5-2003

An investigation of pre-nursing and second-year baccalaureate nursing students' perception of spirituality

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AN INVESTIGATION OF PRE-NURSING AND SECOND YEAR BACULAUREATE NURSING STUDENTS' PERCEPTION OF SPIRITUALITY

A Pilot Study

By

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Submitted to the Graduate School of the
University of Texas-Pan American
In partial fulfillment of the requirements for the degree of

MASTER OF SCIENCE

May 2003

Major Subject: Nursing

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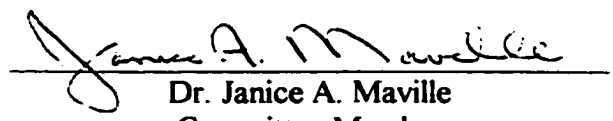

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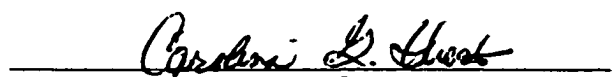

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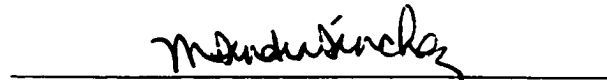

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ABSTRACT

Williams, Jacquelyn K., An Investigation of Pre-Nursing and Second Year Baccalaureate Nursing Students' Perception of Spirituality: A Pilot Study. Masters of Science in Nursing (MSN), May, 2003, 140 pp., 7 tables, references 207 titles. This pilot study investigated whether spiritual care education is a part of the baccalaureate nursing curriculum at a south Texas university. This study used two standardized scales to compare the pre-nursing students' and senior baccalaureate nursing students' attitude about spirituality at different levels in the nursing program. Two quantitative questionnaires were used to investigate the nursing students' personal spiritual involvement and beliefs and their opinions about the spiritual role of the nurse in meeting patient spiritual needs. No statistically significant differences in the two group's personal spiritual involvement and beliefs were found. Statistically significant differences were found in the opinions about the spiritual role of the nurse in meeting patient spiritual needs.

DEDICATION

This pilot study is dedicated to Gwendolyn Fay Richardson Jackson, LMSW – ACP, DAPA. ~~Remember Romans 8:28 is in the book~~. This is MY TRIBUTE.

Love, Jackey

ACKNOWLEDGEMENT

I would like to thank God, and those people in my life who have helped me accomplish this goal. I would like to extend my gratitude and respect to my thesis committee chair, Dr. Barbara Tucker. Thank you for the endless hours you sacrificed so that I could succeed. To my committee, Dr. Bruce Wilson, Dr. Carolina Huerta, Dr. Janice Maville, and Dr. Sandra Sanchez, thank you for your support and guidance during this undertaking. Elena Guel, thank you for your encouragement, kind words, candy, and your administrative support. I would like to thank the staff at the South Texas Veteran Affairs Outpatient Clinic for assuring that I had the needed resources to complete this journey. To Gwendolyn, my twin, thank you for always being a phone call away, I could not have done it without you. To Mr. Clarence, my best friend, we have only just begun to live.

Jackey

TABLE OF CONTENTS

LIST OF TABLES

CHAPTER I

INTRODUCTION

The current nursing focus on optimal health encompasses not only every stage of development but also the physical, emotional, mental, social, and spiritual dimensions of the health–illness continuum (American Association of College of Nursing, 1999a). The practice of professional nursing is based upon a philosophy about the nature of people, health, environment, and nursing (Dettmore, 1986). Although the nursing profession has long prided itself in a holistic approach to care in which the needs of the total person are recognized (Ellerhorst-Ryan, 1985), little attention has been given to the development of spiritual sensitivity in nursing students (Catanzaro & McMullen, 2001).

Nursing's purpose is to promote optimal health (Bevis, 1989, p. 106). Spirituality is an integral component of nursing practice and education (Miklancie, 2001). Nursing theories and holistic perspectives acknowledge the nurse's responsibility to attend to the spiritual aspect of patients (Catanzaro & McMullen, 2001). The spiritual dimension of patient care is perhaps the most profound dimension of health care delivery, yet the most overlooked (Bath, 1992). If the human consists of four essential domains (i.e., biological, psychological, spiritual, and sociological) instead of the usually acknowledged three (i.e., biopsychosocial), then practitioners, guided by academics, have been operating under the

delusion that they have been delivering truly holistic care, when in reality the spiritual domain is generally ignored (Oldnall, 1995).

Statement of the Problem

Nursing students should receive guidance and education from nurse theorists and educators regarding spirituality (Oldnall, 1996); however, nursing students may feel inadequately prepared to address spiritual needs or may be embarrassed to address subjects which are often considered to be highly personal (Goddard, 1995; Shih, Gau, Mao, Chen, & Kao Lo, 2001). Just as spirituality may not be the easiest topic for nursing students to explore with the client, it is also often a difficult area for the client to discuss (Carson, 1989). A review of nursing literature suggests that practicing nurses and nursing students are not educationally prepared to deal with the spiritual problems of patients (Fulton, 1992).

