment and a higher being or God • Both vertical and horizontal components • Relates to life purpose and satisfaction • Meaning in life • Life-long developmental process • Has unique personal connotations and is a property of person
Gilbert, P. (2007) Psychiatry	• What lies deepest within oneself • A framework for meaning and motivation our lives • Connection • Pilgrimage, journey • Sense of the sacred • Belief in transcendence

Literature Source	Attributes of Spiritual Care in the Literature
Ross, L. (1994) Nursing	• Being with the patient • Empathy • Giving of self at a deeper level
Goldberg, B. (1998) Nursing	• Connection through empathy, compassion, giving hope, love/self-giving, appropriate touch, healing
Friedemann, ML. Mouch, J. Racey, T. (2002) Nursing	• Caring relationship • Development of trust and openness • Spiritual self-awareness of provider of care • Exploration of relationships
Pulchalski, C. (2002) Medicine	• Spiritual assessment • Listening
Koenig, H. (2004) Medicine	• Spiritual assessment and history • Referral
McEwan, W. (2004) Nursing	• Relationship building
Narayanasamy, A. (2004) Nursing	• Unconditional love • Building trusting relationships • Providing hope, support, and assistance in assisting another to grow spiritually
van Leeuwen, R. Cusveller, B. (2004) Nursing	• Showing respect for other • Referral as needed to other team members • Active listening • Compassion and authentic use of self • Touch • Spiritual assessment • To support patients' spiritual rituals and habits • Offer hope and comfort • Implement relaxation techniques • Coach others who are in relationship with the patient in the spiritual support of the patient
Gill, S. (2005) Palliative Care	• Not necessarily religious care • Given in a one-to-one relationship
McEwen, M. (2005), Nursing	• Facilitates spiritual health and balance • Promotes a sense of wholeness and well-being

Literature Source	Attributes of Spiritual Care in the Literature
Sawatzky, R. Pesut, B. (2005) Nursing	• Listening presence • Love, being with the patient in love and dialogue • Hope • Compassion • Intuitive • Interpersonal, facilitates connections • Altruistic • Integrative • Therapeutic use of self through engagement and presencing • Defined by the patient's reality
van Loon, A. (2005) Nursing	• How we interact and use ourselves in the everyday nursing care provided in which spiritual care is hidden
DeLaune, S. (2006) Nursing	• Component of holistic care • Ethical duty of nurses • Presence • Establishment of trusting relationship • Improves spiritual support for the client • Active listening • Empathy • Action
Gaskamp, C. Sutter, R. Meraviglia, M. (2006) Nursing	• Active listening • Establishment of a trusting relationship • Being present/presence • Touch • Assists another to feel balanced and connected with a greater power • Facilitates forgiveness and hope
Henderson, M. (2006) Medicine	• Presence • Touch
Pesut, B. (2006) Nursing	• Ethical mandate as part of holistic care of nursing

Literature Source	Attributes of Spiritual Care in the Literature
Puchalski, C. Lunsford, B. Harris, M. Miller, T. (2006) Multidisciplinary (physician, nursing, social work and clergy)	• Listening • Presence • Attention to, consideration • Compassion • Caring • Intuitive listening
Reynolds, D. (2006) Nursing	• Prayer • Meditation • Support, family
Smith, A. (2006) Nursing	• Focus of nursing practice • Caring practice to promote comfort and healing • Give and take between pt and nurse
Tyler, I. Raynor, J. (2006) Nursing and Natural Sciences	• Promotes spiritual health • Promotes individual sense of well-being • Enhances personal spiritual coping strategies

APPENDIX C

RESEARCH LITERATURE

Author/ Source	Study question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Taylor, Highfield, & Amenta 1994 Nursing	Assess oncology nurse clinicians' attitudes and beliefs about spiritual care, how they describe/define spirituality, and demographic factors associated with their attitudes and beliefs	Cross - sectional Descriptive Exploratory	Random sample of 700 Oncology Nursing Society (ONS) members. There were 181 respondents (35%) mostly middle-aged (mean 39.9 yrs., range 23-60), married (70.2%), Caucasian (87.8%) women working in adult inpatient units (97.8%) as staff nurses (68.5%).Ninety percent where Christian, 66% held at least a BSN or above (65.8%). This study included nurses from 40 states except the Northeast	Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS) used. Cronbach's alpha = 0.79 for attitudes subscale. Internal consistency for entire scale = 0.70. Content validity was from a panel of expert nurse researchers, the authors, and members from the ONS SIG Committee. Tool was pilot tested on two nurse clinicians. One hundred and fifty four (85%) answered the two essay questions; content analysis used to identify themes.	(I) Attitudes and beliefs. Relationships Belief in a higher power. Religious services attended. Ethnicity. Education. (D) Spirituality.	Spirituality moderately significant in patients' lives, nursing care. Asian, Latinos, Clinical Specialists held more positive attitudes towards spirituality, strongly agreed relationships important to spiritual health. Content analysis themes: Promoting well-being with holistic care; respecting and supporting patients' beliefs; providing emotional care to the suffering; offering qualities of peace, meaning, purpose; sharing self through presence, sharing personal beliefs, being yourself; transcendent, facilitating relationships; facilitating activities that meet religious needs; verbal interactions through talking and listening.	Valid and reliable tool, weak internal consistency. Sample may be biased toward spiritual care because all oncology nurses, working with adults, self selected. However, 63 returned "pink slips" indicating why they did not/would not fill out survey Minimal discussion of this information. Self-reported scale and tool used. Limited sample: White, Christian, female.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Sellers & Haag 1998 Nursing	To enhance and support the spirituality of clients and family? How do nurses learn about spirituality and spiritual nursing interventions?	Descriptive	North Dakota, Minnesota, Iowa. RNs selected from ONS membership directory; others from lists obtained in the 3 states RNs practiced in parish nursing or hospice. Convenience sample, 224 returned surveys (29.86%). Age ranges, 26-73,with a mean of 48.68 years. Majority female (97.6%), Caucasian (99.52%), from Iowa (51%). Forty-six percent had a BSN or higher. Oncology: 12%; Hospice: 15%;	Panel of nine nurse experts and pilot testing of the tool was done with 19 graduate nursing students. Questions were rephrased for clarity. Nurses were asked to identify, describe and rank in order of frequency specific nursing interventions and then designate how they learned about the particular nursing interventions. Free text area at the end allowed for comments.	NA	Referrals; prayer; active listening; therapeutic communication to validate patient's feelings; conveying acceptance and respect; instilling hope; clarifying patients' spiritual values and experiences with a spiritual history and assessment; presence; touch; community resource referrals. How nurses learned about the interventions included continuing education (65%), clinical experiences (63%), basic nursing education (45%), reviewing the nursing literature & nursing colleagues (39%), and advanced nursing education (38%). 7 major recurring themes emerged from the	Their practice environments affect spiritual care provided. Some findings consistent with other studies: lack of support for spiritual care, lack of education.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			Parish Nursing: 57%.; the rest were in other positions; 53.8% were employed FT.			comments: holistic, spiritual self-awareness of the nurse; lack of support from nurse colleagues; lack of nursing education in spirituality; collaboration among all health care professionals; role of parish nurse in community needed to be recognized.	
Taylor, Highfield, & Amenta 1999 Nursing	Explore possible differences between nurses in different specialties and identify factors that predict nurses spiritual care perspectives and practices.	Secondary analysis Cross-sectional Descriptive	One hundred and eighty- one of 700 surveyed Oncology Nurses Association (ONS) members, sampling was random and stratified by region. Next, 638 respondents from the Hospice Nurses Association (HNA). Both samples were predominantly white, married, female,Christian,	The Spiritual Care Perspectives Survey was developed by the investigators to explore and describe nurses spiritual care practices and attitudes. The survey was based on a literature review of nursing. Content validity was determined by a	NA	Hospice nurses were more comfortable and felt better prepared (training) in providing spiritual care. In addition their attitudes were more positive and they perceived their employers as more supportive. These differences were significant. There was no difference found in referrals between the groups. Pearson r correlations that were significant were ability	Findings indicated hospice nurses were older, more experienced nurses and were more spiritual than religious. This may support the thought that as one ages one becomes more

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			employed full-time and worked with adult patients. ONS members were more educated and younger and reported being more religious as compared to HNA members who were older, not as educated and reported being more spiritual	panel of experts. Pilot testing was done with two staff nurses. Cronbach's alpha was 0.75 for the overall sample.		and frequency (.58), comfort and ability (.63), ability, (.45), perspective and frequency (.50). Personal spirituality was found to best predict perspectives and perceived ability, frequency, and comfort in providing spiritual care.	spiritual vs. religious and more spiritually self- aware. Oncology nurses may deal more with continuing the fight for life or a cure vs. hospice working towards a peaceful death.
Cavendish, Luise, Horne, Bauer, Medefindt, Gallo, Calvino, Kutza 2000 Nursing	Explain the unfolding of opportunities that occur in the lives of adults that promote spirituality. This would hopefully help find	Grounded theory	Purposeful sampling of twelve healthy community residents of 4 men and 8 women, ages 26-64 years old, mean age of 42. Six were married, 3 single and 1 each were separated, widowed and divorced. Nine	Credibility and confirmability were met with nine expert members of the review panel analyzing the interview transcripts. Audibility was met, with the use of exact words of participants to validate themes. An audit trail	NA	Seven themes emerged: connectedness (relationship with self, others, nature, the universe, or higher power); beliefs (framework which life choices are based); inner motivating factors (active process that guides behavior, attitude and one's entire existence); divine providence (benevolent and ever-present guidance from a	Not generalizable. Consistent findings with other research and concepts of spirituality. Life events often trigger for need for spiritual care and development. Nurses are with individuals when many of these

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			were white, 1 Hispanic, 1 Middle Eastern and 1 "other." Seven were Catholic, 2 Jewish, 1 Muslim, 1 Theosophist and 1 Protestant. All had HS diplomas, 8 had bachelor degrees or above, 1 with a Doctorate. Sampling continued until saturation.	was well established.		higher power); understanding the mystery (understand meaning and purpose of life); walking through (transcending life events); and life events (unique to each individual, incidents or occurrences that provokes a spiritual response, meaningful triggers for a spiritual journey).	life events occur: death, illness, suffering, births, etc. These moments evoke a spiritual response and provide opportunities to find meaning and purpose or to transcend beyond self-boundaries. The study added new knowledge to the development of NANDA nursing diagnosis and nursing language.
Highfield, Taylor & Amenta 2000 Nursing	To describe how oncology and hospice nurses learn spiritual caregiving, was this preparation adequate, do experiences with patients	Cross-sectional Descriptive Secondary analysis from 2 studies: 1993 and 1994.	One-hundred and eighty one oncology and 645 hospice nurses randomly picked from their respective professional organizations (ONS and	Spiritual Care Perspectives Scales (SCPS) which included six items. These questions were not amenable to clustering for statistical analysis of	NA	Many had education from several sources: 57% through academics, continuing ed (51%), & through reading (67%). Thirteen percent more hospice than oncology nurses received more spirituality content in the basic nursing education	Findings were consistent with other identified barriers to providing spiritual care in the literature, i.e., lack of education. Hospice nurses

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	influence nurse spirituality, and is there a relationship between the latter and spiritual caregiving.		HNA). Participants were primarily Christian, Caucasian, female, married, middle age (mean 44.8) staff nurses with BSN degrees or	reliability and validity. Content validity was established with review by 2 researchers and 4 doctorally prepared nurse experts in spiritual care.		program.; 24% of oncology RNs reported no training, felt unprepared for spiritual caregiving (52%). Ninety six percent indicated patients had influenced their spirituality; 66% indicated this influence was substantial. Content analysis revealed the following themes regarding patient influence on nurses' spirituality: inspired nurses to recover their own spiritual past, discover new beliefs, rediscover present spiritual beliefs, and uncover patient needs.	were older, not as well prepared academically and were nurses longer. Hospice environments were different than oncology in acute care settings and philosophy may also be different: cure vs. palliative care and peaceful death. This may influence the ability and support of nurses to provide spiritual care.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Carroll 2001 Palliative Care	What does spirituality mean to hospice nurses in the context of their own personal, social, cultural and religious beliefs, and in their role as providers of spiritual care for cancer patients?	Phenomenol -ogical heuristic	Purposeful sampling of 15 hospice nurses in the UK. Nine had worked in hospice for over 5 years, 14 were female, 12 believed in God or a Universal force, three were either atheist or agnostic. All were over the age of 30.	No empirical instrument used. A journal was kept to delineate the decision trail. Immersion in the data by the author was done at appropriate intervals. Review of the literature occurred at the end of analysis to validate the findings of the essences.	NA	Spirituality and the soul held different meanings to several nurses (inner self or essence; life after death; relationship to God/higher being; consciousness).Six themes or essences emerged and included the following items in relationship to spiritual care: • Interconnectedness: to self, God, others and the Universe; being in the world. • Recognizing and assessing spiritual needs of others and	Consistent with other research findings regarding hospice as a more supportive environment for spirituality and spiritual care. Contains attributes of spiritual care and spirituality within the essences as found in other literature. It was difficult to ascertain how individual contexts influenced the meaning of spirituality to the nurses, as there was no discussion on this matter. How nurses became spiritually aware was also not discussed within the body, however, the need to be spiritually aware was discussed at the end of the article. The findings did confirm that the nurses were working

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						self. • Use of empathy and a trusting relationship. • Spiritual care as a multifaceted phenomenon, requires seeking out others to assist the patient and self. • Recognizing when to let the patient be (use of presence). • Fostering the search for meaning.	within a spiritual context, even though the context was not specifically identified or discussed.
Cooper, Brown, Vu, Ford & Powel 2001 Psychiatry	Compare views of African-American and white adults regarding what was important in	Cross-sectional Descriptive (subset of a larger study)	Participants were recruited/volun-teered from an urban university-based primary care clinic. To participate, they completed the 20	One hundred and twenty six items on the instruments were the result of domains obtained from content	NA	Seven domains were identified as important in depression care: health care providers' interpersonal skills (10 items); primary care provider recognition of depression (2 items);	Authors did not discuss study design, patient recruitment strategy, questionnaire development, and reliability and validity testing of the items and domains, stating this

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	depression care.		item CES-D (Center for Epidemiologic Studies Depression Scale) to measure depression level, and be African-American or white. A score of 11 or greater on inclusion criteria. In addition, a clinician administered diagnostic evaluation for DSM III-R was also administered to participants. Recruitment strategies were identical for whites and African–Americans with a total of 76 recruited.	analysis of focus groups of health professionals and depressed patients. Reliability/validity of the instrument was not discussed in this paper but referred to another paper by the same authors for information on this topic. Reliability and discriminant validity testing were used for the top 30 items. A Likert scale was used as part of the questionnaire. Cronbach's alpha on the 9 final domains ranged from 0.81 to 0.92.		(treatment effectiveness 6 items); treatment problems (3 items); patient education and understanding about treatment (2 items); intrinsic spirituality (4 items); and financial access (3 items). Confirmatory factor analysis was undertaken by ethnicity, with life experience and social support then being added. African Americans had higher ratings on all items related to spirituality and were 3-4 times likely to rank spirituality as important in depression care as whites. All other aspects of care were similar between the two groups except for this factor. Mean score for the CES-D scale	were described elsewhere. Limitations were a small sample, non random sample, relative heterogeneity of depression diagnosis. Identified a gap in the literature and added knowledge to area of mental health and spirituality. Spirituality not defined in the article, or the relationship of religion as a possible confounder. The sample included higher socioeconomic status fo both groups. In looking at intrinsic spirituality for both groups, it was by far more important in the care of depression to African-Americans

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			Average age was 34.8 years, with 72% female, 36% African American, 29% married and 32% college graduates with 49% employed full time.			was 22.2.	(AA) vs. whites. Faith in God & a social support network was more important to AA.
Greasley, Chiu, & Gartland 2001 Nursing	Clarify the concept of spirituality, spirituality and health, and the provision of spiritual care within the context of mental health nursing.	Qualitative Focus groups	Nine different focus groups comprised of 4-6 individuals. These groups included inpatients and outpatients as well as specialists in mental health, medicine, and nursing.	Trustworthiness was addressed. No other means of validity and reliability within qualitative research was addressed.	NA	Defining spirituality included ideas of God, religion, metaphysical beliefs as well as meaning and purpose of life, personal well-being, inner peace, hope, and "interpersonal values" in particular love, caring and compassion in the provision of spiritual care. Spirituality and religiosity were seen as distinct and unique concepts. Addressing spiritual needs by nurses and	Addressed both provider of care and those who received care. Patients and providers perceptions of spirituality and spiritual compared. Themes found in were identified in other literature: relationships, meaning, purpose, metaphysical events, providing spiritual care through compassion, love, caring behaviors. Good

Author/Source	Study Question & Purpose	Design	Sample Characteristics Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						professionals requires a trusting relationship. A need for further education and training on spiritual issues was identified.	
Maddox 2001 Nursing	Describing the process of finding a tool to use by nurse practitioner students to assess the spiritual domain of patients they are caring for within a practice setting.	Exploratory Literature review	Eighteen students enrolled in their first clinical course in a nurse practitioner curriculum. They assessed older adults using a tool identified by the course instructor through a literature review. Prior to use of this tool, spiritual assessments shared in case study presentations revealed "yes it was done" but nothing further.	NA	NA	Leetun's protocol was discovered which was specifically designed from a wellness and holistic perspective for use in assessing an older adult population. Students needed education on use of the tool and how to do a spiritual assessment which improved their clinical insights in sharing of case studies regarding spirituality and spiritual care.	tool, limitations: length and time restrictions. Would not be able to complete in one visit; needs to be an ongoing evaluation. Tool includes: self-actualization activities, connectedness activities, healing and new life activities, religious or humanistic activities. No discussion on how added instruction on spirituality, care and spiritual assessment might have affected use of the tool and student spiritual assessments.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Stranahan 2001 Nursing	Examine the relationship between perceptions and attitudes about spiritual care, and spiritual care interventions utilized by nurse practitioners in primary care.	Nonexperi-mential Correlation Descriptive	One hundred and two out of 269 nurse practitioners in primary care returned the questionnaires (40% rate). The mean age of respondents was 50 years old and mean number of years as a nurse practitioner was 7.8 years. Ninety-five percent were female and 85% had been educated as nurse practitioners at the MSN or post master's certificate level. Twenty-two percent had received no training or education in spiritual care,	Reed's Spiritual Perspective Scale was used, and the Cronbach's alpha and construct validity were discussed in relationship to other studies but was not undertaken for this study. Cronbach's alpha was .90 consistently in past research. A second tool called the Nurses Spiritual Care Perspective Scale (NSCPS) was modified from Taylor, Highfield and Amenta's (1994) tool, the Oncology Nurse Spiritual Perspectives Scale (ONSPS).	NA	Fifty-eight percent felt their education in spiritual care was inadequate, 39% felt it was somewhat adequate, and 4% felt it was excellent. Self-identified perceptions of spirituality indicated 74% were very spiritual, 59% rated themselves as very religious. Pearson-*r* found no significant relationship between the SPS tool and participants self-reported spirituality. There was significant correlation between the SPS and how religious they perceived themselves (.433, $p = <.001$). How religious they were and how often they attended religious services was significant (.649, ($p =. 001$). Attitudes toward providing spiritual care were slightly increased. However, 57% indicated	It is apparent that religion and spiritual were used interchangeably by the respondents in this study and the author acknowledges this as a limitation. Without reliability and validity testing on the sample and the adapted tool, there is now way to identify whether spirituality or religiosity was being measured in this study. The number of those who felt their education was inadequate in spiritual caregiving (57%) corresponded to

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent and Dependent	Major Findings	Evaluative Comments
			17% had spiritual care integrated into their BSN courses, and 30% had it integrated into their graduate work. Nine percent had received continuing ed. in spiritual care, and 77% received some ededucation.	No reliability and validity testing discussed regarding the present study's sample although this writer indicates at least alpha = 0.70 reliability and content validity demonstrated in past studies. The new tool had no reliability or validity studies done with the present sample. This was stated in the article.		they rarely or never provided spiritual care, 45% indicated their ability to provide this care was weak or limited,33% were uncomfortable providing spiritual care. Interventions used the most were encouraging patients to pray, bringing religious or spiritual readings to patients' attention, praying privately with a patient. Each of these interventions was provided at least some of the time at 42% or higher. Fifty seven percent rarely or never provided spiritual care.	the number who rarely or never provided spiritual care.
Vance 2001 Nursing	Survey assessment to describe acute care nurses' spirituality and the spiritual care they provide.	Descriptive Correlation	Proportionate, stratified, random sample of RN's (n=425) who provided direct patient care in critical care, medical-surgical, women's health	Two standardized instruments were used: Spiritual Well-Being Scale (SWBS) by Paloutzian & Ellison and the Spiritual	NA	Findings revealed a positive relationship between the nurses' spirituality and the spiritual care delivered that was significant. Only 34.6% a provided spiritual care when interventions were	Survey was self reported. The sample primarily focused on adult care, but was very diverse with regard to the clinical setting. which helped to