Basic nursing programs have the responsibility to prepare nurses to meet the needs of their patients in all realms–not just physical and psychological, but also spiritual (Piles, 1990). This new millennium has become a metaphor for the extraordinary challenges and opportunities available to the nursing profession and those academic institutions responsible for preparing the next generation of nurses (Heller, Oros, & Durney-Crowley, 2001). A renewed focus on spirituality has been evidenced by increased numbers of presentations at professional nursing conferences about spiritual care, new courses or curricular themes about spirituality in nursing programs, and the formation of special interest groups devoted to spiritual care within professional organizations (Taylor, 2002, p. 36).

There is a rediscovery and interest in spirituality at the outset of the third millennium. As the literature addressing spiritual care increases, the merit of spiritual care is attracting more and more attention from nursing scholars. Because it has been argued that spirituality is an important concept related to nursing practice and education, consideration is necessary as to how it can be incorporated into patient care as well as nursing education. It is obvious and imperative that nursing students possess the willingness to address spiritual concerns. The ability to be present and nonjudgmental can be among the most valuable contributions made by a practitioner (Cotter & Strumpf, 2001, p. 364).

A nursing student who has developed spiritual self-awareness will be better able to determine approaches that will serve to promote the client's spiritual well-being (Taylor, 2002, p. 66). The nursing student ministers to the spirit through caring actions and tender hands that say to the patient, "You are a person of value" (Matthew, 2000). They use only the tools of themselves, their compassion, their listening skills, their kindness, and in general all things that make them unique and giving (Carson, 1989, p. 151). The inability to distinguish clearly between the spiritual and psychological dimensions, or the difference between spirituality and religiosity, potentially results in the neglect of, or inability to meet patient's spiritual needs (Goddard, 1995).

Statement of Purpose

The purpose of this research study was to investigate whether spiritual care education is a part of the baccalaureate nursing curriculum at a south Texas university. This study used two standardized scales to compare the pre-nursing students' and senior baccalaureate nursing students' attitude about spirituality at different levels in the nursing

program. Ultimately, these findings will add to the body of professional nursing knowledge, affecting practice, education, research, and patient care.

Conceptual Framework

Dr. Jean Watson's Theory of Human Caring provides the conceptual framework for this study because it explicitly supports the concepts of soul and emphasizes the spiritual dimension of the human existence (Nicoll, 1997, p. 160). Watson believes the world of the spirit and soul becomes increasingly more important as the person ages and matures as an individual and as humankind evolves collectively (Watson, 1988, p. 56). Watson specifically acknowledges that spiritual and religious awareness is one of the nurse's responsibilities and that the nurse should appreciate and respect the spiritual meaning in a personal life (regardless of how unusual a person's belief is) since this is comforting to the individual (Oldnall, 1996; Watson, 1985; Watson, 1988).

A strong theme of Watson's theory is that of spiritual evolution, at both the individual and societal levels. Self-transcendence and transcendence of space and time in higher consciousness and mystical experiences are held to be indicators of spiritual evolution (Nicoll, 1997, p161). Watson believes humans are capable of transcending time and space and possess a spirit, soul, or essence which enables self-awareness, a higher degree of consciousness, and a power to transcend the usual self. Human life is continuous (with time and space) being in the world (Chinn, Jacobs, & Huerther, 1987, p. 195). She uses synonyms such as spirit, inner soul, and essence for soul. Watson identified characteristics of the soul as self-awareness, inner strength, power, intuitive and mystic experience, and continuation beyond physical death (Nicoll, 1997, p. 160).

At nursing's highest level, the nurse makes contact with the person's emotional and subjective world as the route to inner self. Mind and soul are not confined in time and space to the physical universe. A nurse can access inner self through the mind-body-soul, provided the physical body is not perceived separate from the higher sense of self. Illness may be hidden from the "eyes" and require the finding of meaning in inner experiences. Finally, the totality of experiences at the moment constitutes a phenomenal field or the individual's frame of reference (Chinn, et al., 1987, p.195).

Dr. Watson strongly endorses the ideals/content/ theory of liberal arts education integration in the professional nursing education curriculum. She has proclaimed that a strong knowledge in the humanities expands the mind, thinking skills, and personal growth (Tracey et al., 1998, p. 144). In response to nursing's call for commitment to caring, nursing education advocated the inclusion of caring as an essential concept in educational programs (Koswoski, Grams, Taylor, & Wilson, 2001). Dr. Watson's work has been called a treatise, a conceptual framework, and a theory (Tracey, et al., 1998, p. 145). At a time when the nursing profession is attempting to develop its own body of knowledge as an academic discipline it becomes imperative that the language used to define theoretical concept be precise, unambiguous, readily communicated and justifiable (Kyle, 1995).

Watson's work in the original and the evolving form seeks to develop caring as an ontological and theoretical-philosophical framework for the profession and the discipline of nursing (Watson, 2002a). Watson admits to freely drawing upon the theoretical works of psychotherapists and humanistic researchers in the development of the Theory of Human Caring (Walker, 1996). Watson's foundational support was from theorists such

as: Martin Heidegger, Carl Rogers, Erik Erickson, Hans Selye, Arnold Lazarus, and Abraham Maslow. She used the works of Florence Nightingale, Virginia Henderson, Marshall Krueter, Alison Hall, Madeline Leininger, Sally Gadow, Georg Wilhelm, Friedrich Hegel, Gabriel Marcel, Alfred North Whitehead, Søren Kierkegaard, and Pierre Teilhard de Chardin in the background of the theory (Nicoll, 1997, p. 161; Porter & Sloan, 1996, p. 161; Tracey et al., 1998, p. 144).

Watson's Original Theory

Dr. Irvin Yalom's 11 curative factors stimulated Watson's thinking about the psychodynamic and human component that could apply to nursing and caring, and consequently to her 10 carative factors in nursing (Tracey et al., 1998, p. 145). Watson's 1979 original work was organized around 10 carative factors that serve as a guide to the "core of nursing" in contrast to nursing "trim" (Watson, 1979, p. xv). The core of Watson's theory is centered on helping the patient gain a higher degree of harmony within the mind, body, and soul (McCance, McKenna, & Boore, 1999). Unfortunately, the moments available to provide gentle and personal care have been replaced more often than not by technical tasks including monitoring blood gases, weaning patients from cardiac bypass pumps, and caring for a fragile, ventilated patient at home (the trim) (Bartel, 2001). Technological advances emphasize the "doing" rather than the "being" aspect of nursing (Taylor, 2002, p.36). Carative factors structure a number of beliefs, concepts, knowledge, and principles foundational to human behavior in health and illness, from a metaphysical, phenomenological, existential, and spiritual orientation that draws on eastern philosophy (Sourial, 1996).

Watson's 1979 work had proposed the first three carative factors that interact to establish a philosophical foundation for the science of caring (Kyle, 1995). The remaining carative factors are discussed in terms of a scientific base (Kyle, 1995). Each carative factor has a dynamic phenomenological component that is relative to the individuals involved in the relationship as encompassed by nursing (Porter & Sloan, 1996, p.162).

Watson considers any environmental measures that are appropriate to the person or situation conducive to comfort and the relief of mental anguish. Watson states that nurses should seek opportunities, as well as acknowledge an obligation, to become familiar with the religious and spiritual influences in a person's life at home or in the community. Watson argues that nurses should seek to provide a suitable, non-sterile environment to meet the religious requirements of the individual, for example by arranging for privacy, candles, an outdoors setting, flowers or a personalized environment (Oldnall, 1996).

Theory of Human Caring

Dr. Watson's 1999 Theory of Human Caring is frequently cited to support holistic nursing practice, especially spiritual caregiving (Taylor, 2002, p. 39). Since nursing is a caring profession, its ability to sustain its caring ideal and ideology in practice will determine nursing's contribution to society (Watson, 2000a). Watson's Theory of Human Caring focuses on nurse-patient interactions and is based on a spiritual-existential and phenomenological orientation that draws on Eastern philosophies (Martsolf & Mickley, 1998). Watson incorporated spiritual concepts such as soul, spirit, and transcendence in her explication of the nature of a person and the goal of nursing (Reed,

1991b). By relating to Watson's Theory of Human Caring, the nurse will recognize the most important aspects of all nursing activities are those actions that promote professional, compassionate, and human-to-human interactions (Frisch, 2001; Watson, 2000a).

In Watson's theory, caring is considered the essence of nursing practice which requires the personal, social, moral, and spiritual engagement of the nurse (Matsolf & Mickley, 1996). Theory is the prerequisite for any professional nursing activity and it elevates the importance of the healing presence to its rightful state in care (Frisch, 2001). The transpersonal care-healing model is a holistic model for nursing which suggests that a conscious intention to care potentiates healing and wholeness. It does not discard conventional science and all the medical curing that modern nursing and a medical practice have achieved, but is complementary to it (Hoover, 2002).