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			and behavior health in a community hospital in a large Midwestern city. Response rate was 40.7% (n=173).	Involvement &Beliefs Scale (SIBS) by Hatch, Burg, Naberhaus & Hellmich. SIBS assesses spiritual beliefs and actions free of traditional religious and cultural bias. Test-retest reliability for the SWBS was *r* = .93, SIBS *r* =.92. Cronbachs' alpha for the SIBS was .88 and the SWBS was .90. The Spiritual Care Practice Questionnaire (SCP) content validity was by a panel of experts; test-retest reliability of.80. Staff nurses reviewed.		evaluated. Perceived barriers to spiritual care included time, lack of education and the belief that individual spirituality is private and should not be addressed by the nurse. However those scoring higher in the nursing process also perceived fewer barriers to providing spiritual care. Women's health scored significantly lower than any of the other areas in spiritual care delivery. Critical care and Medical-Surgical nurses scored similarly and Behavioral Health scored the highest.	increase potential generalizability of the findings. Lack of time and education have been identified in other nursing literature and medicine as being the two biggest barriers to providing spiritual care. This study was consistent with these other findings.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Van Dover & Bacon 2001 Nursing	To describe how nurses meet the patient-identified spiritual needs in everyday practice	Grounded Theory Qualitative	Purposeful sampling of 20 nurses in a variety of settings who worked with adults of all ages in medical-surgical, labor and delivery, community health, oncology, ICU and parish nursing	NA	NA	The questions focused on the nurse and the provision of spiritual care as death as well as the nurse's interpretation of the outcomes of care. Key elements in the process of providing spiritual care were the nurses' readiness and preparation to provide care, recognition of spiritual concerns of patients, experience in spiritual interventions and ability to move the dialogue with the patient and family into a dialogue with God. Prayer with the patient was the most frequently used intervention. "Coaching" patients in seeking spiritual well-being was also another key element of the nurse's role. The nurse is present during crisis for patients and families, with crisis identified as illness or suffering or death.	Interviewers were Christian faculty and graduate students interviewing Christian patients. This could be a limitation. This research was about the nurses' perspective with no patient input as to what was the identified spiritual need. This article was biased toward Christianity. The primary and almost only intervention identified was connected to prayer or praying out loud with the patient and family or referral to biblical passages.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Chao, Chen, Yen 2002 Nursing Palliative Care (Taiwan)	The purpose of the study was to investigate the essence of spirituality in terminally ill patients involved in hospice care in Taiwan in order to develop some culturally relevant care models in the context of hospice palliative care. Theory generating.	Hermeneutic Phenomeno-logical	Purposeful sampling of 6 patients in hospice care in Taiwan aged 20-83 years old. Four were female, 3 married, 2 single, 1 widowed, two were college students, and 4 had high school diplomas. Four were Buddhists, 1 Protestant and 1 was Catholic.	Credibility was increased through peer debriefings and member checks (sharing transcripts and essesences identified with participants). Fittingness (context applicable to other situations), auditability (decision trail) and confirmability (understanding of researchers' preconceived ideas, biases, etc) were discussed as part of the research process in the article.	NA	The essences of spirituality of the terminally ill consisted of 4 patterns and 10 themes: Communion with self - self identity, authentic self - wholeness - inner peace Communion with others - love - reconciliation Communion with nature - inspiration from nature - creativity Communion with a higher being: - transcendence - faithfulness - hope - gratitude	Connection is the major them that weaves its way throughout the findings. The study was well constructed and undertaken and provided a more pluralistic meaning of spirituality.
McWright 2002 Palliative Care	This study was conducted to discover the objective	Phenomeno-logical (Husserlian tradition)	Purposeful sampling for the first two participants	Semi-structured interviews with validity and credibility	NA	One hundred and forty thousand words of text were generated. Essences that emerged	This article included a pluralistic world view

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	essence of spiritual care from the perspective of an objective observer.		with snowball sampling after this, and eventually 16 experienced spiritual caregivers became participants. Religious backgrounds varied: Jewish, Christian, Hindu, Muslim, Buddhist and those who were self-identified as spiritual but not religiously affiliated. Roles included CEOs, managers, nurses, medical directors, therapists, artists, volunteers and chaplains.	undertaken with participant review of the data analysis. Nothing else was discussed regarding this issue as it pertained to qualitative research.		regarding spiritual care included spirituality (person, relationships, search for meaning, transcendence, religion); prompts (personal experience, role models, spiritual awareness, vocation, illness, organized religious decline); spiritual care (personal, focus, culture, individual affirmation, relationship, being there, respect); difficulties (definition, service, provisions, delivery, personal challenges, lack of confidence among health professionals); and hopes (improvement, assessment, research, resources, training, chaplaincy accessibility).	regarding spirituality. Very little application to practice however, but the purpose was to describe the meaning of spirituality to the participants.
O'Connor, Meakes,	The purpose of this study was to evaluate the	Descriptive Explorative	Databases included Medline (1966-	NA	NA	After deleting duplicates, 2306 citations comparing five criteria were	Somewhat insightful article about the number

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
McCarroll-Butler, Davis, Jadad 2002 Pastoral Care	present state of the art of spiritual care research in pastoral care.		(1999), CINAHL 1982 – 1999) a and HEALTHStar (1975-1999).			discovered in four pastoral counseling journals. The five criteria determined whether the findings belonged to one of five research methods: quantitative (randomized control trials, clinical trials, cohort studies, large surveys, and studies with statistics to present their finding); qualitative (ethnographic, grounded theory, phenomenology, feminist study, focus groups, case studies, all involving interviews and thematic analysis of data); combination of the two which includes all of the above or triangulation; theoretical (systematic, narrative and comprehensive), editorials and articles and books, models of spiritual based on ideas and studies in the literature; and uncertain (did not include an abstract which made categorization a problem).	of writings present in the literature in pastoral care.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						As time increased, so did the amount of citations in each category. The review familiarized the reader with research, and encouraged implementing the findings appropriately into chaplaincy practice with evaluation. This would require more cooperation with other disciplines that have produced most of the evidenced based research. No literature for combined, theoretical, or uncertain research in the four pastoral counseling journals was found, only quantitative and qualitative research. The recommendation was that spiritual care has been based on faith traditions in the past and now evidenced based research is another way to approach spiritual care.	
Walton 2002 Nursing	The purpose of this study was to discover the	Grounded Theory (Glaserian	Participants were volunteers from a rural outpatient	Accuracy and truthfulness were validated by	NA	Findings included spirituality as a life giving force that includes awe,	Insightful, well done. Elicited significant

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	meaning of spirituality to patients on hemodialysis and how this spirituality affects their lives.	method)	based hemodialysis unit affiliated with a hospital in the northwest US. There were 4 men and 7 women ranging in age from 36-78. Ten patients were Caucasian and one was American Indian, with time on dialysis varying from 6 months to 24 years with an average of 7 years. The majority were of Judeo-Christian background although 3 reported no religious affiliation. Three were married. Saturation occurred with the ninth participant.	participants when they were given a copy of the summary and descriptions to critique. Changes were made based on their input. In addition, validation by 10 dialysis nurses and 1 social worker was also undertaken as a focus group.		solitude, and wonder. It encourages one to find balance in life (process) and is nurtured by connections with others, God and the environment. Spirituality is much broader than religion and involves much introspection and reflection. The challenge of everyday life on dialysis makes finding a balance more important and occurred in 4 phases: confronting mortality, reframing, adjusting to dialysis and facing the challenge. Presence of others, nature, environment and God were in all phases. Categories of spirituality included faith, presence of God and others (being with), receiving (life from the dialysis) and giving back (born of the process of introspection/reflection).	descriptors from participants and generated a conceptual model using scales as finding the balance with the other descriptors as part of the balance of the scales. Mid-range theory was elaborate and generated from finding the balance.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Graham, Brush, Andres 2003 Nursing	What is the process and content of spiritual caregiving by a minister to a sample of homeless male addicts in recovery? How can advanced practice nurses (APNs) incorporate this counseling into their practice?	Content analysis, inductive	Eighteen homeless men at a facility for recovering substance abusers who received primary care from faculty and students in a family nurse practitioner program in the Northeast and spiritual care from an ordained minister. All attended on site AA meetings. Sample was convenience and volunteers. Many were lost to treatment after 6 months, consistent with the facility's low retention rate of 25 %. Reed's Spiritual Perspective Scale was used	No reliability and validity studies were discussed regarding the use of Reed's tool, the Spiritual Perspective Scale. Content analysis did not require validation and reliability	NA	Key themes that emerged included: inadequate or abusive parenting; substance abuse at an early age, often with the blessing of parents; anger at God; feelings of shame, guilt, depression and despair; gratitude for current opportunities; desire or need for forgiveness. The minister identified helpful interventions for APNs in providing spiritual care and promoting individual dignity and personal identity: nonjudgmental nature; building a trusting relationship; being real; "being there"; and connecting.	Time is a key element in the provision of spiritual care and adequate time was available in this situation. The authors indicated this fact in their discussion. This would back up the relationship building and connecting part of the study and other studies that is needed to adequately address spiritual concern for advanced practice nurses. Spiritual/ religious leaders attend to issues of meaning as they relate to various contexts: religion, situational etc.,

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			during the intake history and physical. This tool's reliability and validity was not discussed in the article. If spiritual distress was identified, the participant was referred to the minister. The content analysis is taken from the minister's notes on minister-client interactions based on a 2 year period. Sessions with each individual varied from a one time contact to 42 contacts with the median number of contacts at 4. Seven men left the program and were lost to follow up.				for the individual. They may also be privy to information from clients that are not typically shared with health care practitioners unless prompted.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
MacLean, C., Susi, B., Phifer, N., Schultz, L., Bynum, D., Franco, M., . . .Cykert, S. (2003) Medicine	Would patients change the focus of the encounter with the physician, addressing religion and spiritually in the medical encounter instead of health concerns?	Correlate	Health centers primary care clinics in 3 states, which included inner city, suburban and VA settings, were systematically selected using a predetermined scheme and patients were approached in the waiting rooms to participate. Patients had to agree to trade time spent on medical issues for time spent on spiritual or religious issues. Five hundred and forty-two patients were approached with 456 (84%) disagreeing to participate.	SWB tool by Paloutzian and Ellison was used, which measured religious as well as existential well-being as it relates to the spiritual. No reliability and validity information was discussed as it related to this tool in previous or other literature. There was not reliability or validity testing done with this sample. Tools used to measure functional status included the Physical Component Summary and Mental	(I) marital status, race, education SWB score, and medical utilization. (D) outcome variable: patient willingness to forgo time spent on medical problems for spiritual/reli-gious time with physician.	The question was would patients trade time to discuss medical issues for time to discuss spiritual issues with the physician; 12% were neutral and 78% opposed. Those who felt it was more important for spiritual time were lower socioeconomic status (education and income), attended worship/religious services more frequently, and were African Americans. When all possible variables were controlled using logistic regression model, African-American race was the only characteristic that remained significantly associated with trading time for spiritual/religious concerns. Sixty percent of the participants felt physicians should be aware of their religious and spiritual beliefs while 66% would	This was a vulnerable population and nothing was discussed regarding what was done ethically to protect them except informed consent and Human Subjects Committees approval of participating institutions. The situation/ environment (waiting rooms), in which they were approached, especially if by the dominant race and physicians could be seen as threatening and is a power imbalance. No discussion of this

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			Those who declined indicated time limits and feeling too ill as reasons for non-participation. Half of the subjects were African American; half had incomes below $20,000 annual per household, and all were deemed lower functional status in comparison to the general US population. Majority of participants were Christians. Sixty five percent either had no insurance or were on Medicare/Medicaid; 56% had a high school	Component Summary for the SF-36. No reliability and validity testing was done with this sample and these two tools.		not welcome physician inquiry into their spiritual beliefs in an office or hospital setting unless near death.	was found in the article. Not culturally sensitive research. Choosing patient participants could skew data (every third patient was chosen). Authors also mixed spirituality and religiosity, did not define either and combined both into one meaning/ definition. There was no validity and reliability testing

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			education or less. Twenty two percent did not participate in organized worship service in the past year and 61% participated less than once a week.				
Springer, Weaver, Linderblatt, Naditch, Newman, Siritsky, Flannelly & VandeCreek 2003 Pastoral Care	What is the association between depression, loneliness and spiritual beliefs and practices related to other factors such as age, gender and education?	Correla-tion Descrip-tive	Random volunteer sample of 118 Jewish men (19) and women (99) living in New York and clients of one of three Jewish social service agencies were recruited. Mean age was 81.5 (range 65-98 yrs old), years of formal education mean 13.8, years of religious education 5.9. Thirty eight	Demographic data was collected along with the request to respond to question on the Brief Depression Scale version 3 of the UCLA Loneliness Scale and the Index of Core Spiritual. Experience (INSPIRIT). Cronbach's alpha for the depression scale was .76, the UCLA loneliness	(D) Depression loneliness, and spiritual beliefs and practices. (I) Age, gender, years of formal education, years of religious education, physical impairment, ability to venture out, good family relationship, victim of Nazi	A positive correlation was found between depression and loneliness (r = .56) which was significant. Spirituality did not correlate with either of these scores. Depression and loneliness were inversely related to ability to venture out and relationship with families. A sense of purpose was also inversely related to depression and loneliness. Again spirituality did not correlate with any	It was hard to discern whether religiosity or spirituality was being discussed or what either meant to the participants or if they were one in the same. There was no discussion of this by the authors, 5 of which were Rabbis. Little evidence in the that showed spirituality affected anything.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			percent were Conservative religious Jews, 15.3 % were Orthodox, 16.1% were Reform, and 30.6% were other. With regard to marital status, 23.7 %were married, 8.5% divorced, 56.8 % widowed and 11% never married.	scale .87 and the INSPIRIT was .86	persecutions feeling a sense of meaning and purpose in life.	of the independent variables. The authors indicated that other findings in the literature supported the findings in this study, with 38% of the participants being significantly depressed compared to 40% of Jewish elderly nationally. In addition, the authors identified that many of the questions on the INSPIRIT tool were foreign to the participants and recommended the development that more fully captured Jewish spirituality. On a scale of 5, the Orthodox movement was the least depressed at 2.7; the least lonely at 43.9% and tied for being the more spiritual at 2.4.	
Taylor 2003 Nursing	The purpose of the study was to describe what patients with	Describe Cross-sectional	Twenty eight adult Euro-American and African-	The tool included in depth questions regarding	Research variables included spiritual	Content analysis using Miles and Huberman's approach to analysis and data reduction or	Judeo-Christian Predominant views. This was the early part of

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	caregivers wan cancer and their primary family ted from nurses regarding spiritual care.	Qualitativ e using Miles and Huberman 's approach to data reduction.	American patients with cancer who were outpatients or inpatients in a county hospital and a comprehensive cancer center were purposively selected to participate in the study along with their primary family caregivers. Researcher was careful to also select those with a wide variety of religious and philosophical backgrounds. Twenty one were patients and seven were family caregivers. All seven caregivers were women and ten patients were	religiosity, illness distress, and expected outcomes of treatment as well as open ended questions about spiritual needs and how nurses could help meet the spiritual concerns. of the patient or the family caregiver. No reliability or validity data was available on the tool.	needs and spiritual care	concentration was used which included constant comparison between interviews and placing the themes and categories within a matrix. Distress from the illness on a scale of 1-5 averaged 3.3. Six categories for nursing approaches to address patient and caregivers' spiritual needs included: kindness and respect; talking and listening; prayer; connecting; quality temporal nursing care; and mobilizing religious or spiritual resources. Requisites of nurses to provide spiritual care as identified by patients and	a larger study.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			men. Six patients and one caregiver were African-American; all but three of the informants had at least a college degree. Five were Jewish, 6 Roman Catholics, 14 Protestants, 1 the Church of Jesus Christ of Latter Day Saints, 2 were nonreligious individuals. Nine stated they attended religious service weekly or more and 13 reported rarely going. Time from diagnosis of cancer for all ranged from less than 1 year to 12 years.			caregivers included: personal spiritual self awareness; relational requisites including caring, rapport and connection, showing respect; professional role of the nurse to include education and training in providing spiritual care, and one identified nurse on the unit that deals only with spiritual care needs and has the time. The emphasis was on being vs. doing or the combination of the two, but the being aspect was the most important.	

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Conner & Eller 2004 Nursing	The purpose of this study was to examine the spiritual perspectives, spiritual needs and desired nursing interventions of Christian African Americans during hospitalization.	Descrip-tive Correla-tion	A convenience sample of forty-four African Americans from three churches (n=44) were recruited ranging in age from 19-84 (mean of 56) with 86% female, 98% Baptists and 13.5 years average of education. Self ratings of health included 11.4% had excellent health and no disease, 40.9% had good health and one medical diagnosis, and 20.5% had fair to poor health with more than one medical diagnosis.	Reed's Spiritual Perspective Scale was used to measure the relevance of respondents' views on spirituality in their lives. Cronbach's alpha for the total score was 0.81, for spiritual values subscale was 0.84 and for the spiritual interactions was 0.60. Open-ended questions were also used. Inter-rater agreement was 91% initially.	(I) Health (D) Spiritual perspective and spiritual values	Sixty-six percent chose strongly agree about needing spiritual care when hospitalized. There was no significant difference between spiritual perspective and health status or spiritual values and health status. However, significant differences were noted by age for spiritual perspectives and spiritual values. Spiritual values increased as health status worsened ($p = 0.001$). Most common themes included connectedness to God (50%), others (36%) and self (15%). Spiritual interventions desired included: participate in spiritual activities, demonstrate caring qualities, provide comfort measures and reassurance, recognize the spiritual caregiver role and incorporate diversity in care.	Limitations mentioned by the authors included a trust issue since the researchers were white. They cited the Tuskegee Syphilis Study as possible barrier. Other additional limitations included recruitment at their site of worship where concern for anonymity and confidentiality might have been a concern for participants. In addition, only those who attended church were recruited and not the homebound. Finally, there was little religious

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Daaleman & Frey 2004 Medicine	To develop a tool and test the validity and reliability of the tool, the Spirituality Index of Well-Being (SIWB). The authors intended to add health related quality of life research with the tool	Descrip-tive	Adult patients in the greater Kansas City area who visited any of 10 family practice office. Systematic sampling was used to recruit patients, with every fourth selected. Total of 55 were enrolled from all 10 offices. A total of 509 participated with the mean age of 46.8, predominantly white, female, with one half married. Most had at least a high school education, had private health insurance and had an established relationship with	Tools that were used included a pilot tested SIWB in a geriatric outpatient population, the Spiritual Well-being Scale, the General Well-Being Scale, and the Zung Depression Scale to measure mental health status. Minimal discussion of the SIWB reliability and validity was discussed initially very briefly with the only statement found relating to this was the tool had been found to have good reliability and validity in the pilot group.	NA	Reliability was calculated by internal consistency and test- retest. Convergent and divergent validity was determined with a relationship web of correlations examining the similar and dissimilar constructs of the SWBS, GWBS, and the Zung Depression Scale. The 12 item SIWB had a 0.91 coefficient. The 6 item self efficacy had an alpha of .86 and for life scheme a .89. Test-retest was .079, .077 and 0.86 respectively. Confirmatory factor analysis was done and 56% of the total variance was accounted for by this 2 factor model. The SIWB had significant inverse correlations with the Zung Depression Scale (-0.42) and the GWBS (0.62) as well as SWBS. The existential pieces of the SWBS and the SIWB had the highest	diversity in the sample. These factors limit the generalizability of the findings. This instrument is neither disease nor health behavior specific as are many psychological tools. This tool appears to be more specific to spirituality, with the higher the spirituality score the less the depression score. In addition the SIWB with its emphasis on existential well-being focuses on the meaning and purpose aspects of spirituality as indicated in the literature. This appears to be a

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			their physician's office for 7 years or less			correlation (0.75) and a mild correlation with the religious subscale (0.35) of the SWBS.	good tool for use in measuring spirituality with limited bias of religiosity; however, more research using the tool is needed.
Daaleman, Perera, Studenski 2004 Medicine	What is the interaction of religion and spirituality on the health status of community dwelling elders?	Secondary analysis Cross-sectional Correlation	Older community dwelling adults 65 yrs and older (mean age 73.7 yrs) from primary care sites of the Veteran's Affairs (VA) network (n = 142) and a Medicare HMO (n=350) in the Kansas City metropolitan area were screened and recruited. Screening consisted of a home assessment	(Tools used to assess eligibility for participation with no validity or reliability data included: EuroQol (measure of health status & quality of life); Physical Functioning Index (PFI) of the Medical Outcomes Study SF-36 (measures functional status); Geriatric Depression Scale (GDS); Mini-Mental Status Exam (MMSE)	(D) Self-reported health status (I) Age, PFI, EuroQol,SIWB, education, gender, race, GDS	Spirituality but not religiosity was positively correlated with reports of good health status. Other variables that also had high and significant correlations with positive perceived health status included age, male gender, white race, technical or college educated, not depressed, and physical functioning.	Self reported health status from participants could be over or under reported. SIWB is a newer tool and needs continued reliability and validity studies however is so far proving to be a highly reliable and valid tool that addresses spirituality with

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			of multiple health status and functional indicators. Two-hundred and seventy-seven patients participated. Fifty- two percent were male, 78% white, and 85% had at least a high school degree or above.	(measures affective and cognitive features). The Spirituality Index of Well-being (SIWB) was used to assess spirituality. This tool's theoretical base can be found in self-efficacy theory, where meaningful life direction and high positive intentionality or self-efficacy beliefs will promote personal agency to act as a conduit between spirituality and perceived wellbeing. Reliability score for internal consistency of			

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
				this tool is 0.87, factor analysis with a total Eigen value of 43.61% of total variance. Concurrent construct and discriminant validity have been demonstrated this tool.			
El-Nimr, Green, Salib 2004 Psychiatry/ General Medical Practice/ Psychiatric Nursing (UK)	Explore whether mental health professionals perceive spiritual care as important and advocate for involvement of clergy. In addition to examine whether the professionals' personal and cultural background affects views on spiritual care.	Explore	Sixty general practitioners (57%), 8 psychiatrists (62%) and 30 psychiatric nurses (100%) responded for a total of 98 responses. Forty-four percent were 40-50 yrs old, 28% 30-40 yrs old and 4% were 20-30 yrs old. Eighty-three percent were born in the UK.	Questionnaires which included basic demographics and questions which included responses using a Likert scale of 1-5. Questions included attitude about spirituality; do mental health patients have different spiritual needs from others; when do health	NA	Forty five percent of the GPs felt strongly that human beings are made of body, spirit; 33% of the psychiatrist believed this. Nursing had 76% who felt strongly that humans were body and spirit. Nurses also felt spiritual care was more important (52%) than GPs (29%) did and psychiatrists (33%). GPs and psychiatrist felt spiritual needs were different in people with mental health issues (13%) but only 4% of nurses did. Psychiatrists	This supports the holistic approach that nurses take in providing care. However it is interesting to see psychiatrists, who had the least amount of training, experience, or interest in spirituality and spiritual care believe they should be the ones to evaluate and provide this

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			Participants were recruited via mailing of the survey in interdepartmental mail at a mental health hospital.	professionals see themselves providing spiritual care and do they advocate for clergy involvement; is spiritual care important; have they had previous training in spiritual care or would they like more training/.No validity and reliability data was discussed or available.		(25%) believed they should assess and provide spiritual care to patients. 50% of the participants felt mental health professionals were not the best ones to assess and provide spiritual care. 20% of nurses but only 8% of psychiatrists and 2% of the GPs had received spiritual care training. This correlated with those who were best able to and desired to provide spiritual care (nurses).	care even though it was not believed to be appropriate by most of the participants.
McSherry, Cash, & Ross 2004 Nursing (UK)	The aim of this study was to gain a deeper understanding of the concept of spirituality by patients, nurses and people from the major world religions.	Grounded Theory (Glaser & Strauss)	This study was part of phase I of a larger study and involved 22 participants. The participants were identified through a questionnaire indicating their willingness to be involved, with	NA	NA	Two categories emerged: definitions of spiritual & diverse perceptions of spirituality. All 12 nurses had similar definitions of spirituality which the authors identified as having characteristics of Murray & Zentner's definition. Patients were unclear of spirituality's definition, equating it	Review of the literature was undertaken prior to data collection and analysis. No discussion about data collection until saturation, and no reliability and validity discussions in terms of the

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			open sampling used (choose one of four statements that best described their understanding of spirituality). Twelve nurses (9 females), 5 patients (2 males) and 5 from four of the major religions on the Chaplaincy teams (4 males) were identified from a hospice unit and 2 acute care units. Seven were members of the Church of England, 2 were Muslims, and one each were Buddhist, Sikh, Hindu, Quaker, Baha'i, Roman Catholic, Methodist, &			with religion. There were discrepancies between the nurse and patients perspective. Spirituality coming into focus with illness as portrayed by Murray and Zentner's definition was not reflected in patients' definition. Postgraduate education in the UK expanded understanding of spirituality beyond religion for nurses.	qualitative method was discussed.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			Pagan. Five had no religious affiliation.				
Narayanasamy 2004 Nursing	What is the lived experience of spiritual coping mechanisms of chronically ill patients?	Phenomen ology	Purposeful sampling of 15 chronically ill patients of 10 men and 5 women, 23-80 years old, 9 Christians, 2 Hindus and 4 no affiliation. Chronic diseases included cancers, ulcerative colitis, melia fibrosis and chronic liver disease.	NA	NA	The themes that emerged included: reaching out to God with faith, belief; feeling connected to God through prayer; meaning and purpose; strategy of privacy; and connectedness to others. Concealing religious practices may be necessary to avoid being ridiculed about them when overt support related to their spiritual needs is not provided. Chronic illness tends to push one into a search for meaning and purpose, possibly related to this illness.	Findings are consistent with other literature. Christian group which may skew data and responses. Finally, the connection piece emerges that is a common thread throughout most of the research on spirituality.
Narayanasamy, Clissett, Parumal, Thompson, Annasamy, & Edge. 2004 Nursing (UK)	This study sought to explore and describe nurses' perceptions of their roles in	Qualit-ative. Critical Incident. Cross-sectional	A convenience sample of 52 RNs working with older adults attending a continuing	The questionnaire used involved a critical incident with the following areas:	NA	How nurses' became aware of patients' spiritual needs: patients' religious background, spiritual/religious	Similar to case study with little discussion on the methodology except that

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent and Dependent	Major Findings	Evaluative Comments
	providing spiritual care to older adults and what that spiritual care would be based on a critical incident.		education program. Length of experience range from 1 to 30 years in nursing. Twenty-five had diploma level or the equivalent of the first 2 years of a 3-year bachelor's degree. Others had certificate level qualifications (or equal to first year bachelor's degree). These were volunteers who completed a critical incident questionnaire in private and returned them to the research team by the end of the program.	a nursing situation describing when and how participants recognized clients and spiritual needs; how and why specific spiritual needs could be identified; what was done to help clients meet their spiritual needs; what was the outcome of these actions and why the participants concluded the actions had this particular effect. No reliability and validity data was discussed.		loaded conversations, and the nature of the patients' diagnosis. Patients' concerns: religious beliefs and practices (prayer); absolution; connectedness; comfort and reassurance; healing; meaning and purpose. Nurses' actions included: respect for privacy and dignity; helping patients to connect or complete unfinished business; listening to patients' concerns; comforting and reassuring; using personal religious beliefs to assist patients; observations of religious beliefs and practices. Finally the outcomes of the nurses' interventions: positive effects on patients and their families as well as the nurses.	critical incident was the use of real world experiences, not an experience or incident that should be. Again, patients' are seeking many of the things previously identified in the concept analysis of spirituality and of being while nurses' actions are a doing state. Again, no "one" way to provide this type of care.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Curlin, Roach, Gorawara-Bhat, Lantos, Chin 2005 Medicine	What do physician residents think about the relationship between religion, spirituality and health?	Qualitative Semi-structured interviews	Purposeful sampling of 21 physicians to include different religious backgrounds: 7 with no stated religion, 6 Protestants, 4 Jewish, 2 Catholic, 1 Hindu, and 1 Buddhist. Residents serviced a variety of clients with 5 of them from a county hospital with predominantly poor African-American and Latino populations, 13 from 3 other academic settings that served both affluent and underserved populations, and	A semi-structured interview was used with investigator triangulation. The instrument/questions were reviewed by expert colleagues. Credibility checks were done to ensure trustworthiness. Reflexivity was done with bracketing of the interviewer personal dimension of the subject. An external qualitative analyst also systematically reviewed and coded a portion of the transcripts checking for	NA	No definitions of spirituality or religion were given. Researchers noted that whenever the physicians referred to spirituality it was always in the context of religious practices, beliefs, traditions, and values. Religion helped to interpret illness, gave meaning and provided a framework whereas religious communities in which illness is experienced could either be a great source of support or negative influence. This latter statement was supported by physicians speaking of ways in which religious beliefs often	The physicians appeared to be paternalistic toward patients when working with them. An accidental finding was the physicians in this study equated spirituality with religiosity as found in several of the discussions. It is difficult to know whether this is their own revelations or the manner in which they have been socialized within medicine. This research does support other research that is present

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent and Dependent	Major Findings	Evaluative Comments
			3 in private practice in affluent suburbs. Clinical specialties include 8 general internists, 4 OB Gyn, 6 medical subspecialties, 1 radiologist, 1 pediatrician, and 1 internal medicine/pediatrics. The average age was 42 yrs. old and 7 were female. No one refused participation and participants were medical and religious recommended by colleagues, local leaders and other participants.	consistency and fidelity of the analysis. All this increased credibility of the analysis. Interviews continued until theme saturation was reached.		interfered or were contrary to medical recommendations, where patients choose “faith over medicine”. Most believed there was very little empirical evidence linking religions to health and that the influences noted could be explained in scientific terms.	in medicine regarding the interchangeable use of spirituality and religiosity. Physicians believe faith is chosen over medicine, but did not choose to further understand the patient perspective.
Luckhaupt, Yi, Mueller, Mrus, Peterman, Pulchalski, Tsevat 2005 Medicine	The purpose of the study was to assess the beliefs of primary care residents regarding the	Descriptive Correlation	Two hundred and forty seven primary care residents were invited to participate in the study immediately after they had taken	The instrument was developed and adapted from the Religion and Spirituality in the Medical Encounter Study Groups. No	(D) Spirituality and Religiosity scores (I) Age, race,	Forty-six percent of the participants believed they should play a role in patients’ religious or spiritual lives, 90%	More of the tools focused on religiosity than on spirituality and could easily have biased the sample. No reliability and

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent and Dependent	Major Findings	Evaluative Comments
	role of spirituality and religion in the client encounter and in addition, to assess how the residents' own spirituality and religiosity affected those beliefs		their in-service examinations. The residency programs occurred at a large Midwestern teaching institution. Two hundred and seven responded with a mean age of 28.7, 58% women, 74% white and 13% Asian/Pacific Islanders. In addition 47% were Protestant, 26% Catholic, 7% Jewish, 10% claimed r no religious affiliation and 11% were of other religious affiliation. Forty nine percent were peds residents, 27% internal medicine, 12% family practice and 11% internal	reliability and validity was discussed regarding the new instrument. In addition the Center for Epidemiological Studies Depression Scale (CESD-10) was also utilized but again, no reliability and validity data on the tool or use of the tool with this sample was discussed. The Functional Assessment of Chronic Illness Therapy – Spiritual Well-being Scale (FACIT-SpEx) was adapted for use in this sample with working under chronic stress. The original tool was developed for use in samples with	gender, type of residency program, post graduate year, current rotation and religious affiliation which was stratified, overall health status, level of depressive symptoms.	believed they should be aware of the spiritual or religious beliefs of their patients and 27% of the residents believed patients felt their physicians should have strong spiritual beliefs. There was a significant relationship found between religious affiliation and agreement that residents should play a role in patients' spiritual or religious lives: 55% Protestants, 43% Catholics, 42% other, 32% secularists, 20% Jews, with $p = .05$. In addition a significant relationship was found between type	validity data was available nor testing done on most of the tools utilized with the present sample, including those that were adapted and new. This article and research also tended to use spirituality and religion interchange-ably at time and there was no discussion on differentiating the two concepts, making it unclear how the sample interpreted the concepts. Without reliable and valid tools and data on such, it is difficult to ascertain what exactly was being evaluated, religiosity or spirituality.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent and Dependent	Major Findings	Evaluative Comments
				reliability and chronic illness. No validity data was again available for this tool or for use with this sample. The Duke Religion Index which assesses organized religious activity and the Brief RCOPE tool which measures positive and negative religious coping were also used to evaluate the residents' personal spirituality and religiosity without discussion of any reliability and validity data.		internal medicine of program (33% 46% peds, 50% internal med/peds, and 74% family practice, p = .004); frequency of religious involvement; greater spiritual well-being; and greater levels of positive religious coping. Family practice was also the highest (96%) who believed physicians should be aware of patients' spiritual and religious beliefs. Race was the variable associated with the belief that the patient's physician should have a strong spiritual belief (56% blacks, 27% white, 17%	

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						Asians and others). Only 36% felt they should ask about spiritual and religious beliefs at an office visit, while 77% believed it appropriate if the patient was near death. Women were more likely to agree about asking patients about their spiritual and religious beliefs while hospitalized. Across the spectrum, all were less likely to agree with praying silently or with patients than with inquiring about patients beliefs. Only 12% agreed with praying with patients during an office visit but this increases with the	

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						situation. As the post graduate year increased, tendency to discuss spiritual and religious beliefs with patients decreased, possibly R/T time.	
Mactavich & Iwansaki 2005 Rehabilitation	Using empowerment as a conceptual framework, this study identified how people with physical disabilities cope with stress. The key question was “What are the ways or things that you do or use to help you deal with stress in your life?”	Descriptive Qualitative Focus Groups Phenomeno-logical	Purposive sampling was used and those who met the criteria were recruited. The 22 volunteer participants were then divided into one of three focus groups: women only (n=9); men only (n= 4); and mixed (4 women and 5 men). Disabilities reported included 5 with spinal cord injury, 4 with quadriplegia, 3 with paraplegia, 2 with arthritis, 1 with polio, 1 with visual impairment,	Transcripts were reviewed with participants for accuracy. Otherwise, no discussion.	NA	Five common themes emerged: socializing/social support; cultivating and using positive affirmations; reconnecting spiritually; diverting one’s focus; and rejuvenating through leisure/exercise. Women also had one more theme: that of seeking emotionally satisfying outcomes, versus men, who sought conscious avoidance of dealing with or	Not a true phenomenological study but more focus group and processes were present. Would have considered doing this as a grounded theory instead since meaning was never mentioned in any part of the study. The authors indicated for data analysis phenomenology using Moustakas technique was used.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			and 6 with other physical or mobility impairments. Ages ranged from 21-72 years with a mean of 43 years. Eight had completed a university degree, 9 were single, household income ranged from $10,000 to one with about $100,000; 14 Caucasians, 6 Canadian Aboriginals, 1 from Central America and 1 African. 9 unemployed, 4 retired and 2 employed full time.			coping with stress. A conceptual model was developed by the authors.	
Taylor & Mamier 2005 Nursing	The research questions' aims were to understand to what degree cancer patients and their	Descriptive Cross-sectional Concept analysis	A convenience sample of patients and caregivers were recruited from both inpatient and outpatient settings who met	Tool 1: Information about You included demographics, religious tradition, and illness. Tool 2: Spiritual	NA	On a scale of 1-4, most items regarding the provision of spiritual care were between 2 (disagree) and 3	Since this was part of a larger study, it seemed to lack some background information. However the study was valid but not

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	family caregivers want in the way of spiritual care nursing interventions, what constitutes spiritual care, what differences existed between the patient and their caregivers as to what spiritual care interventions they desired, and what demographics or factors based on their illness affected whether a patient or family		criteria. One hundred and fifty six cancer patients and 68 family caregivers were recruited. Patients were primarily white males with prostate cancer and caregivers were primarily white females with 60% reporting spending 5-10 hours /day in caregiving. Eighty seven percent of both patients and caregivers were Christians.	Interests Related to Illness (SpIRIT). The first part included items identifying spiritual needs by cancer patients and their family caregivers during a prior qualitative phase. The second part of the tool had face validity supported by a panel of six nurse experts with doctoral degrees. Factor analysis was also done. There was a high internal reliability of $r = 0.97$. This tool was renamed the Nurse Spiritual Therapeutics Scale (NSTS).		(agree). There was no significant difference found between what patient and caregiver preferred regarding spiritual care. In general, spiritual care that was less intimate and not overtly religious was preferred. There appeared to be a weak correlation ($r = 0.26$) between frequency of attendance at religious service and preference for spiritual caregiving by nurses.	generalizable based on a predominantly white, Christian sample of both patients and caregivers.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent and Dependent	Major Findings	Evaluative Comments
	member wanted spiritual nursing care interventions.						
Wachholtz & Pargment 2005 Behavioral Medicine	The purpose was to compare relaxation techniques, secular and spiritual forms of meditation to assess the benefits as a spiritual intervention during psychological and physiological stress, and whether spirituality is a critical component of meditation.	Descriptive Correlation	Eighty-four participants who were in a college psychology class were recruited through fliers and through the university computer system for potential research project participants. Twenty- five participants were accepted into the Spiritual Meditation group, 21 into the Secular Mediation group, and 22 into the Relaxation group. The three groups were not significantly different in demographics, psychological, and	Tools used to rate participants included the Positive and Negative Affect Scale with internal consistencies of .89 for positive affect and .85 for negative affect in the literature; the State-Trait Anxiety Inventory to measure anxiety with high internal reliability of α = .91 in the literature. Spirituality measures were done using parts of the Brief or peak Multidimensional Measure Religiousness/	(I)Spiritual Meditation, Secular Meditation, Relaxation Methods (D) Pain, Anxiety, Mood, Spiritual well-being	Cardiovascular relaxation was significantly lower in all 3 groups with the cold water bath challenge but the most with the Spiritual meditation group. Psychological post-hoc tests reported significantly less state-trait anxiety in the Spiritual Meditation group. This group also reported a significantly more positive mood and greater existential well-being (SWB scale), feeling closer to God, others and nature, and had more l	No reliability and validity testing was done with any of the instruments with the sample population. However, the tools used are well known to have high reliability and validity in previous research as stated by the authors. The sample was young and it would be interesting to follow through. and repeat this study on an older population. Research has shown that spirituality increases with age and religiosity

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			spiritual indicators. Demographics for the Spiritual /secular/relaxation groups: mean age of 18.9 /19.1 /19.4; female 76% /61.9% /63.6% ; Caucasian 88% / 95.2%/ 100%; Catholic 40% /52.4%/ 36.4%, and 48% / 23.8%/ 40.9% Protestant, with 4%/ 9.5%/ 13.6% as no religion.	Spirituality (Fetzer Institute, 1999) with reliability of the religious intensity at α =.77 for self reported religiosity and spirituality, per the literature.		mysticaexperiences (Mysticism scale). All were at *p* =<.05, several at *p* = .001. Pearson's correlation coefficients were all moderate to highly correlated, ranging from .40 to .90 except for existential well-being and total time in water (.35), EWB.	stays the same or decreases.
Bingham & Habermann 2005 Nursing	What is the role of spirituality in defining and managing Parkinson's' Disease (PD) for people with PD and their families.	Descriptive Content analysis	The maximum-variation sampling technique was used to recruit participants for a larger study from which this study was a part. Participants were part of PD support groups in the southeastern US and a movement disorder clinic. A total of 27 families, with 24 couple	Trustworthiness was established by having an individual with clinical and research expertise about people with PD and their families examine the findings and interpretations. Increase rigor was established with a follow-up interview with	NA	Feelings of a sense of gratitude and hope emerged from both the person with PD and the family. Finding support in family and friends, defining and managing the disease through a divine power (God) and church, all assisted them in finding meaning	Religious affiliation or type of spirituality was not discussed. Since church was the only way of expressing spirituality mentioned in this article, the authors should have discussed religiosity and spirituality and differentiated the

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			dyads, 2 with an adult daughter and 1 with an adult mother-son dyad were recruited. A total of 56 participants mostly Caucasian who were from both urban and rural settings with incomes ranging from $20,000 to $60,000 annually. The person with PD age range was 41-87 yrs. (*M* = 71) and primary caregiver 44 – 88 (*M* = 72), with married couples being together on an average of 43 years. Seventy percent had PD for 6-9 years and had stage 3 or 4 (bilateral disease with balance impairment, or	both the person with PD and the family member together to clarify the previous interviews of each individually. Validity was established by sharing the findings with friends from church as it was established that social activities were limited to church attendance. These individuals provided support beyond church attendance.		and purpose in life. The authors indicate that spirituality is the way in which people with PD and their families manage the day-to-day challenges of the illness. Spiritual ritual needs to be supported to enhance coping was one of the conclusions of the researchers.	two. As it stands, they have used the two interchangeably, although religion is one possible means of expression of spirituality. However, other confounders also need to be addressed such as social support found within the friends from church. Finding connection to others and the divine, and meaning and purpose in life are related concepts to existential spirituality; however the context in which the authors use spirituality is primarily a religious context.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			moderate to severe disease without being bed bound).				One example is the statement that spiritual rituals need to be supported to help with coping of the disease. Rituals are typically affiliated with religions.
Callaghan 2006 Nursing	The research questions are as follows: What are the relationship among health-promoting self-care behaviors, self-care self-efficacy, and self-care agency in older adults? Does a significant relationship exist between spiritual growth and self-	Correlation Descriptive	Volunteer, convenience sample of older adults in multiple community settings in Philadelphia, with an average age of 79 years, were recruited. Network sampling was used to recruit the sample with a total of 247 questionnaires being returned out of 661. Twelve were not usable because of missing data for a total of a 37% respond rate. Seventy five	Four instruments were used in this study and included the Health-Promoting Lifestyle Profile II with good reliability with alphas for this study of .70 to. 93 for the six subscales. Content, construct and criterion-related validity were also reported by an expert. Next the Self-Rated Abilities for Health Practices Scale was used to measure four areas, with internal	(D) Four subscales of the measure of self-care agency (self-concept, initiative and responsibilit y, knowledge and information seeking, and passivity). (I) Four subscales for self care efficacy (nutrition,	The sample scored just above the midpoint for the Health-Promoting Lifestyle Profile II meaning the sample tended to practice healthy behaviors. The Self-Rated Abilities for Health Practices Scale was also above midpoint (high levels of self-efficacy were present related to healthy behaviors), and the mean score for the Exercise of Self-Care Agency	Significant limitations to this study exist including a predominantly Caucasian, assumed Christian (one family indicated they were Baptist), sample living in an area the authors referred to as the “Bible Belt” of the US. Generaliza-bility is limited with a non-