Caring is a desired transcendental quality of all helping professions. The questions being raised relate to its particular bond to nursing and its substantive nature (Reilly & Oermann, 1992, p.297). Caring is the essence of nursing and most central to a unifying focus for nursing practice (Watson, 2000). The quintessence of nursing is caring. Nursing care strives to be holistic, providing clients with support and nurture for their physiologic, emotional and spiritual needs (Taylor, 2002, p.137). Caring is a nursing term, representing all factors the nurse uses to deliver health care (Bennett, et al., 1989; Porter & Sloan, 1996, p. 164; Watson, 1979, p.6). Watson essentially believes that nursing is an intersubjective human process and places a high value on the caring relationship between the nurse and the recipient of care (Sourial, 1996).

The therapeutic essence of giving care is not a restricted, one-way dynamic; quite simply, in giving, nurses also receive. Caring can be described as the beneficent attending of one person through actions and omissions, toward another (Kendrick & Robinson, 2000). Caring requires commitment; it is contextual, relational, and subjective. Caring is different from caring about, for caring implies action whereas caring about may or may not entail action (Reilly & Oermann, 1992, p. 298).

There is a renewed concentration of community, prevention, primary care, population-based practice, clinical outcome research and teamwork (Watson, 1996). There has been a recent upsurge of interest in the concept of caring, especially in the United States of America, with the growing realization that caring is the central core for all that is nursing (Kyle, 1995). National reports and studies acknowledge the core of all health professionals' being is a return to relation-centered caring and healing which transcends any one health profession (Watson, 1996). Current economic pressures have placed demands on the nurse's ability to deliver care within environments which are increasingly concerned with cost control. These are not inconsiderable demands and suggest that caring literature has yet to examine them in sufficient depth (Kelly, 1998).

Watson and her colleagues have attempted to study the concept of caring by collecting data to use in classifying caring behaviors, to describe similarities and differences between what nurses consider care and what clients consider care, and to generate testable hypothesis around the concept of nursing care. They studied responses from registered nurses, student nurses, and clients to the same questionnaire covering a variety of aspects of taking care of and caring about patients. Their findings revealed discrepancies in the values considered most important to the client versus the student

nurses versus the registered nurses. Their conclusions stressed the need for further study to clarify values that are important from each view point (Porter & Sloan, 1996, p. 162).

The transpersonal caring relationship is a special kind of human care relationship--a union with another person--a high regard for the whole person (Watson, 1988, p. 63). To engage in a transpersonal caring-healing model involves transformation. The transformed self is a transpersonal self, beyond the ego self (Watson, 1999, p. 154). Transpersonal caring looks for the deeper sources of inner healing that may be defined more in spiritual terms than in relation to the elimination of disease (Hoover, 2002).

Watson refers to health as the unity and harmony of body, mind, and spirit (Watson, 1985, p. 57). It is also related to "actualizing the real self, thereby developing the spiritual essence of the self, and in the highest sense, to become more Godlike" (Watson, 1985, p. 57). Nurses who include spirituality in their professional practice believe that they have a transcendental relationship with patients (Dunajski, 1994). The individual is able to draw from inner strengths to facilitate the healing process. For healing to take place the modality of the healing presence is an important technique to provide trust, support, and to initiate the caring encounters (Frisch, 2001).

The Human Caring model can be considered a philosophical and moral/ethical foundation for professional nursing and part of the central focus for the nursing discipline. The concept promotes the change in the role of the nurse from a technical assistant to a distinct health professional, who works side by side with other distinct health professionals. This transforms the nurse to a healer within a caring-healing profession (Watson, 1999). Institutions that seek to use a holistic approach to nursing care are using many aspects of Watson's theoretical commitment to caring (Bennett, et

al., 1989, p. 169). The clinical caritas framework is a decidedly spiritual dimension and an overt evocation of love and caring merged into a new paradigm (Watson, 2001, p. 347). Through her "carative factors" and other principles, Watson makes clear the clinical relevance of faith and hope, humanistic and altruistic values, and provision of a "spiritual environment" for the client (Reed, 1991b).

As a part of the evolution of the Theory of Human Caring, Watson has proposed to transform the "carative factors" into the "clinical caritas process" (Watson 2002a; Watson, 2001). The clinical caritas framework is the emerging model of transpersonal caring which moves from carative to caritas (Watson, 2002a: Watson, 2001, p. 346-347) with some of the basic tenets of the original work project still held within the context (Watson, 2002a). Preservation of human care is a significant issue; human care can be practiced only interpersonally; and nursing's social, moral, and scientific contributions lie in its commitment to human care ideals (Chinn, et al., 1987). Preservation and advancement of human care as both an epistemic and clinical endeavor is a significant issue for nursing today and in the future (Watson, 2000). The value of caring could also be explored to confirm the unique contribution which nursing makes to the healthcare setting. Exploring the relationship between caring and disease outcomes, for example, could provide valuable evidence when the professional status of nursing is questioned (Kelly, 1998).