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	care agency in the older adult?		percent were women, 91% white, 46% widowed, 42% married, 88% had children, 60% did not live alone, 97% had a support system, 84% had at least a HS education, 87% practiced a religion, 85% had adequate income and health insurance, 97% had adequate living conditions, 74% had medical problems and disabilities and 47% had multiple problems.	reliability for this sample of .82-.94. Experts also reported strong construct validity. Exercise of Self-Care Agency Scale measured four dimensions of self-care agency and was revised for the study based on construct and discriminant validity studies by experts. Reliability scores for the subscales ranged from .70 to .89. Finally, a demographic instrument was added.	psycholo-gical well-being,exerci se, responsible health practices) and six subscales for the measure of health-promoting self-care behaviors (health responsibi-lity, physical activity, nutrition, spiritual growth, interperson-al relations, and stress manage-ment).	Scale (high abilities for self-care). Canonical correlation statistics were done with only 3 out of 4 canonical variates statistically significant, and only one of the 3 theoretically interpretable. This one variate had a canonical correlation of .74 (*p* = .000), and included one variable in set 1 (spiritual growth) and two in set 2 (self-concept *p* = <.05 to .001.and initiative and responsibility). These loaded on canonical variate 1 and could account for 55% of the variance. Those who reported frequent practices	randomized, network sampling. Excellent reliability and validity of the tools within this sample. Good article relating self-care agency, self-care self-efficacy and spirituality.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						of spiritual behaviors and growth, had more positive self-concepts, more initiative and responsibility for self-care.	
Cavendish, Konecny, Naradovy, Luise, Como, Okumakpeyi, Mitseliotis, & Lanza 2006 Nursing	Explore recently hospitalized adults' perceptions of spirituality and of the nurse as a spiritual care provider.	Qualitative	Purposeful sampling was done and 9 recently hospitalized adults ranging in age from 48-91 (mean 61) who resided in the New York Metropolitan area agreed to participate in the study. Theoretical sampling was used and data was collected until saturation occurred. Seven were female, 2 divorced, 1 widowed, and another living in a committed	Eight nurse researchers who were experienced in qualitative methods and experts on spirituality analyzed the data line by line and coded for pattern recognition of themes and conceptual categories with 2 rounds of analysis. Credibility and audibility were accomplished using the same probes in the interview, clarifying participants' statements		Eight themes emerged: "relationships and connectedness are important and meaningful in life; spirituality is a kinetic life force; spirituality is ever present and varies in its intensity; spiritual beliefs stem from a philosophy of life; spiritual practices fulfill spiritual needs; spirituality strengthens coping where clustered under conceptual category 1 (patient's perception of	Interesting patient comments regarding the themes. Perceptions of spirituality are consistent with other literature. Perceptions of the nurse as provider of spiritual care are contrary to what nursing perceives as its role in this matter. Patients perceived nurses as not comfortable in

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			relationship. One graduated from 8th grade, 2 from high school and the rest from college. Three worked full time, 1 part time, 2 unemployed and the rest retired. Six were white, 4 were Catholic, 3 Protestant and the average hospital stay was 13 days.	throughout, comparing tape-recorded interviews with transcripts for accuracy, reviewing field notes and research committee minutes. Confirmability of theme recognitions was established with 7 or more researchers identifying the same theme concepts from one participant's responses. Inter-rater reliability was achieved with the mutual agreement and confirmation of the conceptual category and themes by the research members, with a formula for the coefficient being the number of agreements divided by the		spirituality); nurses do not offer spiritual care; spiritual support is not a nursing role were explicated from the conceptual category 2 (patients' perceptions of the nurse as provider of spiritual care, p 44-45)."	this role, are there to only provide physical care, and as having little time to do anything else. Patients also do not feel nurses were comfortable discussing a spirituality different from their own.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
				number of disagreements. An Audit trail was present along with coded transcripts, field notes, data reduction, meeting minutes, data analysis.			
Hampton & Weinert 2006 Nursing	The purpose was to explore expressions of spirituality in women living with chronic disease in rural areas.	Secondary analysis Exploratory Content analysis	Women were recruited through the Women to Women project in Montana State University, and through health agencies, word of mouth and media sources. After determining eligibility, the participants were randomized to computer and non-computer groups. The compute group received health information surveys and had access to chat rooms where they could support	Lincoln and Guba's 4 criteria for credibility, transferability, dependability and confirmability were used to establish trustworthiness.	NA	A total of 280 messages were posted in the conversation on spirituality, a category initiated by the researchers but not participated in by them. Thirty two percent contained spiritual content. Six categories emerged from the analysis: prayer, faith, verse, transcendence, finding meaning and family	Consistent findings with other research. Christian focused, use of Bible verse, prayer groups at church, etc. Mixed religion and spirituality without any definition for the participants of the concepts. This was apparent in the results, the last3 findings indicating more connection to

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			each other. The secondary analysis used data from 15 women who participated in the computer group ranging in age from 38-61 (mean 48.4). Each had at least one chronic disease process, 5 were working; median incomes of $30,000 to $35,000 annually. Mean years of education, 14.4 years; distance to routine care, 66.7 miles; distance to emergency care, 12.7 miles. Seven had children > 18 years still at home. Nine participants were married, 2 divorced, 1 separated.				others, transcending, and existential meaning in life. The first 3 findings would be appropriate to religious practice.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Kaiser 2006 Diagnostic Imaging	Use of functional imaging of PET and SPECT techniques to chart brain activity during religious or spiritual practices.	Review	Multiple studies were examined and compared regarding the performance of meditation and its effect on the neurophysiology of the brain and cognitive function: Tibetan Buddhist meditation, centering prayer, transcendental meditation, and yoga meditation. The relationship to cognitive function in dementia patients and normal adults was reported. No data on how individuals were recruited for the studies was discussed.	NA	(D) Brain activity (I) Different types of mediation and religious and spiritual practices	Meditation increased activity in the frontal lobes (attention) while decreasing activity in the parietal lobes (orientation of body in time and space). No activate of the language area of the brain during the outbursts by those speaking in tongues. In other studies, SPECT imaging showed increase activity in certain areas of the brain during the practice itself but no changes long-term. The conclusion is there are consistent patterns of brain activity that occurs when individuals focus their attention on spiritual, meditative, or religious practices.	A review article without numbers (empirical indicators); however, within the article various NIH grants and research in progress at large Universities was discussed. Interesting summary of the use of imaging techniques to capture brain function during spiritual activity.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Olson, Sandor, Sierpina, Vanderpool & Dayao 2006Medicine	The aim of the study was to talk with family physicians and gain their perspective regarding their beliefs, attitudes, and practices toward spirituality and clinical care.	Phenomenology (perceptions and essences of experiences; meaning and themes) & Grounded Theory (categories and concepts that emerge from the texts)	Purposeful sampling of 17 third-year family medicine residents from a medical school in the Southwest. 65% were male, 47% White, 29% Asian, 12% Hispanic, and 12% Black. Mean age was 34, ranging from 29-44 years of age. Each had had opportunities to participate in didactic sessions that focused on spirituality and clinical care in their residency program. Previous knowledge base and contact of the participants regarding spirituality and clinical care was unavailable.	Not applicable for a tool however no discussion regarding qualitative methodology, reliability and validity was presented.	NA	Four main themes emerged: spiritual assessment in clinical practice; connecting spirituality and medicine; barriers to personal practice; and strengths of integrating spirituality in medicine. Difficulty in taking a holistic approach within the dominant medical culture was expressed.	More enlightened article of medicine on spirituality and appropriately separated spirituality and religiosity. No discussion on the spirituality and / or faith of the participants and the potential of influence this had on the participants in their beliefs, values, etc.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Smith 2006 Social Work	What is the importance of Spiritual Transcendence in the lives of Certified Rehabilitation Counselors (CRCs)? What is their willingness to introduce and address Spiritual Transcendence in counseling sessions with clients? Is there a correlation between the two research questions?	Description Correlation	This was a volunteer convenience sample. Thirty-five respondents were contacted through clinical supervisors who were affiliated with a local CORE accredited rehabilitation counselor education program, 8 more that were identified by others in this group, and the final 15 from those acquainted with the author who were Certified Rehabilitation Counselors. Only 35 agreed to participate (68%). Twenty one were female, 31 had Masters Degrees and 4 had PhDs; all were credentialed as Certified Rehabilitation	Piedmont's Spiritual Transcendence Scale- (STS-R) Short Form (renamed Assessment of Spirituality and Religious Sentiments, ASPIRES). The STS-R produces a total score (TS) and 3 facet scores of prayer fulfillment, universality, and connectedness. The internal consistency for the original tool for the TS was .76, for prayer fulfillment .89, universality .59,and connectedness .68. The ASPIRES scores were .90 for TS, .94 for prayer fulfillment, .89 for universality, and .81 for	(D) Willing-ness to introduce and address Spiritual Transcen-dence in counseling sessions with clients (I) Import-ance of Spiritual Transcen-dence in the lives of CRCs.	Eighteen of the thirty-five had t-scores >55, in the high range and indicating they lived life based on an understanding of being part of the larger universe and a larger purpose. Seven however scored <45, in the lower range, indicating they were more focused on "tangible realities" of day-to-day living. With prayer fulfillment, 6 scored high, meaning prayer and meditation provided great internal satisfaction to them, while 5 were in the lower category, not "bothering" with	Interesting outcomes in that those who had additional training in spirituality did not score much differently than those who did not. No discussion regarding the reluctance to introduce discussions on spirituality within counseling sessions. No definitions were presented either however, the Piedmont tool appeared to measure more of an existential perspective of spirituality

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			Counselors. Twenty Five majored in Rehabilitation Counseling, 4 in Counselor Education, and 2 in Counseling Psychology, 2 in Social Work, and 1 in Pastoral Counseling, 1 in Psychology. Ages ranged from 29-61 years with a mean of 43.74. Years of work experiences ranged from 2-34 with a mean of 13.86 years. Nine of the respondents have further coursework or training in the area of spirituality. Eleven worked primarily with clients with mental health disabilities, 10 with substance abuse, 7 with	connectedness. All this was however, based on normative sample and not the present sample for both tools. Validity was undertaken using cross observer convergence and content validation was done with three experts in the field.		this type of inner work. The Universality facet had 18 of the CRCs in the high range of internalizing the belief that all humanity has a common bond and heritage, are more alike than different, and "converge" at one point. Six on the other hand were low scorers in the area believing each person must rely on themselves. Connectedness had 14 CRCs scoring high, reflecting a "sense of responsibility and gratitude" for all humanity, while 9 found it difficult to find a sense of belonging and meaning in any group or community. Of	within the individual. It might have been interesting to make the different types of educational backgrounds as an independent variable to see if this made a difference as to whether Spiritual Transcendence was present in the life of the counselor and in their practice, since there is a wide variety of educational backgrounds present in the participants.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			cognitive disabilities, 4 with physical disabilities, 2 with learning disabilities and 1 with "other" disabilities.			those who had additional training, in spirituality, 6 scored high on the TS, 2 in the average range and 1 in the low range. This compares to those who had no additional training with 12 in the high range, 8 in the medium, and 6 in the low. Fifty percent were willing to introduce Spiritually Transcendent issues into their counseling. Sixty would feel comfortable encouraging clients to talk about spiritual issues, 46% actually integrated these issues into individual sessions, and 30% into group sessions. Only 50%	

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						of those with spirituality training indicated a willingness to do so in group sessions.	
Sorajjakool, Aveling, Thompson & Earl Pastoral Care 2006	Finding meaning in the presence of continual chronic pain.	Phenomeno-logical	Purposeful sampling of 15 individuals who were participant in a Chemical Dependency treatment program and out of detoxification for at least two weeks. Eleven of the participants were religiously affiliated, 3 were not, and 1 indicated no religious affiliation. Age ranged from 23-60; 8 were married, 4 divorced, 2 widowed and 1 was in a common law marriage. Twelve were female; all	NA	NA	Five themes emerged: meaning was defined as the ability to engage in meaningful activities and have positive relationships with others; chronic pain removed meaning from life and was all consuming; medication was used as a coping mechanism for pain and led to isolation, dependency, and addiction; dependency and addiction resulted in greater loss of self and meaning;	Interesting article. However, the treatment center was located at Loma Linda University. There was no discussion about what the spirituality and religiosity of the participants were before and after treatment as well as whether there was any influence from the institution which is a

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			but 2 were white. Drug dependency for pain management ranged from 1-10 years. A variety of treatments had been sought both within allopathic and complementary medicine. Pain scales were typically at 9 or above on an analog scale of 1-10.			rediscovery of meaning was complex and entailed gaining an understanding of self, embracing suffering and the ability to see the relationship of pain, emotions, and addition in a complex web of self-revelation and understanding. Eleven of the 15 believed spirituality played an important role in their coping by enabling them to achieve a certain attitude. Pain had also decreased for most participants to 0-7 on the analog scale.	faith based institution (Mormon) as well as those practicing within it and working with the patients.
Tanyi, Werner, Recine, Sperstad 2006	What is the meaning of spirituality; and understanding	Phenomeno-logical	Purposive sampling of community-dwelling women with end-stage renal disease	The qualitative reliability and validity items discussed were maintenance of	NA	Eighty-three significant statements were extracted and clusters of themes	Rich and thick descriptions present, well done study. However,

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
Nursing	patient preferences for spiritual care from their nurses in a hemodialysis outpatient center.		(ESRD) receiving hemodialysis (HD) from two outpatient centers in the Midwest for at least 6 months, and who attended HD three times a week, were recruited. Twenty-five potential subjects were identified with 16 agreeing to participate. Ages ranged from 29 -77; 11 identified themselves as African or Black Americans, 3 as Caucasians, 1 as Hispanic and 1 as Asian. The length of time with the diagnosis of ESRD was 7 months to 21 years. Time on HD was 7 months to 13 years. Two stated they were Protestant, 3 Catholic, 1 Jewish,	a journal to record thoughts before and after each interview and to bracket presuppositions. Rigor and trustworthiness were maintained throughout the data collection and analysis and data validation was done through member check with participants, who corroborated the findings. Credibility was done through several interactions with participants, and audit trail		emerged and were validated with the data. These included: a.) displaying genuine caring through: listening, being kind and patient, being sensitive to each person, being nice, respecting where their patients' spirituality comes from, understanding the patient better, treating the person how you want to be treated, smiling now and then, being friendly, letting the patient know that they're with them, talking	participants mixed religiosity and spirituality, using them interchangeably especially when discussing what interventions would suffice for spiritual interventions (meaning vs. relationship with God). This was discussed by the authors in the article, where most of the findings indicated an existential spirituality. Spiritual self awareness by the nurse was identified by the

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
			3 Christian, 3 Baptist, 1 Lutheran, 1 Seventh Day Adventist, 1 Pentecostal and 1 non-denominational. Three were married, 2 had live in partners, 7 never married, 3 were widowed and 1 was divorced. Monthly incomes ranged from $200 to $2000.	evaluation established confirmability and dependability and the thick and rich data and purposive sample established transferability. Colaizzi's method was used for interpretation.		with the patient and telling them what is going on and performing their duties as they are supposed to; b.) building relationships and connectedness which fostered spiritual care through putting the professional part aside and being a friend, understanding each other, being friendly, willing to talk, don't argue ; c.) initiating spiritual dialog overtly to understand where the patients' beliefs and spirituality come from, what their essences is, what "got them up and here today?"; d.) mobilizing spiritual activities	patients as increasing the likelihood that the nurse would engage in spiritual dialogue and understand the patient's perspective. This was reliant on the individual nurse. Distinctly Christian in its focus, using examples of prayer and use of bibles in the HD unit.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						through use of bibles on the units, spiritual pamphlets available, counselors	
Arnold, Herrick, Pankratz, & Meuller 2007 Nursing	What is the relationship between spiritual well-being (SWB) and emotional distress, SWB and perceptions of health after MI, and emotional distress and self-perception of health?		Convenience volunteer sample of 124 patients from 3 telemetry units of a large Midwestern hospital. Ages ranged from 35-100 years (mean 64 yrs) and during hospitalization, the subjects received the diagnosis of MI for the first time.	SWB scale, which measures existential and religious well-being. Validity was discussed in relation to other research, not with this sample. The tool has good content, construct, concurrent and face validity. Test-retest reliability and in internal consistency was also discussed in relation to other research but had about a .70 for all aspects of the scale. Emotional distress was measured using 3 subscales of the Profile of	(D) Perception of health after MI and emotional distress (I) SWB and emotional distress	available, talking about God with the patients and praying with the patient, and some existential things, even use of humor. SWB scales mean score was 98.4 with the existential scale mean of 48.4 and the religious well-being score of 49.8. Mean tension-anxiety scores of 41.8; depression-dejection 40.9, and anger-hostility 42.4 were the result of the POMS tool. Health perception scores were lower than the original RAND study but Sickness	No reliability and validity data on this sample with the tools. In addition the RAND tool and study seemed to be a weak study based on what the authors presented, making it questionable why they used the Health Perceptions Questionnaire for this study. There are others that could be used to measure different characteristics

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
				Mood States (POMS) which included tension-anxiety, depression-dejection, and anger-hostility. Again, reliability and validity which was excellent, was discussed in relationship to other research but not about this sample. Self perception of health was measured with the Health Perceptions Questionnaire developed by the RAND Corporation for the National Insurance Study. In the original research internal consistency was >.50, but has not been tested for validity and was found to correlate		Orientation scores were higher. Significant correlations were found between SWB and all the factors of the emotional distress. In addition all correlations were slightly higher and significant for theexistential well-being subscale, and no relationship was present between the religious well-being and the tension-anxiety or anger-hostility subscales. SWB correlated positively with Current Health, Health Outlook, and General Health Ratings Index, EWB, RWB and SWB were all strengthened or remained the same.	of the patients that the researchers were looking for such as state-trait tools, depression-anxiety tools, especially since they only used specific parts of the RAND tool.

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
				weakly with the Sickness Impact Profile		SWB was modestly negatively correlated with emotional distress and the 3 elements of self perceptions: current health, health outlook and the GHRI. EWB was more strongly correlated with emotional distress that was RWB. Meaning in life may impact emotional distress in this	
Campbell & Ash 2007 Hospice, Palliative Care, Nursing	How is the experience of African-Americans living at home with a life-limiting illness described? What processes do they use to manage the experiences of living with a	Grounded Theory	Purposive sampling of participants who lived in a rural community within 50 miles of a large Southeastern university were invited to participate. Ten men and 3 women ranging in age from 58-90 years (mean 73.3 and 70 years respectively) who	Not applicable for the instrument. No qualitative reliability and validity was discussed.	NA	Data were analyzed using the QSR NVivo version 2.0.163 software sample. The constant comparison method was used for data analysis. A basic social problem and basic social psychological process was	Many similar findings to other researchers regarding connection to God, others, self in different ways. Storytelling was a big concept, to talk about one's

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	life-limiting illness?		were enrolled in the local hospice program or the Home Based Primary Care program of the VA agreed to be interviewed. Seven had diagnoses of cancer, 4 with heart failure, and 2 with chronic obstructive pulmonary disease. All were African-American and able to participate in at least 2 interviews over a period of 28 months.			discovered in the analysis. How to affirm life was the basic problem that was identified by the group. The process that was discovered to do this was an integration of religion and spirituality through three concepts. These concepts included connecting to family and community (maintaining relationships, passing on a legacy, storytelling and connecting with ancestors); connecting with God (praying, talking, receiving communication from God, feeling his presence, belief in	ancestors and life and pass this information on as a legacy. As stated by the authors, people of color do not use hospice services as much as whites, and the reason many chose hospice in this study was for the financial benefits. Many verbalized that they were still fighting to a certain degree and 2 had been in hospice for 1 year. There was no discussion of data on the financial situation of the participants

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						God's omniscience, compromising, holding on/ not ready to let go, weighing costs and benefits of hospice), and connecting with self (managing the mind by not thinking about the illness, relating to loss of physical independence and control, personal search for meaning).	and whether this might have an impact ontheir choice of hospice at this time of the illness or other support for care.
Ka'opua, Gotay, Boehm 2007 Social Work	To describe spouses of long-term prostate cancer survivors ways of coping with cancer-related issues related to spiritual based	Descriptive Secondary analysis Longitudinal interviews Grounded theory Content analysis	Twenty-eight wives who had completed a quality-of-life survey were purposively sampled based on age, race, and ethnicity. Ages ranged from 55-86 years (mean 72.6). Race and ethnicity included	Trustworthiness in interpretation was done by having at least 2 research team members co-code data; participant verification and senior colleague not involved in the research	NA	"Nurturance of the embracing spirit" was the primary theme found in the women's' adaptations and identified by 92.8% of the participants. Four core areas of adaptation occurred within the spiritual	SBR is both religious and spiritual per the authors in spite of being called spiritually base resources. The authors recognized the differences between the

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
	resources (SBR).		White(28.6%), Japanese (28.6%), Chinese (21.4%), Filipina (10,7%), and Native Hawaiian (10.7%). Number of years since husband's first diagnosis ranged from 6-15 years (average 8.5 years). Husbands received either radiation (46.4%), surgery (42.8%), or both (7.1%). Two interviews were done and SBR was discussed only if the women brought this up themselves. Two were Buddhist, 19 Christians, 2 Taoist, and 5 no spiritual or religious affiliation.	reviewed the data as well as key leaders from religious organizations from those identified by the informants.		domain: preserving the marriage and promoting couple intimacy (92.8%); life-long learning and continuous growth (92.8%); attitudes and beliefs that promoted a healthy lifestyle (85.7%); and maintaining community connections for social support (71.4%). Existential and daily resolution of challenges was at the core of positive adaptation per the authors.	two and identified religion as an institutionalized body of formal beliefs, rituals and practices. Limitations were higher seriocomic class of wives. The perception given of the sample was the wives had time to meditate, take care of their husbands needs, "see things as much as possible from" the husbands' point of view, take classes for their (wives) own enjoyment. Perhaps a discussion of the socioeconomic issues or of the potential influence of culture on the relationship and outcome of the findings would also provide more

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
							insight.
Muller & Dennis 2007 College Health	To determine whether high life-changes (college) were related to spirituality. Is there any relationship between life change events and degree of spirituality?	Descriptive Correlation	All participants were part of a required for graduation wellness course at a university in the Northeast and volunteers. One hundred and eighty students completed the online surveys and ranged in age from 18-26 years old.	Schedule of Recent Experience (SRE) was one tool, and Life Attitude Profile-Revised (LAP-R) was the second tool used. LAP-R had a coefficient of internal consistency for young adults aged 17-27, ranging from .77-.91 for all subscales and composite scores in previous research. No other validity or reliability for the tools was discussed in the literature for this sample for either tool.	(D) Spirituality (I) Life changes, life attitude	All spirituality scores were lower for men than women. An increase in life change resulted in increases in existential vacuum and goal seeking scores; higher life change was related to a decrease in existential transcendence. Correlation between life change and EV was 0.28, life change and GS was 0.18, and life change and EV was 0.15. Whether life changes were positive or negative the GS and EV subscales were higher. EV refers to lack of meaning or	Difficult article to follow with significant abbreviations for multiple variables throughout, forcing one to constantly flip back to previous pages. Did not discuss findings as thoroughly as should, used scatter plots instead. Scatter plots seemed to have a good regression line but no discussion of this was in the text. The correlations were weak and this was not discussed. Wide age range of 17-27 and no distinction of whether the cohorts were freshman, etc. This could impact significantly the findings and responses of the participants,

Author/Source	Study Question & Purpose	Design	Sample Characteristics, Size, Sampling Method/Setting	Instrument Reliability and Validity	Outcome Variables/ Independent Dependent	Major Findings	Evaluative Comments
						"antithesis of the agreed –upon definition of spirituality by many health educators (p.57)." Those who had higher GS were also less spiritual. The authors concluded that this sample had high levels of life changes, less spirituality, desired to find spirituality but lacked knowledge how to find spirituality.	especially regarding maturity, etc.