Research Questions

Based on the premise that spirituality education should be an integral part of the baccalaureate nursing curriculum, the investigator proposed two questions for this pilot study. The research questions were:

1) Is there a difference between pre-nursing students' and senior baccalaureate nursing students' personal spiritual involvement and beliefs?
2) Is there a difference between pre-nursing students' and senior baccalaureate nursing students' opinions about the spiritual role of the nurse in meeting patient spiritual needs?

Hypothesis

1) There are differences between the pre-nursing students' and senior baccalaureate nursing students' spiritual involvement and belief.
2) There are higher levels of spiritual involvement and belief in senior baccalaureate nursing students.
3) There are differences between pre-nursing students' and senior baccalaureate nursing students' conception of the spiritual role of the nurse in meeting patient spiritual needs.
4) There is a lower level of perception about the spiritual role of the nurse meeting the patient's spiritual needs in the pre-nursing students.

Significance of the Problem

Holistic nursing embodies the philosophy of *holism,* which was first formulated in the 1930s and emphasized the importance of understanding a person's whole being rather than breaking down, studying, and treating only the component parts. In fact, the "hol" in holistic is also the root of several other words that help to define the nursing profession: whole, health, heal, hale (as in "hale and hearty"), and holy (WholeHealthMD, 2000). For health purposes, a human being cannot be treated as a group of parts but as an integrated whole, living and interacting with his environment, with the entire suprasystem

being in ecological balance progressing toward perfection and wellness for these systems involved (Bevis, 1989, p. 110).

Holism is nursing's central philosophical tenet. Therefore the principles and practice modalities of holism should be the essence of nursing education, research, and practice (Butcher, 1998). Traditionally, Western society has treated man as a set of assembled parts (dualistically). In reality, dualism treats man as having two parts – his emotional aspect, called psyche, and his physical aspect, called soma (Bevis, 1989, p.110). The concept of holism diverges from the medical model to a modality of care and service that recognizes each person as a biophyschosocial-religious being (Carson, 1989, p. 262). Paradoxically, holistic nursing is now an area of specialty certification because of the unfortunate dominance of the mechanistic and reductionistic biomedical model in nursing (Butcher, 1998).

The dimension of holism includes the components of balance, culture, and relationship. Silence, male, female, noncompartmentalization, flowing with harmony, and pursuing peace are the characteristics of balance. Spirituality, belief, and healing are components of the characteristics of culture. Components of the characteristic of relationship are interacting nonverbally, honor, being non-judgmental, a common language, trust, and family and community (Lowe & Struthers, 2001).

The holistic perspective in health care is not a recent development in professional nursing. Nurses have traditionally recognized that humans are tripartite, the three dimensions are interrelated, and healing often occurs through restoring balance among mind, body, and spirit (Stranahan, 2001). The integration of body, mind, and spirit in healthy individual leads to a balanced, healthy life (Tuck, McCain, & Elswick, 2001).

Throughout professional preparation that nurses undertake, there is an emphasis on rendering holistic care. The profession's growing interest in holistic health is reflected in attendance at workshops and a voracious appetite for books and journals on the subject. Since 1990, the literature on nurse as healer and holistic health has grown and become more focused (Keegan, 1996).

Holistic nursing is a way of thinking, reflecting, practicing, and being-in-the-world (Frisch, 2001). Practicing holistic nursing requires nurses to integrate self-care in their lives. Self-responsibility leads the nurse to greater awareness of the interconnectedness with self, others, nature, and God/Life Force/Absolute/ Transcendent. This awareness further enhances nurses' understanding of all individuals and their relationships to the human and global community, and permits nurses to use this awareness to facilitate the healing process (Dossey, Keegan, & Guzzetta, 2000, p.28).

Common to all nursing theories is the assumption that human beings comprise various dimensions and that each dimension is related to health and well-being (Taylor, 2002, p.38). Spiritual care is not a mechanic act but a humanistic act. The success of spiritual care relies mainly upon the delicateness of the process of interactions between human beings, the nurse, client, and the client's significant other (Shih, et al., 2001). An extensive review of various theoretical and operational conceptualizations of spirituality found within nursing and allied health found three critical attributes, or central characteristics, of spirituality, including: an integrating or unifying force, or energy; relational connections to God (however defined), others, self, and nature; and self-transcendence, or the ability to move beyond physical and/or emotional situational constraints (Goddard, 1995).

Holistic nurses recognize each person as a whole body-mind-spirit being and mutually create a plan of care consistent with cultural background, health beliefs, sexual orientation, values, and preferences (American Holistic Nurses' Association, 2002). Nurses are the best witness of the impact of disease on a human being's life in his or her physical, affective, cognitive, social, and spiritual dimensions (Shih, et al., 2001).