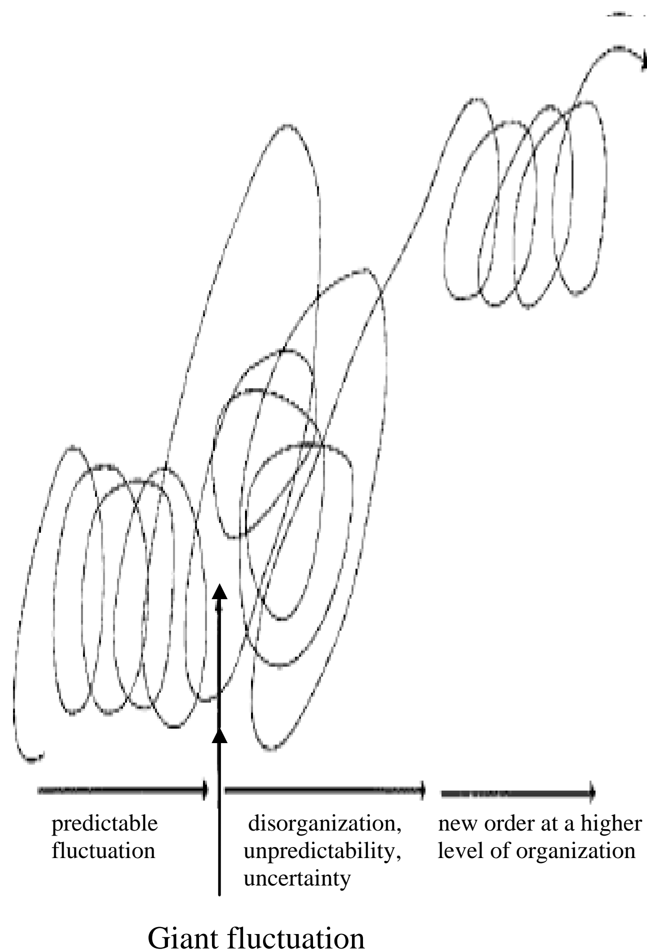
APPENDIX D

CONCEPTUAL MODEL

MARGARET NEWMAN'S THEORY OF HEALTH AS EXPANDING CONSCIOUSNESS BASED ON PRIGOGINE'S THEORY OF DISSIPATIVE STRUCTURE

Conceptual Model

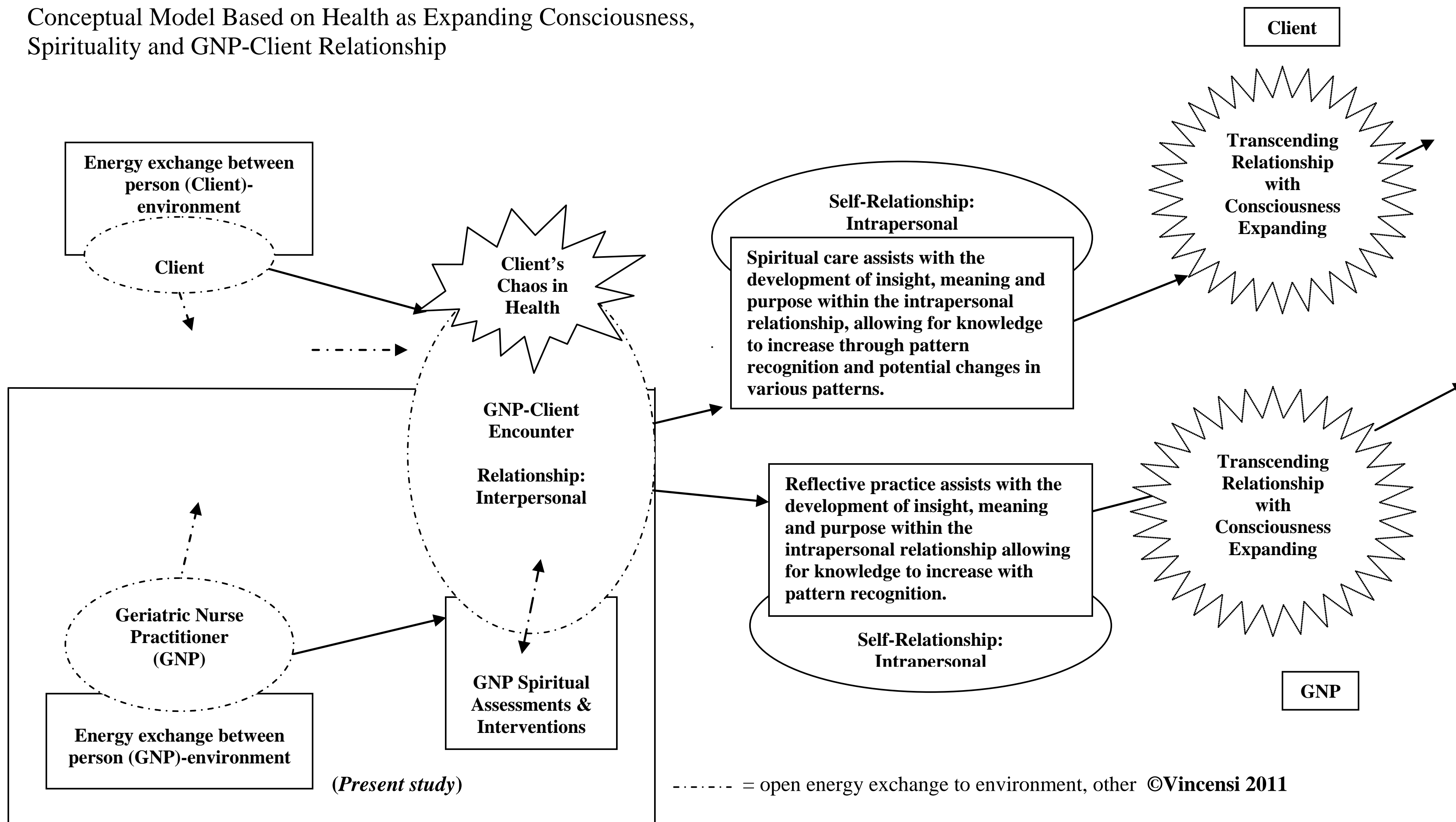
Margaret Newman’s Theory of Health as Expanding Consciousness Based on Prigogine’s Theory of Dissipative Structure (Newman, 2000)



APPENDIX E

CONCEPTUAL MODEL BASED ON HEALTH AS EXPANDING CONSCIOUSNESS, SPIRITUALITY, AND GNP-CLIENT RELATIONSHIP

Conceptual Model Based on Health as Expanding Consciousness, Spirituality and GNP-Client Relationship



APPENDIX F: TOOLS IN THE LITERATURE

Tool & Tool Author(s)	Reliability (reference)	Validity (reference)	References/ Other
Spiritual Index of Well-being (SIWB) (Daaleman & Frey, 2004) Subscales: Life Schema Self Efficacy	Cronbach's α Full Scale / Life Schema / Self Efficacy Primary Care (1): 0.91 / 0.89 / 0.86 Geriatric Care (2): 0.87 / 0.80 / 0.83 Test-Retest (1): 0.79 / 0.86 / 0.77	Well Being (1) / Full Scale / Life Schema / Self Efficacy Existential: 0.75 / 0.61 / 0.75 General: 0.64 / 0.61 / 0.57 Spiritual: 0.62 / 0.49 / 0.63 Religious: 0.35 / 0.27 / 0.38 $p < .0001$	(1) Daaleman & Frey (2004) (2) Frey, Daaleman, & Peyton (2005)
Spiritual Involvement & Beliefs Scale (SIBS) (Hatch, Burg, Naberhaus & Helmich, 1998)	Cronbach's α 0.88 (1) 0.92 (2) Test-Retest 0.92(1) 0.92 (2)	Content Validity (1) Construct Validity 0.72 (1) 0.80 (2)	(1) Vance, 2001 (2) Hatch et., al (1998)
Spiritual Perspectives Scale (SPS) Subscales of spiritual: Values/perspectives Behaviors	Scale: Full / Values / Behaviors Cronbach's α (1) 0.09 / NR / NR (2) 0.81 / 0.84 / 0.60 NR= not reported	Construct validity demonstrated in covariance with religious background and SPS scores (1)	(1) Stranahan (2001) (2) Conner & Eller (2004)

Tool & Tool Author(s)	Reliability (reference)	Validity (reference)				References/ Other
Functional Assessment of Chronic Illness Therapy, Spiritual Care (FACIT-Sp 12)	Cronbach's α Total score 0.94 Meaning/Purpose 0.90 Faith 0.90		Construct / Convergent- QOL	Faith	Construct/ Convergent- Meaning & Purpose	Peterman, et al., (2002) Brady, et al., (1999) Luckhaupt et al., (2005)
		Rand-36 Emotional Well-Being	0.70	0.00	0.00	
		FACIT – Fatigue-12	0.00	0.00	0.53	
		Chicago Multiscale Depression Inventory	0.00	0.00	0.83	
		Religious Growth	0.00	0.68	0.00	
		FACIT-G	0.64	0.00	0.73	

Tool & Tool Author(s)	Reliability (reference)	Validity (reference)	References/ Other
Spiritual Well-being Scale (SWB) (Paloutsian & Ellison, 1982)	Scale: Full EWB* RWB** Cronbach's α (1) 0.09 NR NR (2) 0.89 0.78 0.87 Test-Retest (1) 0.93 NR NR (3) 0.93 0.86 0.96 * Existential Well-Being **Religious Well-Being NR = not reported	Content validity by experts (1) <u>Convergent Validity</u> Scale: Full EWB* RWB** purpose of life 0.52 (3) 0.68 (4) NR intrinsic religious orientation 0.67 (4) NR 0.79 (3)	(1) Vance (2001) (2) Paoloutzian, & Ellison (1982) (3) Allport & Ross (1967) (4) Crumbaugh & Maholick (1969)
Oncology Nurse Spiritual Care Perspectives Survey (ONSCPS) (Taylor, Highfield & Amenta, 1999)	Cronbach's α(1) Entire scale 0.75	Content validation with 3 researchers and 3 experts in the field. (1) Convergent (construct) validity supported with hypothesis testing as follows for Spiritual Caregiving: (columns: <u>Comfort</u> / <u>Increase Ability</u> / <u>Frequency</u>) <u>Positive Attitude</u> 0.51 0.46 0.43 <u>Increase Ability</u> 0.63 NR 0.58 <u>Increase Comfort</u> NR 0.63 0.50 <u>Perspective/ Belief</u> 0.43 0.45 0.50 $p < .001$	(1) Taylor, Highfield & Amenta (1999)

APPENDIX G

SOCIAL EXCHANGE THEORY & NURSING SPIRITUAL CARE CONCEPTS

Social Exchange Theory & Nursing Spiritual Care Concepts

Social Exchange Theory	Nursing Spiritual Care
Mutual trust and association	Interpersonal relationship, connection
Face to face exchange	Interpersonal relationship, connection
Supply and demand	Nurse and patient needs and resources (internal and external resources to provide and ability to receive spiritual care)
Cost-benefit analysis	Resources and benefits to nurse and patient
Service	Temporal and spiritual nursing care
Reciprocity	Mutuality, trust, relationships

APPENDIX H

POWER ANALYSIS

Power Analysis

t tests - Correlation: Point biserial model

Analysis: A priori: Compute required sample size

Input: Tail(s) =Two
Effect size |ρ|=0.3
α err prob=0.05
Power (1-β err prob) =0.80

Output: Noncentrality parameter δ=2.8477869
Critical t=1.9900634
Df=80
Total sample size=82
Actual power=0.8033045

APPENDIX I

LETTER TO CONTENT VALIDITY EXPERTS

Letter to Content Validity Experts

January 30, 2010

Dear Content Expert,

Thank you for your willingness to provide your expert evaluation of the two tools developed as part of my doctoral work. My research is focused on current nurse practitioner (NP) practice in primary care regarding the assessment of spiritual needs and provision of spiritual care to clients. This is being undertaken in order to better describe how NPs integrate spiritual care into their practice. Since the provision of spiritual care has been shown to improve client's health, it is important to examine how NPs integrate spiritual care into their practice and to potentially identify areas for future education.

The two tools were developed based on findings in the conceptual and research literature on spirituality and spiritual care. The NP Spiritual Assessment tool was developed from the nursing and psychiatry literature related to spirituality, oncology, cultural, and geriatric care. Phenomenological, conceptual, and quantitative articles provided support for the development of each question.

Spiritual care nursing interventions are focused on enabling clients to tap into inner resources to meet life's challenges and gain meaning, purpose, and insights into their health. In my research, spiritual care nursing interventions also imply both doing (action) and being (state). The Spiritual Care Interventions tool was developed from the nursing literature of parish nursing, doctoral nursing curriculum based on Newman's theory and reflective practice, and the spirituality nursing literature. Phenomenological, conceptual, and quantitative articles also provided support for the development of each question of this tool.

Please read each question and determine whether the question is essential, useful but not essential, or not essential to the purpose of the tool. Please make any comments if needed in the comment box with each question or at the end of the tool.

Please feel free to contact me at 616-392-3842 or vincensi@hope.edu if you have questions.

I would appreciate your feedback by February 15, 2010 if possible and again thank your for your input.

Peace,
Barbara Vincensi MSN RN FNP AHN-BC, PhD student
Marcella Niehoff School of Nursing
Loyola University, Chicago

January 30, 2010

Dear Content Validity Expert,

This is to request your assistance in participating as a content expert in my doctoral research related to spiritual care in nurse practitioner practice. Your expertise in spirituality/spiritual care as well as your expertise as a nurse practitioner is highly valued to help review two new tools related to spiritual assessment and spiritual intervention. Enclosed are both of those tools.

To complete the content validity portion of the study, please read each question and rate each question as essential, useful but not essential, or not essential. It will take approximately 20 minutes to complete the survey. A $10 Starbucks gift card is being sent via regular mail in appreciation of your time and effort.

Potential Benefits

There will be no direct benefits to you. However, this tool will further assist with assessing NPs' abilities in geriatric practice to 1) recognize certain patient behaviors as an indicator of a patient need for spiritual care; 2) further assess for spiritual care needs based on the recognition of these indicators; and 3) provide certain spiritual care interventions. This information will be used to guide NP graduate education.

Potential Risks

There is minimal risk to you if you participate. Participation is purely voluntary.
Your responses will be calculated as a group and used to make appropriate changes to the two tools. Responses will be confidential, and surveys will be stored in a locked file cabinet in the researcher's office. My academic advisor in the School of Nursing at Loyola University will have access to the data, Lisa Burkhart, PhD, RN as well as the statistician I am working with, Nathan Tintle, PhD, Math Department, Hope College, Holland, Michigan. Surveys will be destroyed after the study is completed. This study has been reviewed and approved by the Institutional Review Board at Loyola University Health System to ensure the protection of human rights.

If you have questions, please contact Barbara Vincensi MSN RN FNP at 616-392-3942 (bvincen@luc.edu). If you have questions regarding your rights as a participant please contact the Compliance Manager, Loyola University Health System at (708) 216-4608.Thank you for your time and consideration.

Sincerely,

Barbara Vincensi MSN RN FNP-BC , PhD Nursing Student
Marcella Niehoff School of Nursing
Loyola University Chicago

APPENDIX J

CONTENT VALIDITY SUMMARY: VSAT AND VSCIT

Content Validity Summary: VSAT AND VSCIT

SPIRITUAL ASSESSMENT (VSAT)

Content Validity Ratio (CVR) in Parentheses

Directions: NPs may identify spiritual needs in a variety of ways. One way may be that the patient displays, verbalizes, or expresses a need for spiritual care. In this case, the enclosed tool lists possible patient behaviors that may indicate a need for spiritual care. Please rate how essential each item is as a possible indicator for needing spiritual care.

Displayed, verbalized or expressed need for spiritual care	**Essential**	**Useful, but not essential**	**Not Essential**	**Comment**
Demonstrate difficulty coping with certain health concerns or diagnosis.	xx (-0.34)	xxxx (+0.34)		• This depends on the time frame. Initially this could be part of the healthy grieving, but protracted could indicate a problem. • Could be natural reaction to diagnosis not necessarily spiritual. • Can happen with many diagnoses.
Display a sense of helplessness.	xxxx (+0.34)	xx		• This may offer some insight into spiritual needs but can also be a personality stance or "way of being" in the world. • This depends

				on the time frame. Initially this could be part of the healthy grieving, but protracted could indicate a problem.
Cry during their visit.	xx (-0.34)	xx	x	• This may or may not be indicative of spiritual concerns, but the reason for crying is always important to explore. • This is not a good indicator- it's very cultural and also involved with gender role implementation issues. • So often seen with spiritual distress.
Appear to have lost meaning or purpose in life.	xxxxxx (+1.00)			• Should be ascertained by direct questioning and not just assumptions. • Essence of spiritual issues.
Appear to have become disconnected from relationships.	xxxx (+0.34)	xx		• Again timing is essential

				here- people may pull away and turn inward for a while, but if it's protracted, it's a problem. • Can be part of mental health issues.
No longer appear comfortable with accepting love from others.	xxx (0)	xxx		• Again have to see this in context of style before diagnosis. • Can be part of personality and mental health issues.
Are having difficulties forgiving.	xxx (0)	xxx		• Most significant is the lack of being able to forgive self- that usually is the better indicator of spiritual deficit. • Essential concept of many world religions. • Depends on the circumstances.
Are grieving over various losses, including health losses.	xxxx (+0.34)	x	x	• Proceeding through healthy grieving is appropriate. Spiritual

				support during this time is essential but the fact that a person is grieving doesn't indicate a spiritual deficit.
Verbalize fear or anxiety related to health concerns.	xx (-0.34)	xxxx		• Anyone in the "lion's den" is afraid, it's how they manage the fear that's the important spiritual indicator. • Could be natural reaction to diagnosis. • This is very common in general practice.
Express life has no meaning or purpose now.	xxxxxx (+1.00)			• Excellent one.
Display, verbalize, or express anger related to health.	x (-0.66)	xxxxx		• This may or may not relate to spiritual concerns, and is important to explore. • Again, depends on the timeline. • Could be natural reaction to diagnosis, not necessarily

				spiritual. • Again may be seen with multiple diagnosis.
Tell you they no longer are involved with spiritually or religiously related activities or rituals which have brought them peace, comfort, or a sense of connection in the past	xxxxxx (+1.00)			• A good indicator, but has to be tempered with the realization that drawing inward and trying to connect with God on a more personal level might be healing- and rejection of past practices that no longer fit may be OK. • Very important.
Mention directly they are interested in talking about their spiritual needs with someone.	xxxxxx (+1.00)			• The cry for help should NEVER be ignored. • An obvious clue that we wish was said more often.
Display a sense of hopelessness.	xxxxxx (+1.00)			• Faith and spirituality tend to give hope. This is essential.
Are having difficulties being forgiven.	xxxxx (+0.66)	x		• If you are saying here that they are having difficulty

				accepting forgiveness then I would say it is essential. If you are saying that they are not being forgiven by others or even "feeling" forgiven by others then I would say it is not essential. I would suggest changing the wording of this statement if you are wanting to get at the sense of whether they can accept forgiveness. • This is a hard one- lots depends on earlier patterns of behaviors. • Need sense of Higher Power to often feel forgiven.
In general, how often, if ever, do you believe you are able to recognize when your patients are in need of spiritual care?	xxx (0)			• 3 did not answer **Global indicator question**

Overall, do you have any comments about the tool?

SME#1: See comments in spiritual care interventions tool.

SME # 2: In my experience, the need for spiritual support and the grieving process are often intertwined. Your instrument gets at many behaviors that are synonymous with grieving. In my opinion, all grieving is better accomplished when a person has an adequate level of spiritual well-being. The concepts of hopelessness, hardiness, relationship and legacy (that of being remembered in a positive way by descendents) are ones that have worked well in my assessments.