Because holistic nursing care connotes care of the whole person, spiritual concerns must be addressed concomitantly with biophysical and psychosocial concerns. Nursing students are expected to meet the health-related needs arising from each of the domains (Goddard, 2000). If a patient is to be treated as a whole person, he must be respected as a whole person-biologic, psychologic, social, and spiritual (Astrow, Puchalaski, & Sulmasy, 2001). The person is a whole being and cannot be separated into segments for diagnosis and care (Carson, 1989, p. 8). The holistically trained nurse views a myriad of assessment data—physical functionality, mental status exams, laboratory data—within the context of trying to know this person and thus help him or her know the self as well (Piles, 1990).

A key point is that spirituality per se is not measurable any more than would be such concepts as physicality, emotionality, or wholeness (McSherry & Draper, 1998); however, research evidence clearly demonstrates that addressing the spiritual dimension of care makes a considerable difference in the physical and psycho-social outcomes (Vance, 2001). Nursing theories and the holistic perspectives acknowledge the nurse's responsibility to attend to the spiritual sensitivity in nursing patients, (Catanzaro & McMullen, 2001). Professional nursing practice must rest on a solid educational basis covering a broad range of physical, psychosocial, spiritual and cultural competencies

(American Nurses Association, 1997); however, little is known about how to teach and enhance caring practices (Hoover, 2002).

Spirituality is an integral component of nursing practice and education (Miklancie, 2001). Spirituality is concerned with the whole personality and in particular the development of awareness of the 'other' (for example self, other person, wider communities, environment, deity). This evolving awareness is a dynamic process that involves a deepening integration of cognitive, affective, somatic, and experiential knowledge (Kendrick & Robinson, 2000). The recognition and retention of spirituality as an essential disciplinary tenet is a distinctive characteristic of holistic nursing care (Goddard, 2000); however, nurses in a study conducted by Cimino (1992) reported the most important and effective nursing intervention was listening to whatever the patient had to share. Many nurses felt they needed more formal and informal education on spiritual care and more time in their practice day to give spiritual care. Spirituality may seem not to add any weight to nursing attempts to establish itself as a scientific discipline (Oldnall, 1995).

Although there is little argument that a holistic focus of nursing includes spirituality, exactly what aspects of humans may be addressed as spiritual has remained rather amorphous. As a result both researchers and practitioners are often confused in how to address spiritual issues. One of the reasons is that most nursing models and theories do not address spirituality (Martsolf & Mickley, 1998). Many of the nursing theorists acknowledge the nurse's responsibility to attend to the spiritual needs of patients; none of them addresses the spirituality of the nurse or of the nursing student (Catanzaro & McMullen, 2001). Many nurse educators and theorists do not acknowledge

spirituality because the concept of spirituality is too nebulous and cannot be quantified (Oldnall, 1995).

The student does not enter the practice setting with a tabulae rasa; some value inherent in nursing are developed, some are still the value indicator stage, and some have not been recognized. For those values that have been developed, their expression in nursing may be different from what the students have experienced in their life encounters (Reilly & Oermann, 1992, p. 321). The nursing student, as a future caregiver, needs to be cognizant that his or her role is to understand the patient's spirituality and to help the individual to access and utilize his own spirituality (Rolph, 2001). A nursing student who develops his/her spiritual self-awareness will be better able to determine approaches that will serve to promote client spiritual well-being (Taylor, 2002, p. 66).

Operational Definition of Terms

Caritas: derived from the Greek word meaning "to cherish, to appreciate, to give special attention; it connotes something that is very fine, that indeed is precious" (Watson, 2001, p. 345).

Depository-repository approach: so named because the instructor "deposits" knowledge in the students' brains where it "reposes" until accessed by the student (O'Connor, 2001a, p. 104).

Health: Unity and harmony within the body, mind, and soul. Health is also associated with the degree of congruence between the self as perceived and the self as experienced (Watson, 2000).

Religiosity or religious practice: is primarily operationalized in terms of religious rituals such as attendance at formal group worship services, private prayer and meditation,

reading of spiritual books and articles, and/or the carrying out of such activities as volunteer work or almsgiving (O'Brien, 1999, p. 63).

Spirit: a force that encompasses the entire being, an unseen force that alternatively presents as energy and as heart (Moxley, 2001).

Spirituality: derived from the Latin *spiritus,* meaning breath, and relates to the Greek *pneuma* or breath, which refers to the vital spirit or soul (Dossey, Keegan, & Guzetta, 2000, p. 92).

Transcendence: stepping back and moving beyond what is (Ellison, 1983).

Transpersonal: conveys a human-to-human connection (usually in a caring moment), in which both persons are influenced through the relationship and the being together in a given moment (Watson, 1999, p. 290).

(W)Holistic: the comprehensive and total care of a patient.