The last question (16 in the actual assessment tool) you have here is an excellent one. In my experience, the key to being able to provide adequate spiritual care lies in the level of spiritual well-being that is experienced by the **care giver**. Thus, internal (intrapersonal) analysis is very important for (in our case) nurses who are working on doing accurate spiritual assessments of patients. Unless the nurse is comfortable with his/her inner sense of spiritual well-being, the exercise of assessment of the patient's state is pretty much doomed to superficial platitudes or well meaning but often ineffectual referrals rather than becoming an integral part of the care provided.

I have also found that the classic sense of spiritual relationship (that of the cruciform person→God and Person→Person) is quite culturally determined. My study in Appalachia with women demonstrated quite a different path to SWB (as did Peggy Burkhardt's) than the Augustinian sense of deep dive to nhil and then resurfacing. So, I think that there may be cultural aspects to your instruments that need to be considered. Particularly the views of Islam, Judaism, Hindu, Buddhism and Tao. While I hasten to say that spiritual wellbeing is not to be confused with religiosity, the concept of SWB (as you know), I have found, needs to be understood within the context of the culture of the individual. Even though that person may not practice the religion, if they come from a culture where religion was highly influential in its development (and who isn't from such a culture?) our assessment has to be flexible enough to accommodate the differences.

Your instrument strives to do just that, although if pressed I would identify a western emphasis on the items (not a criticism, just an observation).

In the questionnaire for NPs I do like the format. For both your instruments, I believe the elements are appropriate. In item 9, you might define if "touch" means placing the hand on the patient in a neutral spot (like the forearm) or can be construed as holding hands while praying or giving hugs.

I haven't read your proposal and so I am assuming that you are looking at patients with chronic illnesses rather than those who are in the acute dying process. As a Family Nurse Practitioner, I see the interaction of the NP with the family system as being lacking in your instruments, but it may be that your conceptual framework only uses family as context rather than as client. However, I think there should be some indication that the family's responses add a significant dynamic to the assessment and intervention

I hope this is helpful. I'd be glad to talk with you more as you further refine your instruments. I know that this is an arduous process!

SME # 3: I think this is a great tool. I might use the word "is" instead of "are" in the questions, as it works better with considering the patient as "singular."

All of these items can really be considered important in spiritual distress, but the ones I marked as useful, but not essential, can be seen in other circumstances that are not necessarily spiritual distress.

Also, the list of spiritual tools that are given are good, but I was not familiar with the first one. It might be useful to mention the author(s) of the tools, as people are often familiar with the author(s). Perhaps you should add one more conventional tool, as there are so many.

SME # 4 & #5: See comments above

Content Validity Summary
SPIRITUAL CARE INTERVENTIONS (VSCIT)

Content Validity Ratio in Parentheses

Attached is a tool that measures how often NPs provide spiritual care interventions. Please review the tool and evaluate how essential each item is in describing spiritual interventions in NP practice. Check the appropriate box.

Possible Spiritual Intervention	**Essential**	**Useful, but not essential**	**Not Essential**	**Comment**
I have listened to a client talk about their spiritual concerns.	xxxxxx (+1.00)			Wondering if the word encouraged is important, as in “encouraged to talk.” Makes the focus more on NP intervention
I have listened to a client talk about their recent spiritual insights as related to health and chronic disease.	xxxxx (+0.67)	x		Perhaps again “I have encouraged a client…”
I have actively listened to clients tell their story.	xxx (0)	xxx		Part of practice in general.
I have discussed with clients potential spiritual resources to help meet their needs in the community or institution setting.	xxxxxx (+1.00)			
I have provided support for clients’ spiritual practices.	xxxxx (+0.67)			Give a little more explanation for type of support. Not sure what

				you're getting at here.
I have arranged for a visit or made a referral to clients' clergy or spiritual mentors.	xxxxxx (+1.00)			Add word "a" to "a" client's.
I have encouraged my clients to talk about their spiritual challenges of living with chronic disease.	xxxxxx (+1.00)			Interesting; some might question what a spiritual challenge is.
I have offered to pray with a client.	xxxxx (+0.67)	x		Essential.
I have encouraged clients to talk about what gives their life meaning and purpose in the midst of chronic disease.	xxxxxx (+1.00)			Essential as part of spirituality- what gives meaning and purpose.
I have encouraged clients to talk about how chronic disease affects their relationship to God or whatever they determine is their Transcendent truth or reality.	xxxxxx (+1.00)			Wordy. Might use the words "Higher Power" instead of Transcen-dent truth or reality. More commonly used.
I have documented spiritual care I provided in clients' charts.	xxxxx (+0.67)	x		Good point, often not thought about.
I have discussed clients' spiritual care needs with colleagues.	xxxxx (+0.67)	x		Meaning colleagues also working with this client?
I have encouraged a client to talk about coping at the spiritual level.	xxxxxx (+1.00)			How about "coping using spirituality"
I use touch appropriately as spiritual	xxxx	x		Used in other

needs arise with clients.	(+0.34)			non-spiritual cases. Again, not sure what you're getting at here.
I have encouraged clients' to talk about their grieving as it relates to their health, chronic disease, and spiritual well-being.	xxxx (+0.34)	x		Doesn't need apostrophe after clients. Not sure this is a different concept than those listed out above.

Overall, do you have any comments about the tool?

SME # 1: In the previous tool (assessment) you ask several questions regarding relationships with others, particularly #'s 5, 6, 7, 15. It seems appropriate to include spiritual interventions related to those items in this tool. An example might be "I have discussed issues related to forgiveness of self and others with clients." or "I have encouraged clients to consider ways of healing discordant relationships**."**

SME # 2: (same as spiritual assessment)

SME # 3: I do like this tool. I think it is very innovative and I have not seen one focusing on such topics from the caregiver's point of view. Very original and creative tool. It might be useful to keep all the statements either singular (a client) or plural (clients) for consistency. The focus on geriatrics just seems to show up at the end. I think this tool is useful for anyone, but are you planning on just using it for geriatric practitioners in your study? It was not clear. Very nice work!

SME #4 & #5: See comments in spiritual assessment tool.

APPENDIX K

PARTICIPANTS' SURVEY PACKET

Participants' Survey Packet

March 20, 2010

Dear Colleague,

My name is Barbara Vincensi and I am currently a nurse practitioner and a doctoral nursing student at the Marcella Niehoff School of Nursing, Loyola University Chicago. I became interested in studying spiritual care through my practice as a nurse practitioner (NP) in primary care. Although the literature offered much on the provision of spiritual care by nurses and physicians, I found very little research rooted in the NP role.

The purpose of this descriptive study is to gain a better understanding of how NPs incorporate spiritual care into their practice, the association between NP practice and the provision of spiritual care, and the NPs' spiritual perspectives. This research is important for NPs because the literature indicates a relationship between spirituality and improved patient health dimensions. In addition, research also indicates that patients want spiritual care from their health care providers. This desire increases as chronic disease processes progress and as one ages. Based on this information, certified geriatric NPs have been identified as potential participants for this study.

I ask that you please take the time to read the information/consent letter and consider participating in this study. I would like to thank in advance for your time.

Sincerely,

Barbara Vincensi PhDc MSN FNP-BC
PhD Nursing Student
Marcella Niehoff School of Nursing,
Loyola University Chicago

March 20, 2010

Dear Nurse Practitioner Research Participant,

My name is Barbara Vincensi and I am currently a doctoral nursing student at the Marcella Niehoff School of Nursing, Loyola University in Chicago. As a member of AANP, you are invited to participate in this research study, which is part of my doctoral degree work. The purpose of this study is to gain a better understanding of the association between spiritual perspectives of Nurse Practitioners (NPs) and the types of nursing spiritual assessments and interventions commonly used in geriatric practice. Your participation is important whether or not you believe you provide spiritual care.

To participate in this NP study, please fill-out the attached survey and demographic information sheet and return it in the enclosed, self-addressed, stamped envelope. It will take approximately 20 minutes to complete the survey. A $10 gift card has been included in appreciation of your time. In addition, if you would like the results of the survey, please contact me at bvincen@luc.edu with your contact information.

Potential Benefits
You will not directly benefit from participating in this study. However, the results of this study will be used to determine whether there is a relationship between NPs spiritual perspectives and the types of nursing assessment and interventions commonly performed. Results of this study will help inform graduate nursing NP education.

Potential Risks
This is a minimal risk study. Participation in this study is purely voluntary. You can withdraw from this study at any time. You may skip any questions you do not want to answer. Participation in this research will not affect your membership in professional organizations.

Do not put your name on the survey. All data will be coded by number, statistically analyzed in aggregate, and presented in aggregate. No findings will be linked to a specific research participant. Responses will be kept confidential and surveys will be stored in a locked file cabinet in the researcher's office. My academic advisor in the School of Nursing at Loyola University will have access to the data, Lisa Burkhart, PhD, RN as well as the statistician I am working with, Nathan Tintle, PhD, Math Department, Hope College, Holland, Michigan. Surveys will be destroyed after the study is completed. This study has been reviewed and approved by the Institutional Review Board at Loyola University Health System to ensure the protection of human rights. Completing and returning the survey implies that you agree to participate in the study.

If you have questions, please contact Barbara Vincensi MSN RN FNP at 616-392-3842 (bvincen@luc.edu). If you have questions regarding your rights as a research participant please contact the Compliance Manager, Loyola University Health System at (708) 216-4608.Thank you for your time and consideration.

Sincerely,

Barbara Vincensi PhDc MSN FNP-BC, PhD Nursing Student
Marcella Niehoff School of Nursing,
Loyola University Chicago

SPIRITUAL PERSPECTIVE SCALE ©Reed, 1986 Code No.______

Introduction and Directions: In general, spirituality refers to an awareness of one's inner self and a sense of connection to a higher being, nature, others, or to some purpose greater than oneself. The Spiritual Perspective Scale below includes 10 questions designed to assess a person's spiritual perspectives. There are no right or wrong answers. Answer each question to the best of your ability by marking an "X" in the space above that group of words that best describes you. All responses are confidential.

1. In talking with your family or friends, how often do you mention spiritual matters?

____________/____________/___________/___________/_____________/___________

Not at all | Less than once a year | About once a year | About once a month | About once a week | About once a day

2. How often do you share with others the problems and joys of living according to your spiritual beliefs?

____________/____________/____________/___________/___________/___________

Not at all | Less than once a year | About once a year | About once a month | About once a week | About once a day

3. How often do you read spiritually-related material?

____________/____________/_____________/____________/____________/___________

Not at all | Less than once a year | About once a year | About once a month | About once a week | About once a day

4. How often do you engage in private prayer or meditation?

____________/____________/_____________/____________/____________/___________

Not at all | Less than once a year | About once a year | About once a month | About once a week | About once a day

Directions: Indicate the degree to which you agree or disagree with the following statements by marking an "X" in the space above the words that best describe you.

5. Forgiveness is an important part of my spirituality.

____________/__________/____________/____________/____________/___________

Strongly Disagree | Disagree | Disagree more than agree | Agree more than disagree | Agree | Strongly Agree

6. I seek spiritual guidance in making decisions in my everyday life.

_________/_________/___________/__________/___________/____________

Strongly Disagree | Disagree | Disagree more than agree | Agree more than disagree | Agree | Strongly Agree

7. My spirituality is a significant part of my life.

____________/____________/_____________/____________/____________/___________Strongly
Disagree Disagree more Agree more Agree Strongly
Disagree than agree than disagree Agree

8. I frequently feel very close to God or a "higher power" in prayer, during public worship or at important moments in my daily life.

____________/___________/_____________/____________/____________/____________
Strongly Disagree Disagree more Agree more Agree Strongly Agree
Disagree than agree than disagree

9. My spiritual views have had an influence upon my life.

____________/____________/_____________/____________/____________/___________
Strongly Disagree Disagree more Agree more Agree Strongly Agree
Disagree than agree than disagree

10. My spirituality is especially important to me because it answers many questions about the meaning of life.

____________/____________/_____________/____________/____________/___________
Strongly Disagree Disagree more Agree more Agree Strongly Agree
Disagree than agree than disagree

If possible, please describe how you define spirituality, or provide any other comments you feel are important for the researcher to know about.
Thank you for completing the SPS.

Code No.______ **Vincensi Spiritual Assessment (VSAT)**

This survey is designed to assess how often nurse practitioners in clinical practice might recognize cues to determine if a patient might have spiritual needs. The following lists possible patient cues for needing spiritual care. Rate how likely you would recognize this behavior as an indicator of a client's need for spiritual care and then rate how likely you would further assess each possible cue if the patient displayed that behavior. There are no right or wrong answers. All responses are confidential. For each item, circle the most appropriate response as it applies to your practice.

Displayed, verbalized, or expressed patient behavior	**How likely would you recognize this behavior as an indicator of a client's need for spiritual care?**	**If a patient displayed this behavior, how likely would you further assess spiritual care needs?**
1. Appears to have lost meaning or purpose in life.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always
2. Displays a sense of helplessness.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always
3. Is having difficulties accepting forgiveness.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always
4. Displays a sense of hopelessness.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always
5. Appears to have become disconnected from relationships.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always
6. Is grieving over various losses, including health losses.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always
7. Expresses that life has no meaning or purpose now.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always
8. Tells you they no longer are involved with spiritually or	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always

religiously related activities or rituals which have brought them peace, comfort, or a sense of connection in past.		
9. Mentions directly they are interested in talking about their spiritual needs with someone.	1 2 3 4 5 Never Sometimes Always	1 2 3 4 5 N/A Never Sometimes Always

II. Please circle the answer in the statement which best describes your nurse practitioner practice.

10. In general, how often, if ever, do you believe you are able to recognize when your clients are in need of spiritual care

1 2 3 4 5 N/A
Never Sometimes Always

III. There are formal tools available to use to assess spiritual care needs of patients. Please answer the following questions related to your practice as a NP working with geriatric patients.

11. Have you ever used a tool or rating scale to assess a patient's spiritual needs?
Yes______ No________

If Yes, please check which of the following ones:

_____ **FACIT-Sp** (Functional Assessment of Chronic Illness Therapy-Spiritual well-being scale) (Cella)

_____ **FICA** (**F**aith/Spirituality, **I**mportance of faith/spirituality, belong to a faith **C**ommunity, how should heath care provider **A**ddress concerns) (Puchalski & Romer)

_____ **SIWB** (Spirituality Index of Well-being) (Daaleman & Frey)

_____ **SWB** (Spiritual Well-being scale) (Paloutziain & Ellison)

_____ **SPS** (Spiritual Perspective Scale) (Reed)

_____ **Other**(list)____

IV. Is there any other information you would like to share with the researcher?

Code No. ______ Vincensi Spiritual Care Interventions Tool (VSCIT)

This scale is designed to identify how often NPs provide certain interventions. Please identify how frequently you perform the following interventions in your NP practice. There are no right or wrong answers. All responses are confidential.

Item	Response
1. I have encouraged clients to talk about their spiritual concerns.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
2. I have encouraged clients to talk about their recent spiritual insights as related to health and chronic disease.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
3. I have encouraged clients to talk about their spiritual difficulties of living with chronic disease.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
4. I have encouraged clients to talk about what gives their life meaning and purpose in the midst of chronic disease.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
5. I have encouraged clients to think about ways to heal relationships in which they are experiencing dissonance.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
6. I have encouraged clients to talk about how chronic disease affects their relationship with God or a Higher Power.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
7. I have documented the spiritual care I provided in clients' charts.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
8. I have discussed a client's spiritual care needs with other health care providers as it impacts the client's health.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A
9. I use touch appropriately as spiritual needs arise with clients.	1 Never, 2 Rarely, 3 Sometimes, 4 Frequent, 5 Always, N/A

Item	1 Never	2 Rarely	3 Sometimes	4 Frequent	5 Always	N/A
10. I have encouraged clients to talk about their grieving as it relates to their health, chronic disease, and spiritual well-being.	1	2	3	4	5	N/A

II. Upon request from clients I have done the following:

Item	1 Never	2 Rarely	3 Sometimes	4 Frequent	5 Always	N/A
11. In the primary care setting, I have discussed with clients potential spiritual resources in the community to help meet their spiritual care needs.	1	2	3	4	5	N/A
12. I have provided support for clients' spiritual practices.	1	2	3	4	5	N/A
13. I have arranged for a visit or made a referral to clients' clergy or spiritual mentors.	1	2	3	4	5	N/A
16. I have offered to pray with clients.	1	2	3	4	5	N/A
17. I have encouraged clients to cope using spiritual practices or spirituality.	1	2	3	4	5	N/A

III. Please share any thing else you believe is important regarding spiritual care interventions in nurse practitioner practice.

Demographic Data

Please check or provide the appropriate information.

Gender: M____ F____ What year were you born? __________

Race/Ethnicity:

Hispanic______ Non-Hispanic______
Black/African-American______ Asian______
White______ Native Hawaiian/Other Pacific Islander ___
Other______ American Indian/Alaskan Native_______

Religious Affiliation:

Evangelical______ African-American/Black Churches_______
Catholic______ Mormon ______
Orthodox ______ Jewish ______
Muslim ______ Buddhist ______
Other Christians ______ Jehovah's Witness ______
Unaffiliated ______ None ______
Other (please identify) ____

Years in Practice as a RN prior to Nurse Practitioner certification: ________

Years in Practice as a Gerontological Nurse Practitioner: ________________

Are you presently practicing as a Gerontological Nurse Practitioner? Yes _ No _

If yes, please describe:

Full time __ Part time __ Currently not employed __ Not practicing anymore ___

Nurse Practitioner education:

Masters ____ DNP____
Post master's certificate_____ Other (please specify) ____

Did your undergraduate education provide you with education on how to provide spiritual care: Yes ___ No ___

Did your graduate education provide you with education on how to provide spiritual care: Yes___ No ___

Have you sought out education in spirituality/spiritual care beyond undergraduate or graduate education: Yes ___ No ___

Thank you for completing this survey

APPENDIX L

COMPARISON OF RECOMMENDED COMPETENCIES AND CURRICULUM FOR NURSE PRACTITIONERS IN GERIATRIC CARE

Organizations	*American Association of Colleges of Nursing:* **The Essentials of MSN Education for Graduate Core Curriculum Content & Advanced Practice (1995).** **The Essentials of Doctoral Education for Advanced Nursing Practice (2006). (**The DNP is built upon the generalist foundation acquired through an advanced generalist master's in nursing.)	*National Organization of Nurse Practitioner Faculties:* **General Domains and Core Competencies of Nurse Practitioner Practice (2002).** **Primary Care Competencies in Specialty Areas (2006).**	*Hartford Geriatric Nursing Initiative:* **Nurse Practitioner Competencies for Older Adult Care (2004).**

	American Association of Colleges of Nursing	*National Organization of Nurse Practitioner Faculties*	*Hartford Geriatric Nursing Initiative*
Relationship to self & others	**DNP Essential VIII: Advanced Nursing Practice** (2006) • Develop and sustain therapeutic relationships and partnerships with patients (individual, family or group) and other professionals to facilitate optimal care and patient outcomes.	**Gerontological Nurse Practitioner Specialty Competencies** **II. NP-Patient Relationship** Competencies in this area demonstrate the personal, collegial, and collaborative approach which enhances the gerontological nurse practitioner's effectiveness of patient care. The competencies speak to the critical importance of interpersonal transactions as they relate to therapeutic patient outcomes. • assists older adults and their families in dealing with grief and bereavement	**Competency II: NP-Patient Relationship** Competencies in this area demonstrate the personal, collegial, and collaborative approach which enhances the NP's effectiveness in providing patient care to the geriatric population. These competencies stress the critical importance of interpersonal transactions as they relate to therapeutic patient outcomes. • Develop caring relationships with patients, families and other caregivers to address sensitive issues.