Assumptions

This research proposal explored pre-nursing students' and senior baccalaureate nursing students' spiritual education levels. A baccalaureate nursing curriculum enhances and empowers the nursing student's attitude about providing spiritual care. The identified assumptions inherent to this research study proposal are:

1. Spiritual education in the nursing curriculum empowers the baccalaureate nursing students with tools to provide spiritual care to the patient.
2. The tools are valid and reliable for the study.
3. Students will answer truthfully.

Limitations

This cross-sectional design was be limited to pre-nursing and senior nursing students attending the baccalaureate nursing program at a university located in south Texas. The investigator is aware that the cross-sectional sample might have: (a) had bias recall, (b) not allowed for a composite picture of the subjects feelings and emotions, and (c) might not consider present and past tenses (LoBiondo-Wood & Haber, 1994, p.240). Additionally, the targeted cross-sectional sampling might have been atypical of the population, biased, and predominately homogeneous.

Summary

Based on the premises of the significance and the conceptual framework of this pilot study, the investigator attempted to discover if a difference existed between the pre-nursing and senior baccalaureate-nursing students' attitudes about the health professional's role in meeting the patient's spiritual needs. A difference between the pre-nursing and senior baccalaureate-nursing students' spiritual status was also investigated.

CHAPTER II

REVIEW OF RELATED LITERATURE

This section discusses the historical background of spirituality in the nursing profession and relationships between religion and spirituality. This section also discusses the concept of the call and the nursing student. Lastly, it discusses research studies that pertain to nursing spirituality.

Historical Background of Spirituality in the Nursing Profession

During the early years of organized professional nursing in the United States, the education of nurses included some attention to the spiritual and moral qualities of the nursing student (Catanzaro & McMullen, 2001). Historically, philosophies of nursing have included psychological and spiritual realms, and the nurse has been expected to provide holistic care that includes spirituality (Boutell & Bozett, 1990). Interest in the spiritual dimension of patient care is a thread that can be traced through the historical evolution of nursing, nursing theories and philosophies, and contemporary practice (Stranahan, 2001). More than 100 years ago, Florence Nightingale envisioned nursing as assisting a person to gain spiritual perspectives through health and especially through illness (Cimino, 1992). In Nightingale's view, spirituality was the experience of our unity with the divine power and consciousness that underlies the created world (Macrae, 2001, p. 22).

By the 1920s, secular nursing schools, both hospital and university based, saw the responsibility for moral and spiritual development as belonging to the individual student (Catanzaro & McMullen, 2001). Since the 1950s, spiritual care has been often overlooked as a dimension of nursing, referred to as the "ignored" dimension (Soeken & Carson, 1986). Subsequent to the 1960s the nursing profession experienced a resurgence of interest in spirituality. There has been development of nursing theories that address the holistic needs of the patient and the nurse's responsibility to provide care to the body, mind, and spirit (Catanzaro & McMullen, 2001). In the 1980s and 1990s, the "New Age" nursing literature placed an even stronger emphasis on spiritual care (Sumner, 1998).

Religiosity

The definition of religion is derived from two Latin words 're-ligare' and 'religio' meaning life being 'tied up to' or linked to a deity or to God. Religion can also be considered as a social institution that joins individuals who share the same beliefs, traditions and worshipful acts and rituals (Burkhardt & Nagai-Jacobsen, 2002; Strang, Strang, & Ternestedt, 2002). Religion refers to a system of beliefs and practices that ideally serve to enhance and express the experience of spirituality (Macrae, 2001, p. 22). Religion involves mutually interacting systems whereby symbol, myth and ritual (Strang et al., 2002). Religion, as a concept, is perceived by many in the West as not being interchangeable with spirituality (Rassool, 2000). Most religion in the West asks adherents to consider the nature of God and what God wants of them. The three great religions of China (Confucianism-Taoism-Buddhism) start not with God but with people (Dobrin, 2001).

Religious practice, or religiosity, relates to a person's beliefs and behaviors associated with a specific religious tradition and denomination (O'Brien, 1999, p.4). Religious beliefs and practices provide hope and a mean to cope with loss while religious communities provide social and spiritual support (Weaver, Flannelly, & Flannelly, 2001). Religion offers a system of meaningful symbols. Symbols are more than informational signs. Symbols are expressions of profound feelings about the meaning of life. Symbols may act to produce powerful, pervasive, long lasting moods (e.g., awe and trust). Through symbols and rituals, religion can address psychospiritual needs that facilitate healing from life crisis (e.g., evil and suffering) and coping with life transitions (e.g., sexuality, birth, death) (Lauver, 2000).

Historians often depict the development of professional nursing as emerging from a domestic avocation. They have inferred that professional nursing grew from natural roles of women caring for sick family members who expanded their interest to caring for the community (Sorenson & Wall, 1999). Religion and spirituality have been an integral part of health and healing throughout history. American society has been strongly influenced by Judeo-Christian beliefs and values; however, with the rapid immigration of peoples from diverse cultures, nursing students must be taught that not all people will be subscribers to religious or belief system, shaped by Judeo-Christian philosophy (Johnson, 1998).