	American Association of Colleges of Nursing	*National Organization of Nurse Practitioner Faculties*	*Hartford Geriatric Nursing Initiative*
Relationship to self & others		**Domain II: NP-patient relationship core competencies** (2006) ■ uses self-reflection to further a therapeutic relationship ■ negotiates a mutually acceptable plan of care ■ respects the patient's inherent worth and dignity ■ creates a climate of mutual trust ■ provides comfort and emotional support	

	American Association of Colleges of Nursing	*National Organization of Nurse Practitioner Faculties*	*Hartford Geriatric Nursing Initiative*
Holistic Care	**MSN Essential VII. Health Promotion and Disease Prevention** ■ develop and monitor comprehensive, holistic plans of care that addresses health promotion and disease prevention		**Competency I: Health Promotion, Health Protection, Disease Prevention, and Treatment.** **C. Plan of Care:** Prevent or work to reduce common risk and environmental factors that contribute to: ■ decline in physical functioning ■ impaired quality of life ■ social isolation ■ excess disability in older adults

	American Association of Colleges of Nursing	*National Organization of Nurse Practitioner Faculties*	*Hartford Geriatric Nursing Initiative*
Cultural & Spiritual	**MSN Essential VI. Human Diversity & Social Issues** ■ develop, design and implement culturally competent health care	**Domain VI: Culturally Sensitive Care core competency** ■ incorporates patient's spiritual beliefs in care ■ assists patients and families to meet their spiritual needs	**Competency VII: Cultural & Spiritual Competence** ■ assess patients' and caregivers' cultural and spiritual priorities as part of a holistic assessment ■ incorporate culturally and spiritually appropriate resources into the planning and delivery of health care

APPENDIX M

CONTENT ANALYSIS: DIRECT QUOTES AND MEANING UNITS MAPPED INTO RESEARCH DEFINITION

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
16. I do not consider myself spiritual but I consider myself moral. I am thinking of my strong moral and ethical beliefs and practices as spiritual in some sense. My beliefs are not grounded in religious instructions but in a highly developed respect for life, human rights, and our (Human) need to live our lives in harmony. But I don't discuss my beliefs in a spiritual or religious sense. Hence some of my answers.	not grounded in religious instructions need to live in harmony	Not religious Harmony
18. Spirituality –belief in something bigger than yourself. A way of living/acting to promote the greater good. Sort of like a morality "do unto others" motto trying to look at the good in people – that everyone has pain in their life that influences their behavior.	belief in something bigger than yourself	Connection to Higher Being
99. Spirituality is a belief that a higher power can have an influence on all aspects of your life.	belief that a higher power can have an influence on all aspects of your life	Connection to a Higher Power Connection to self
269 I am a Catholic Christian and have a strong faith in God. My spirituality rests in that faith, specifically seeking truthful answers to all life's questions.	strong faith in God spirituality rests in that faith seeking truthful answers to all life's questions	Connection to God Spirituality is expressed through religion (faith in God) Self-Connection

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
173. Spirituality is a guide for my actions. I believe that the way I treat others is paid forward. Protecting those less able to protect themselves, such as animals, is an important part of my belief in a "higher power." But I don't think of that "higher power" in day-to-day life.	protecting those less able to protect themselves, such as animals belief in a 'higher power' totality of the picture	Connection to nature Connection with a Higher Power Total picture
87. Understanding the totality of the picture, by whatever means, extending beyond the here and now and emotions at the moment.	extending beyond the here and now	Transcendence
24. My daily prayer is to seek God's favor in my life.	prayer seek God's favor	Religious rituals Seek connection to God
15. Spirituality is a connection to your emotional and physical life. All three work together to provide holistic health. To ignore your spirituality is a disconnect to health.	connection to emotional and physical life all three work to provide holistic health ignore spirituality, disconnect to health belief of someone/something greater	Holistic Promoting reconnection of body, mind, and spirit. Spirituality is a resource for health

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
29. Spirituality is my belief of someone/something greater. Belief of life after death. Belief in doing good.	belief of life after death.	Connection to a Higher Power Transcendence
4. As a Christian, spirituality is a definition by man that describes a relationship between him and his higher power.	relationship between man and his higher power	Connection to a Higher Power
7. Spirituality is knowing that there is something higher than myself, knowing that this higher being is besides me daily.	knowing there is something higher than myself higher being with me daily	Connection to a Higher Being Connection to a Higher Being
114 Spirituality to me is the "spirit" working within you- how you use/practice your connection to that "higher power" in your everyday life.	spirit working in you connection to a higher power use/practice your connection to higher power	Connection to a Higher Power Connection to Self Connection to a Higher Power Connection to a Higher Power
276 Spirituality-Calmness of the ocean, blueness of the sky, deepest values, belief in something beyond the physical beyond the here and now, peace within, saying the rosary.	calmness of ocean, blue sky beyond the physical and the here and now	Connection to nature

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
	peace within saying the rosary	Transcendence Sense of well-being
100 A personal relationship with Jesus Christ. I don't read daily but listen to spiritual radio programs daily on commute. I see nursing as my vocation and the path where I do my best to serve God!	personal relationship with Jesus listen to spiritual radio programs nursing as vocation and path to serve God	Religious ritual Connection with God Connect with others/ world around us/ music
201 Spirituality is the belief in higher power that we need to rejuvenate our souls with love of God. Strive to maintain a balance between body mind and soul.	belief in higher power higher power rejuvenates us with love balance between body mind soul	Connection to God Connection with a Higher Power Connection to a Higher Power Restores balance between body mind soul
75 Spirituality means a personal relationship with God and depending solely on him for my daily needs; by reading and studying his word and daily prayer. I pray daily for my performance at work and at home, that I will be a witness to others and especially to my	personal relationship with God reading and studying God's	Connection with God

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
patients. I also pray for them daily before or after work, as well as in the exam room when I feel led to do so or if they request it. I could never have continued to remain active if not for the blessings from God to keep me well and health. I own my nurse practitioner clinic and have been fortunate and blessed to employ Christian people as providers and as my ancillary staff. At age 71, I work 2-3 days a week and continue to really enjoy my work. May God bless you as you do this research. 86. Spirituality to me is a connection to a higher power, to me God. It is having a feeling of peace knowing there is an all knowing all loving father like figure who is watching over me in this life and who I will be with in the "after" life. 107. I define spirituality as faith in a higher being. To me there are no coincidences. Everything happens for a reason. There are things we don't understand but my "faith" guides me and comforts me. I know at the end of each day that God guided my thoughts and actions and he holds me in the palm of his hand. I know beyond a shadow of a doubt that he is guiding and protecting me. I know this because I have "faith."	word prayer connection to God/all knowing all loving father like figure feeling of peace will be with God in the after life. faith in higher being guides my thoughts and actions comforts me	Connection to God Religious ritual Connection with God Sense of well-being Transcendence Connection to a Higher Being

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
176 I frequently tell my patients I will either say a prayer for them or keep them in my prayers. Clearly there is a higher power and it is comforting. I pray everyday that I know what is right and that I do what is right.	higher power prayer pray to know what is right and do what is right	Presence of a Higher Power Religious ritual Religious ritual
203. "Spirituality" refers to the part of oneself that is connected to something greater than oneself. For me personally, this is my connection to God, ie Jesus Christ.	connected to something greater than self, God	Connection to God
199. Very similar to the documented definition prior page.		
133. I don't define myself as spiritual because I have been an atheist most of my adult life. However, I am firmly grounded in the philosophy of Humanism (or describe myself as a humanist) in terms of how I relate to others and how I judge myself. I try to connect with patients immediately (our encounters tend to be brief and often only once) and provide the best service and plan that I am capable of. Did I treat that person the best that I could? Those are the types of things that guide me.	connect with patients and others	Connection to others

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
236. I define spirituality as a sense of a higher being who looks over my life and leads me in the right path. Spirituality is knowing that your life has a higher purpose.	higher being leads me in the right path knowing your life has a higher purpose	Connection to a Higher Being Higher purpose in life
106. Sense of well-being, calm.	sense of well-being	Sense of well-being
97 Belief and/or connection with God.	connection to God	Connections with God
284 Spirituality is a sense of connectedness to nature, self and others. To me it is the fullness and joy I have experienced feeling my 1st grandchild's movement in my daughter's womb. It is the sense of peace esp. as I reflect at the end of the day (most days) of being able to connect and "hear" the needs of my patients and their family members. It is the sense of satisfaction when a family/spouse finally gets it. That may be that the dementia will not get better and that comfort and care are the most important ministrations at this phase of life. It is the ability to "touch" the life of another person and make a difference in their life. It also makes a difference in mine- a reinforcer to take the extra step/effort forward the "healing' of the person/family unit.	connections to: nature, self, others fullness peace healing	Connections to nature Connections to self Connections to others

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
152 Spirituality is the way in which we realize our interconnectedness with the "Ground of All Beings" and the rest of creation. It is our way of getting past our ego. As soon as I speak of "spirituality" or of "God" I realize that the words do not work. If I say something of God—the opposite is likely just as true. We can not know in the usual sense. I was raised Roman Catholic and continue to practice although my beliefs vary widely from official teachings.	interconnectedness with the "Ground of all Beings" (consciousness; researcher's addition) and the rest of creation.	Connections to nature Connections to self Connections to others Fulfillment
233 Spirituality is the willingness to accept and believe in a higher being. To know that there is a greater power than ourselves.	belief in a higher being.	Sense of well-being Making whole
101. I don't consider myself a spiritual person. I don't believe in a higher being. I meditate regularly but to find inner awareness and calmness.		Connections to the world/ environment, others.
229 Spirituality it is the greatest power of the universe. It is perfection, love and goodness. It is what I have failed at many times in my life, but it is what I strive to emulate each day. My spirituality is culminated in the St Francis Prayer.	meditation, finding inner awareness and calm	Connections to God/Higher Power/ Transcendent

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Mapped into Research Definition
212 Spirituality is the belief/faith that something – an energy, a being(s)- exists. This something is not able to be measured or quantified, this is why it takes faith. This power has the ability to influence the goings on in the world that we can observe. People's ability to pray (or use their spiritual beliefs) can influence certain things. The higher being/energy is complex and not easily understood which is why I believe there are so many religions. Each one struggles to find ways to help us wrap our minds around a sometimes incomprehensible force. I don't subscribe to any particular religion as I believe most strive for the same thing – help us treat each other better. My beliefs and spirituality help me to provide open-minded support to my patients.	power of the universe prayer non-measurable energy or higher being exists is complex, not easily understood prayer/spiritual beliefs can influence things spirituality helps provide open-minded support to other	Connections to self Connection with a Higher Being Connection to self (intrapersonal relationship) Sense of a Higher Power Religious ritual Non-measurable energy Religious ritual Connection to others
124. I believe that everyone has a right to their own spirituality and level of participation in that.	a right to their own spirituality and participation in it	Individual

APPENDIX N

CONTENT ANALYSIS: DIRECT QUOTES AND MEANING UNITS WHICH DID NOT MAP INTO RESEARCH DEFINITION

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Which Did Not Map Into Research Definition
16. I do not consider myself spiritual but I consider myself moral. I am thinking of my strong moral and ethical beliefs and practices as spiritual in some sense. My beliefs are not grounded in religious instructions but in a highly developed respect for life, human rights, and our (Human) need to live our lives in harmony. But I don't discuss my beliefs in a spiritual or religious sense. Hence some of my answers.	moral and ethical beliefs as spiritual practice highly developed respect for life, human rights, and our (Human) needs	Moral and ethical beliefs as spiritual practice Respect for human life, rights, needs
18. Spirituality – belief in something bigger than yourself. A way of living/acting to promote the greater good. Sort of like a morality "do unto others" motto trying to look at the good in people – that everyone has pain in their life that influences their behavior.	a way of living/acting to promote the greater good. Sort of like a morality "do unto others" pain in life that influences behavior	Moral living/acting for the greater good of others Moral and ethical issues of pain in life
173. Spirituality is a guide for my actions. I believe that the way I treat others is paid forward. Protecting those less able to protect themselves, such as animals, is an important part of my belief in a 'higher power.' But I don't think of that "higher power ' in day to day life.	guide for my actions	Guides actions
29. Spirituality is my belief of someone/something greater. Belief of life after death. Belief in doing good.	Belief in doing good	Doing good

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Which Did Not Map Into Research Definition
276 Spirituality-Calmness of the ocean, blueness of the sky, deepest values, belief in something beyond the physical beyond the here and now, peace within, saying the rosary	deepest values	Deep moral and ethical sense
201 Spirituality is the belief in higher power that we need to rejuvenate our souls with love of God. Strive to maintain a balance between body mind and soul.	Rejuvenate our souls with love	Meets human needs
107. I define spirituality as faith in a higher being. To me there are no coincidences. Everything happens for a reason. There are things we don't understand but my "faith" guides me and comforts me. I know at the end of each day that God guided my thoughts and actions and he holds me in the palm of his hand. I know beyond a shadow of a doubt that he is guiding and protecting me. I know this because I have "faith."	guides my thoughts and actions comforts me	Guides thought and action Meets human needs
176 I frequently tell my patients I will either say a prayer for them or keep them in my prayers. Clearly there is a higher power and it is comforting. I pray everyday that I know what is right and that I do what is right.	comfort pray to know what is right and do what is right	Meets human needs to know what is right and to do what is right
236. I define spirituality as a sense of a higher being who looks over my life and leads me in the right path. Spirituality is knowing that your life has a higher purpose.	knowing your life has a higher purpose	Higher purpose

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Which Did Not Map Into Research Definition
133. I don't define myself as spiritual because I have been an atheist most of my adult life. However, I am firmly grounded in the philosophy of Humanism (or describe myself as a humanist) in terms of how I relate to others and how I judge myself. I try to connect with patients immediately (our encounters tend to be brief and often only once) and provide the best service and plan that I am capable of. Did I treat that person the best that I could? Those are the types of things that guide me.	guidance in how to treat others humanist philosophical approach (from atheist perspective)	Guide in how to treat others Philosophical non-religious approach
106. Sense of well-being, calm.	calm	Provides for a human need
229 Spirituality it is the greatest power of the universe. It is perfection, love and goodness. It is what I have failed at many times in my life, but it is what I strive to emulate each day. My spirituality is culminated in the St Francis Prayer.	love goodness	Human need Related to morals and ethics
284 Spirituality is a sense of connectedness to nature, self and others. To me it is the fullness and joy I have experienced feeling my 1st grandchild's movement in my daughter's womb. It is the sense of peace esp. as I reflect at the end of the day (most days) of being able to connect and "hear" the needs of my patients and their family members. It is the sense of satisfaction when a family/spouse finally gets it. That may be that the dementia will not get better and that comfort and care are the most	joy	meets a human need

Sampling Units (Direct Quotes)	Meaning Units	Data Meaning Units Which Did Not Map Into Research Definition
important ministrations at this phase of life. It is the ability to "touch" the life of another person and make a difference in their life. It also makes a difference in mine- a reinforcer to take the extra step/effort forward the "healing" of the person/family unit.		

REFERENCE LIST

Achterberg, J. (1990). *Woman as healer.* Boston: Shambhala Publications, Inc.

Allport, G., & Ross, J. (1967) Personal religious orientation and prejudice. *Journal of Personality and Social Psychology, 5*(4), 432-443. doi:10.1037/h0021212 .

American Association of Colleges of Nursing (AACN). (2006). *The essentials of doctoral education for advanced nursing practice*. Retrieved from http://www.aacn.nche.edu/DNP/pdf/Essentials.pdf.

American Association of Colleges of Nursing (AACN). (1995). *The essentials of MSN education for graduate core curriculum content & advanced practice.* Retrieved from http://www.aacn.nche.edu/.

American Association of Colleges of Nursing and The John A. Hartford Foundation. (2004). Nurse practitioner and clinical nurse specialist competencies for older adult care. In the *Hartford Geriatric Nursing Initiative*. Retrieved from http://www.aacn.nche.edu/education/pdf/apncompetencies.pdf.

American Nurses Association (ANA). (2001). *Code of ethics for nurses with interpretive statements.* Silver Springs, Md.: Nursebooks.org.

American Nurses Association. (2003). *Social policy statement*. Silver Springs, Md.: Nursebooks.org.

Armstrong, G. (1998). Parametric statistics and ordinal data: A pervasive misconception. *Nursing Research, 30*, 60-62.

Arnold, S., Herrick, L., Pankratz, V., & Mueller, P. (2007). Spiritual well-being, emotional distress, and perception of health after myocardial infarction. *Internet Journal of Advanced Nursing Practice 9*, (1), 4. Retrieved from: http://search.ebscohost.

Berry, D. (2005). Methodological pitfalls in the study of religiosity and spirituality. *Western Journal of Nursing Research, 27* (5), 628-647.

Bingham, V., & Habermann, B. (2006). The influence of spirituality on family management of Parkinson’s disease. *Journal of Neuroscience Nursing, 38* (1), 422-427.

Boland, C. (2000). Social support and spiritual well-being: empowering older adults to commit to health-promoting behaviors. *Journal of Multicultural Nursing Health.* Retrieved from http://findarticles.com/p/articles/mi_qa3919/is_200010 /ai_n8913042.

Brady, M., Peterman, A., Fitchett, G., Mo, M., & Cella, D. (2000). A case for including spirituality in quality of life measurement in oncology. *Psycho-Oncology: Journal of the Psychological, Social, and Behavioral Dimensions of Cancer, 8 (5), 417-428.* doi: 10.1002/(SICI)1099-1611(199909/10) 8:5<417::AID-PON398>3.0.CO;2-4

Buck, H. (2006). Spirituality: concept analysis and model development. *Holistic Nursing Practice, 20*(6), 288-292.

Bulechek, G., Butcher, H., & McCloskey Dochterman, J. (2007). *Nursing interventions classifications (NIC)*. St Louis: Mosby.

Burkhart, L. (2001). Notes on NDEC: report from the spirituality and religiousness diagnosis working group. *Nursing Diagnosis, 12* (2), 61-62.

Burkhart, L., & Hogan, N. (2008). An experiential theory of spiritual care in nursing practice. *Qualitative Health Research, 18 (*7), 928 - 938.

Burkhart, L., & Solari-Twadell, P. (2001). Spirituality and religiousness: differentiating the diagnoses through a review of the nursing literature. *Nursing Diagnosis, 12* (2), 45-54.

Callaghan. D. (2006). The influence of growth on spiritual self-care agency in an older adult population. *Journal of Gerontological Nursing.32* (9), 43-51.

Carroll, B. (2001). A phenomenological exploration of the nature of spirituality and spiritual care. *Mortality, 6*(1), 81-98.

Cavendish, R., Konecny, L., Naradovy, L., Luise, B., Como, J., Okumakpeyi, P., Mitzeliotis, C., & Lanza, M. (2006). Patients’ Perceptions of Spirituality and the Nurse as a Spiritual Care Provider. *Holistic Nursing Practice*, *20* (1), 41-47.

Cavendish, R., Luise, G., Horne, K., Bauer, M., Medefindt, J., Gallo, M., Calvino,C., & Kutza, T. (2000). Opportunities for enhanced spirituality relevant to well adults. *Nursing Diagnosis, 11* (4), 151-163.

Chao, C. Chen, C. Yen, M. (2002). The essence of spirituality in terminally ill patients. *Journal of Nursing Research, 10* (4), 237-244.

Chong-ho, Y. (2009). Do subjects tell the truth? Reliability of self-report data. Retrieved from http://www.creative-wisdom.com/teaching/WBI/memory.shtml

Como, J. (2007). Spiritual practice: a literature review related to spiritual health and health outcomes. *Holistic Nursing Practice, 21*(5), 224 – 237.

Connelly, R. & Light, K. (2003). Exploring the "new" frontier of spirituality in health care: identifying the dangers. *Journal of Religion and Health, 42*(1), 35– 46.

Conner, N., & Eller, L. (2004). Spiritual perspectives, needs and nursing interventions of Christian African-Americans. *Journal of Advanced Nursing, 46* (6), 624-632.

Cooper, L., Brown, C., Hong, T., Ford, F., & Powe, N. ((2001). How important is intrinsic spirituality in depression care? A comparison of White and African-American primary care patients. *Journal of General Internal Medicine, 16*, 634-638.

Council of State Governments. (2006). *Costs of chronic diseases: what are the states facing?* Washington, DC: Government Printing Office.

Daaleman, T., & Frey, B. (2004). The spirituality index of well-being: a new instrument for health-related quality-of-life research. *Annals of Family Medicine, 2* (5), 499-503.

Daaleman, T., Perera, S., Studenski, S., (2004) Religion, spirituality and health status in geriatric outpatients. *Annals of Family Medicine, 2* (1), 49-53. doi: 10.1370/afm.20.

Dailey, D., & Steward, A. L. (2007). Psychometric characteristics of the Spiritual Perspective Scale in pregnant African-American women. *Research in Nursing & Health, 30*, 61-71.

DeLaune, S. (2006). *Fundamentals of Nursing: Standards and Practice.* Clifton Park, New York: Thomson Delmar Learning.

Donohue, R. (2003). Nurse practitioner-client interaction as resource exchange in a women's health clinic: an exploratory study. *Journal of Clinical Nursing, 12*, 717-725.

Dossey, B., Keegan, L., & Guzzetta, C. (2005). *Holistic Nursing: a Handbook for Practice*. Sudbury, Massachusetts: Jones and Bartlett.

Ellis, M., Vinson, D., & Ewigman, B. (1999). Addressing spiritual concerns of patients: Family physicians attitudes and practices. *Journal of Family Practice, 48* (2), 105-109.

Elkins, M. & Cavendish, R. (2004). Developing a plan for pediatric spiritual care. *Holistic Nursing Practice, 18* (4), 179-184.

El-Nimr, G., Green, L., & Salib, E. (2004). Spiritual care in psychiatry: Professionals' views. *Mental Health, Religion and Culture, 7* (2), 165 – 170.

Emotional and Spiritual Care Committee of the National Voluntary Organizations Active in Disaster, (2004). *Spiritual care, a working document.* Retrieved from http://www.nvoad.org/articles/ESCCchaptersB.pdf.

Fawcett, T., & Noble, A. (2004). The challenge of spiritual care in a multi-faith society as experienced as a Christian nurse. *Clinical Nursing Issues, 13,* 136-142.

Finkelstein, D., Harper, D., & Rosenthal, G. (1998). Does length of hospital stay during labor and delivery influence patient satisfaction? Results from a regional study. *American Journal of Managed Care, 4* (12), 1701 – 1708.

Frey, B., Daaleman, T., Peyton, V. (2005). Measuring a dimension of spirituality for health research. *Research on Aging, 27* (5), 556 -577. doi: 10.1177/01640275277847.

Friedemann, M., Mouch, J., & Racey, T. (2002). Nursing the spirit: The framework of systemic organization. *Journal of Advanced Nursing, 39* (4), 325-332.

Gaskamp, C., Sutter, R., & Meraviglia, M. (2006). Evidence-based guidelines: Promoting spirituality in the older adult. *Journal of Gerontological Nursing,* 8-13.

Gilbert, P. (2007). Spirituality and mental health: a very preliminary overview. *Current Opinions in Psychiatry*, *20* (6), 594-598.

Gill, S. (2005). Spirituality and religion in multiethnic palliative care. *Cancer Nursing Practice, 4* (1), 17-21.

Gillman, J., Gable-Rodriguez, J., Sutherland, M., & Whitacre, J. (1996). Pastoral care in a critical care setting. *Critical Care Nursing Quarterly, May,* 10-20.

Glas, G. (2007). Anxiety, anxiety disorders, religion and spirituality. *Southern Medical Journal, 100* (6), 621-625.

Goldberg, B. (1998). Connection: An exploration of spirituality in nursing care. *Journal of Advanced Nursing, 27,* 836-842.

Govier, I. (2000). Spiritual care in nursing: A systematic approach. *Nursing Standards, 14* (1), 32-36.

Graham, J., Brush, B., Andrew, R. (2003). Spiritual-care process and content: lessons learned from the ECHO Project. *Journal of the American Academy of Nurse Practitioners, 15,* (10), 473-478.

Granberg-Rademacker, J. (2010). An algorithm for converting ordinal scale measurement data to interval/ratio scale. *Educational & Psychological Measurement, 70* (1), 74-90. doi.10.1177/00131.64409344532.

Gray, J. (2006). Measuring spirituality: Conceptual and methodological considerations. *The Journal of Theory Construction & Testing*, *10* (2), 58 – 64.

Greasley, P., Chiu, L., & Gartland, M. (2001). The concept of spiritual care in mental health nursing. *Journal of Advanced Nursing, 33* (5), 629 -637.

Hagedorn, M. (2004). Caring practice in the 21st century: The emerging role of nurse practitioners. *Topics in Advanced Practice Nursing eJournal, 4* (4), retrieved from http://www.medscape.com.

Hampton, J., & Weinert, C. ((2006). An exploration of spirituality in rural women with chronic illness. *Holistic Nursing Practice, 20* (1), 27-33.

Handzo, G., & Koenig, H. (2004). Spiritual care: Whose job is it anyway? *Southern Medical Journal, 97* (12), 1242-1244.

Harrison, D., Brady, A., & Rowan, K. (2004). Case mix, outcome and length of stay for admissions to adult, general critical care units in England, Wales and Northern Ireland: the intensive care national audit and research centre case mix programme database. *Critical Care, 8* (2), 99-111.

Hatch, R., Burg, M., Naberhus, D., Hellnick, L. (1998). The spiritual involvement and beliefs scale: development and testing of a new instrument. *Journal of Family Practice, 46,* 476 – 486.

Henderson, G. (2006). Spirituality in the nursing home. *Southern Medical Journal, 99* (10), 1182-1183.

Highfield, M., Taylor, E., & Amenta, M. (2000). Preparation to care: The spiritual care education of oncology and hospice nurses. *Journal of Hospice and Palliative Nursing, 2* (2), 53-63.

Hollins, S. (2005). Spirituality and religion: Exploring the relationship. *Nursing Management, 12* (6), 22 – 26.

Hubbell, S., Woodard, E., Barksdale-Brown, D., & Parker, J. (2006). Spiritual care practices of nurse practitioners in federally designated nonmetropolitan areas of North Carolina. *Journal of the American Academy of Nurse Practitioners, 18,* 379-385.

Hunter, R. (Ed.). (2005). *Dictionary of pastoral care and counseling: Expanded edition.* CD-ROM Edition. Nashville, Tennessee: Abingdon Press.

ISD Data Dictionary. (2002). Spiritual Care. Retrieved from http://www.datadictionaryadmin.scotnhs.uk/isdd/11240.html.

Jesse, D. E., & Reed, P. G. (2004). Effects of spirituality and psychosocial well-being on health risk behaviors in Appalachian pregnant women. *Journal of Obstetric, Gynecologic, and Neonatal Nursing* (*JOGNN*), *33,* 739-747.

Joint Commission on Accrediting Healthcare Organizations. (2004). Retrieved from http://www.jointcommission.org/Standards/

Jonson, H., & Magnusson, J. (2001). A new age of old age? Gerotranscendence and the re-enchantment of aging. *Journal of Aging Studies,* 15, 317-331.

Kaiser, C. (2006). Radiology, religion cross paths at University of Pennsylvania - researchers hope to unlock spiritual mysteries using function SPECT and PET techniques. *Diagnostic Imaging, 28*, (11), 16.

Ka'opua, L., Gotay, C., Boehm, P. (2007). Spiritually based resources in adaptation to long-term prostate cancer survival: perspectives of elderly wives. *Health & Social Work. 32* (1), 29-39.

Klemke, E., Hollinger, R., & Rudge, D. (Ed) (1998). *Introductory readings in the philosophy of science*. Amherst, New York: Prometheus Books.

Kociszewski, C. (2004). Spiritual care: A phenomenological study of critical care nurses. *Heart & Lung, 33* (6), 401-411.

Koenig, H. (2004). Religions, spirituality, and medicine: Research findings and implications for clinical practice. *Southern Medical Association Journal, 97* (12), 1194-1200.

Krippendorff, K. (2003). *Content Analysis: An Introduction to its Methodology*. Beverly Hills, California: Sage Publications.

Lawshe, C.H. (1975). A quantitative approach to content validity. *Personal Psychology, 28* (4), 563 – 575.

Lee, S. (2005). Doctoral student exemplar: transformation of the patient-nurse dyad. In Picard, C., & Jones, D. (Eds). *Giving voice to what we know: Margaret Newman's theory of health as expanding consciousness in nursing practice, research, and education.* Sudbury, Massachusetts: Jones and Bartlett.

Leininger, M., & McFarland, M. (2002). *Transcultural nursing: Concepts, theories, research and practice.* New York: McGraw-Hill.

Luckhaupt, S., Yi, M., Mueller, C., Mrus, J., Peterman, A., Puchalski, C., & Tsevat, J. (2005). Beliefs of primary care residents regarding spirituality and religion in clinical encounters with patients: a study at a Midwestern U.S. teaching institution. *Academic Medicine*, *80* (6), 560 – 570.

MacLean, C., Susi, B., Phifer, N., Schultz, L., Bynum, D., Franco, M., Cykert, S. (2003). Patient preference for physician discussion and practice of spirituality. *Journal of General Internal Medicine, 18,* 38-43.

Mactavish J., & Iwaski, Y. (2005). Exploring perspectives of individuals with disabilities on stress-coping. *Journal of Rehabilitation, 71* (1), 20-31.

Maddox, M. (2001). Teaching spirituality to nurse practitioner students: The importance of the interconnection of mind, body, and spirit. *Journal of the American Academy of Nurse Practitioners, 13* (3), 134-139.

Malinski, V. (2002). Developing a nursing perspective on spirituality and healing. *Nursing Science Quarterly, 15* (4), 281-287.

Marchione, J. (1993). *Margaret Newman: Health as Expanding Consciousness*. Newbury Park, California: Sage Publications, Inc.

Martsolf, D., & Mickley, J. (1998). The concept of spirituality in nursing theories: differing world-views and extent of focus. *Journal of Advanced Nursing, 27,* 294-303.

Mayer, J. (1992). Wholly responsible for a part, or partly responsible for a whole? The concept of spiritual care in nursing. *Second Opinion, 17* (3), 26 – 55.

McBrien, B. (2006). A concept analysis of spirituality. *British Journal of Nursing, 15* (1), 42-45.

McEwen, W. (2004). Spirituality in nursing: What are the issues. *Orthopedic Nursing, 23* (5), 321 – 326.

McManus, J. (2006). Spirituality and health. *Nursing Management, 13* (6), 24-27.

McSherry, W., Cash, K., Ross, L. (2004). Meaning of spirituality: implications for nursing practice. *Journal of Clinical Nursing, 13*, 934- 941.

Merriam-Webster On-line Dictionary. (2009). Retrieved from http://www.merriam-webster.com/dictionary/perspective">perspective.

Mesnikoff, J. (2002). Practical response to spiritual distress by nurse practitioners. *Clinical Excellence for Nurse Practitioners, 6* (3), 39-44.

Minority Nurse. (2010). Minority Nurse Statistics. Retrieved from http://www.minoritynurse.com/minority-nursing-statistics.

Moser, P., & VanderNat, A. (2003). *Human knowledge: Classical and contemporary approaches*. New York: Oxford University Press.

Muller, S., & Dennis, D. (2007). Life change and spirituality among a college student cohort. *Journal of American College Health, 56* (1), 55 -59.

Munro, B. (2001). *Statistical methods for health care research*. Philadelphia, Pa.: Lippincott, Williams & Wilkins.

Musgrove, C. McFarlane, E. (2004). Intrinsic and extrinsic religiosity, spiritual well-being, and attitudes toward spiritual care: A comparison of Israeli Jewish oncology nurses' scores. *Oncology Nursing Forum, 31* (6), 1179-1183).

Narayanasamy, A. (2004). The puzzle of spirituality for nursing: a guide to practical assessment. *British Journal of Nursing, 13* (19), 1140 – 1144.

Narayanasamy, A., Clissett, P., Parumal, L., Thompson, D., Annasamy, S., & Edge, R. (2004). Responses to the spiritual needs of older people. *Journal of Advanced Nursing, 48* (1), 6-16.

National Center for Chronic Disease Prevention and Health Promotion. (2008). *Chronic Disease Overview*. Retrieved from http://www.cdc.gov/NCCdphp/overview.htm

National Health Service in Scotland (SEHD). (2008). *Guidelines on Chaplaincy and Spiritual Care.* Retrieved from http://www.nes.scot.nhs.uk/media/3796/211108spiritual_care_revised_guidelines.pdf

National Organization of Nurse Practitioner Faculties (NONPF). (2002). *Domains and Core Competencies of Nurse Practitioner Practice.* Retrieved from http://www.nonpf.com/2002domainsandcorecomps.pdf.

National Organization of Nurse Practitioner Faculties (NONPF). (2006). *Domains and Core Competencies of Nurse Practitioner Practice.* Retrieved from http://www.nonpf.org/NONPF2005/Buttons/DNP-NPCurricTemplates0907.pdf

Newlin, K., Knafl, K., & Melkus, G. (2002). African-American spirituality: A concept analysis. *Advances in Nursing Science, 25* (2), 57-70.

Newman, M. (1994, 2000). *Health as Expanding Consciousness*. Sudbury, Massachusetts: Jones and Bartlett Publishers.

Newman, M. (2008). *Transcending presence: The difference that nursing makes*. Philadelphia: E.A. Davis, Co.

Nightingale, F. (1969). *Notes on nursing: What it is and what it is not.* New York: Dover Publications, Inc.

O'Connor, T., Meakes, E., McCarrol-Butler, P., Davis, A., & Jadad, A. (2002). Review of quantity and types of spirituality research in three health care databases (1962-1999): implications for the health care ministry. *The Journal of Pastoral Care and Counseling, 56* (3), 227-232.

Olson, M., Sandor, M., Sierpina, V., Vanderpool, H., & Dayao, P. (2006). Mind, body and spirit: Family physicians' beliefs, attitudes and practices regarding the integration of patient spirituality into medical care. *Journal of Religion and Health, 45* (2), 234-247.

Omen, D. & Thoresen, C. (2006). The many frontiers of spiritual modeling. *International Journal for the Psychology of Religion, 13* (3), 197-213.

Paloutzian, R., & Ellison, C. (1982). The Spiritual Well-Being Scale. Retrieved from http://www.lifeadvance.com/spiritual-well-being-scale.html.

Pesut, B. (2003). Developing spirituality in the curriculum: worldviews, intrapersonal connectedness, interpersonal connectedness. *Nursing Education Perspectives, 24* (6), 290 – 294.

Pesut, B. (2005). "A Philosophic Analysis of the Spiritual in Nursing Literature." (Doctoral Dissertation University of British Columbia, Canada). Retrieved from http://proquest.umi.com.flagship.luc.edu/pqdweb?index=1&did=1037884041&SrchMo.

Pesut, B. (2006). Fundamental or foundational obligation? Problematizing the ethical call to spiritual care in nursing. *Advances in Nursing Science, 29*(2), 125-133.

Peterman, A., Fitchett, G., Brady, G., Hernandez, L., & Cella, D., (2002). Measuring spiritual well-being in people with cancer: The functional assessment of chronic illness therapy—spiritual well-being scale (FACIT-Sp). *Annals of Behavioral Medicine, 24* (1), 49-58, DOI: 10.1207/S15324796ABM2401_06.

Post, S., Puchalski, C., & Larson, D. (2000). Physicians and patient spirituality: Professional boundaries. *Annals in Internal Medicine, 132,* 578-583.

Puchalski, C. (2002). Spirituality and end-of-life care: A time for listening and caring. *Journal of Palliative Medicine 5,* (2), 289 – 294.

Puchalski, C., Lunsford, B., Harris, M., & Miller, T. (2006). Interdisciplinary spiritual care for seriously ill and dying patients: A collaborative model. *The Cancer Journal, 12* (5), 398-416.

Puchalski, C., & Romer, A. (2000). Taking a spiritual history allows clinicians to understand patients more fully. *Journal of Palliative Medicine, 3*(1), 129-137.

Reed, P. (1987). Spirituality and well-being in terminally ill hospitalized adults. *Research in Nursing and Health, 10,* 335 – 344.

Reed, P. (1991). Self-transcendence and mental health in oldest-old adults. *Nursing Research, 40*(1), 5-11.

Reed, P. (1992). An emerging paradigm for the investigation of spirituality in nursing. *Research in Nursing & Health, 15*, 349-357.

Reed, P. (2008). The theory of self-transcendence. In M. Smith & P. Liehr (Eds.), *Middle Range Theory for Nursing* (pp. 105-129). New York: Springer Publishing Company.

Reynolds, D. (2006). Examining spirituality among women with breast cancer. *Holistic Nursing Practice, 20* (2), 118-121.

Ross, L. (1994). Spiritual aspects of nursing. *Journal of Advanced Nursing, 19*, 439-447.

Ross, L. (1997). Elderly patients' perceptions of their spiritual needs and care: a pilot study. *Journal of Advanced Nursing, 26,* 710-715.

Rungtusanatham, M. (1998). Let's not overlook content validity. *Decision Line,* 10-13.

Sawatzky, R., & Pesut, B. (2005). Attributes of spiritual care in nursing practice. *Journal of Holistic Nursing, 23* (1), 19-23.

Scherb, C., & Weydt, A. (2009). Work complexity assessment, nursing interventions classification, and nursing outcomes classification: Making connections. *Creative Nursing.* Retrieved from http://findarticles.com/p/articles/mi_7514/is_200901/ai_n32316742/

Sellers, S., & Haag, B. (1998). Spiritual nursing interventions. *Journal of Holistic Nursing, 16* (3), 338-354.

Shaw, J. (2005). Pathway to spirituality. *Psychiatry, 68 (*4), 350 – 362.

Sinclair, S., Pereira, J., & Raffin, S. (2006). A thematic review of the spirituality literature within palliative care. *Journal of Palliative Medicine, 9* (2), 464-479.

Singleton, J. (2002). Caring for themselves: Facilitators and barriers to women home care workers who are chronically ill following their care plan. *Health Care for Women International, 23*, 692-702.

Smith, D. (2006). Rehabilitation counselor willingness to integrate spirituality into client counseling sessions. *Journal of Rehabilitation, 72* (3), 4-11.

Solari-Twadell, P. (2002). The differentiation of the ministry of parish nurse practice within a congregation. (Doctoral dissertation, Loyola University, Chicago). Retrieved from http://proquest.umi.com.flagship.luc.edu/pqdweb?index=0&did=727422161&SrchMoD

Solomon, J. Hunter, J. (2002). A psychological view of spirituality and leadership. *School Administrator, 58* (8), 38-41.

Sorajjakool, S., Aveling, L., Thompson, K., Earl, A. (2006). Chronic pain, meaning and spirituality: A qualitative study of the healing process in relation to the role of meaning and spirituality. *The Journal of Pastoral Care and Counseling, 60* (4), 369-378.

Speck, P. (2005). The evidence base for spiritual care. *Nursing Management, 12* (6), 28-31.

Springer, M., Newman, A., Weaver, A., Siritsky, N., Linderblatt, C., Flannelly, K., & VandeCreek, L. (2003). Spirituality, depression, and loneliness among Jewish seniors residing in New York City. *Journal of Pastoral Care and Counseling, 57* (3), 305-318.

Stranahan, S. (2001). Spiritual perception, attitudes about spiritual care, and spiritual care practices among nurse practitioners. *Western Journal of Nursing Research, 23* (1), 90-104.

Tanyi, R. (2002). Towards clarification of the meaning of spirituality. *Journal of Advanced Nursing, 39* (5), 500-509.

Tanyi, R., Werner, J., Racine, A., Sperstad, R. (2006). Perceptions of incorporating spirituality into their care: a phenomenological study of female patients on hemodialysis. *Nephrology Nursing Journal, 33* (5), 532-537.

Taylor, E. (2003). Nurses caring for the spirit: patients with cancer and family caregiver expectations. *Oncology Nursing Forum, 30* (4), 585-590.

Taylor, E. (2008). What is spiritual care in nursing? Findings from an exercise in content validity. *Holistic Nursing Practice, 22* (3), 154-159.

Taylor, E., Amenta, M., & Highfield, M. (1995). Spiritual care practices of oncology nurses. *Oncology Nursing Forum, 22*, 31 – 39.

Taylor, E., Highfield, M., & Amenta, M. (1994). Attitudes and beliefs regarding spiritual care. *Cancer Nursing, 17* (6), 479 – 487.

Taylor, E., Highfield, M., & Amenta, M. (1999). Predictors of oncology and hospice nurses' spiritual care perspectives and practices. *Applied Nursing Research, (12)* 1, 30-37.

Taylor, E., & Mamier, I. (2005). Spiritual care nursing: what cancer patients and family caregivers want. *Journal of Advanced Nursing, 49*(3), 260-267.

Thomas, J.C., Burton, M., Quinn Griffin, M. T., & Fitzpatrick, J. J. (2010). Self-transcendence, spiritual well-being, and spiritual practices of women with breast cancer. *Journal of Holistic Nursing, 28*, 115-122.

Tinley, S., & Kinney, A. (2007). Three philosophical approaches to the study of spirituality. *Advances in Nursing Science, 30* (1), 71-80.

Tornstam, L. (2003). *Gerotranscendence from young old to old old age.* The Social Gerontology Group, Uppsala, Sweden. Retrieved from http://www.soc.uu.se/publications/fulltext/gtransoldold.pdf.

Tuck, I. (2004). Development of a spirituality intervention to promote healing. *The Journal of Theory Construction and Testing, 8* (2), 67-71.

Tuck, I., McCain, N. L., & Elswick, R. K. (2001). Spirituality and psychosocial factors in persons living with HIV. *Journal of Advanced Nursing, 33*, 776-783.

Tyler, I., & Raynor, J. (2006). Spirituality in the natural sciences and nursing: an interdisciplinary perspective. *The Association of Black Nursing Faculty*, 63-66.

Vance, D. (2001). Nurses' attitudes towards spirituality and patient care. *MedSurg Nursing, 10* (5), 264-268, 278.

Van Dover, L., & Bacon, J. (2001). Spiritual care in nursing practice: A close-up view. *Nursing Forum, 36* (3), 18-30.

van Leeuwen, R. & Cusveller, B. (2004). Nursing competencies for spiritual care. *Journal of Advanced Nursing, 48* (3), 234-246.

van Loon, A. (2005). Commentary on Fawcett T and Noble A (2004): The challenge of spiritual care in a multi-faith society experienced as a Christian nurse. *Journal of Clinical Nursing, 14,* 266-268.

Wachholtz, A., Pargament, K. (2005). Is spirituality a critical ingredient of meditation? Comparing the effects of spiritual meditation, secular meditation, and relaxation on spiritual, psychological, cardiac, and pain outcomes. *Journal of Behavioral Medicine, 28* (4), 369-384.

Wadensten, B. & Carlsson, M. (2001). A qualitative study of nursing staff members' interpretations of signs of gerotranscendence. *Journal of Advanced Nursing, 36* (5), 635-642.

Wallace, M., & O'Shea, I. (2007). Perceptions of spirituality and spiritual care among older nursing home residents at the end of life. *Holistic Nursing Practice, 21* (6), 285 – 289.

Walton, J. (2002). Finding a balance: a grounded theory study of spirituality in hemodialysis patients. *Nephrology Nursing Journal, 29* (5), 447-457.

Watson, J. (1999). *Postmodernism: nursing and beyond.* New York: Churchill Livingstone.

Watson, J. (2008). *The Philosophy and Science of Caring.* Boulder, Colorado: University Press of Colorado.

Wright, M. (2002). The essence of spiritual care: a phenomenological enquiry. *Palliative Medicine, 16,* 125-132.

VITA

Barbara Baele Vincensi was born and raised in South Bend, Indiana. She attended Purdue University in Lafayette, Indiana, where she earned her Associate Degree in nursing (1975) and her Bachelor of Science in Nursing in 1978. She earned her Master of Science in Nursing from Indiana University, Indianapolis, Indiana, in 1985. In 1997, she obtained a Post-Master's certificate as a family nurse practitioner from Grand Valley State University in Grand Rapids, Michigan, and began working fulltime as a family nurse practitioner in primary care in Holland, Michigan.

Barbara has worked in various roles during her career as a nurse, starting as a staff nurse in diverse clinical areas. Her roles have also included being a manager, as well as a clinical nurse specialist, family nurse practitioner, and a wound ostomy and continence nurse. She was adjunct faculty for the Kirkhoff School of Nursing Graduate Program at Grand Valley State University from 1990 to 2004. She developed a local parish nurse ministry in a multi-cultural, multi-lingual parish in Holland, Michigan. In addition, Barbara also volunteered as a family nurse practitioner and wound ostomy and continence nurse in a medically underserved clinic in Holland, Michigan, for several years. Since 2006, Barbara has been a full-time Assistant Professor of Nursing at Hope College, Holland, Michigan, and continues to practice part time as a family nurse practitioner.