Spirituality

Florence Nightingale adopted the spiritual dimension of nursing, grounded in the Judeo-Christian tradition. The principles were regarded an essential basic for high quality patient care (Rassool, 2000). The secular model adopted by the United States,

although it acknowledged religious pluralism, seems to cautiously view the individual nurse's religion as a potential obstacle for the nursing student's ability to develop an attitude of tolerance and acceptance toward the religion of the patient (Catanzaro & McMullen, 2001). Historically, care in the nursing sense had evolved from a religious vocation; those freed from self-preoccupation by their knowledge of God's love were enabled 'into fruitfulness for others" (Greenstreet, 1999).

Whilst many accept the role of religious practice in the expression of spirituality, given the emerging paradigm and the incorporation of a broader perspective, expressions of spirituality cannot be restricted to this narrow view. If spirituality is concerned with self, others, and 'God', the spiritual expression will take a variety of forms (Dyson, Cobb, & Forman, 1997). For the most part, teaching the concept of spirituality is often forgotten, or at best, the intervention most attempted is to refer the client to a religious member of the health care team (Maddox, 2001). Many nursing curricula present students with an overview of particular religious doctrines, practices, and dietary restrictions common to a variety of cultures. This leads students to assume that attention to the patient's religious rituals and requirements will satisfy spiritual needs (Goddard, 1995).

Nursing students often make a link between spirituality and religion when comments about patient religion are placed in the space devoted to spirituality (Kendrick & Robinson, 2000); however, spirituality is not reliant upon religious, secular, or agnostic themes but forms the very essence of human person irrespective of which ideology that individual chooses to embrace (Kendrick & Robinson, 2000).

Spirituality is frequently equated with a religion or religions, even a particular doctrine or belief (Johnson, 1998). Spirituality does not require the practice of religious rituals nor does it require participation in a religious organization (Castellaw, Wicks, & Martin, 1999). If nurses clearly distinguish what they mean by spiritual and religious care, they will be able to actually provide whichever care is appropriate. The assessment and interventions for needs are more easily accomplished when the concepts are clearly defined (Emblen, 1992). Even for the healthcare professionals who profess atheism and agnosticism, or who are skeptical about organized religion, the spiritual aspects of health care, in the broad sense in which the term is defined cannot be ignored (Astrow, et al., 2001).

Spirituality is, in a sense, a two dimensional concept. The vertical dimension has to do with the person's transcendence (beyond and/outside self) relationship, the possibility of person-relatedness to a higher being not necessarily defined by a particular religion. The vertical, God related dimension does not stand alone. The horizontal facet reflects and "fleshes out" the supreme value experiences of one's relationship with God through one's beliefs, values, life-style, quality of life, and interactions with self, others, and nature (Stoll, 1989, p. 7).

There is a host of critical analysis of the concept of spirituality in the nursing literature (Rassool, 2000). The challenge for nursing is to provide a definition of spirituality which is universal in its approach, taking in account the importance and relevance of the phenomenon to clinical practice and allowing for the uniqueness of individuals (McSherry & Draper, 1998). The term spiritual refers to spirit, that which has

no material body or form and that which is sacred and holy. An individual may find spiritual meanings beyond one's present time, place, or person (Lauver, 2000).

The definition of spirituality is broad and variable. In today's multicultural environment, its implications for both patient and nurse differ from case to case. To many, spirituality is a sense of connectedness to a Divine Other, to God. Spirituality is what connects us to others and is a sense that we are not alone and there is meaning beyond our own actions (Rolph, 2001). Spirituality refers to the "human propensity to find meaning in life through self-transcendence; it is evident in a sense of relatedness to something greater than the self; it may or may not include formal religious participation" (Reed, 1991a).

Spirituality is complex, multidimensional, and is uniquely experienced and interpreted by each person (Carson, 1989, p. 13). There is, however, general agreement that spirituality is a basic human phenomenon that helps create meaning in the world (Sumner, 1998). Spirituality is a dynamic activity, a journey, and a quest; it is the evolutionary process of integration through which individuals are impelled to ascribe meaning and purpose of their existence (Goddard, 2000). Spirituality is the process of cultivating the divine nature; that is, discovering and establishing the best conditions for the development of higher qualities. It is the spirit which enables human beings to search for meaning and purpose in life, to seek the supernatural or some meaning which transcends, to wonder about origins and identities, to require morality and equity (Ellison, 1983).

Spirituality maybe defined as connecting to systems such as God, nature or other people, and thus finding meaning through relationships. Key to spiritual care is the

establishment of a balance between control and spirituality that is tailored to an individual patient's history, values and needs (Friedemann, Mouch, & Racey, 2002). A strong sense of spirituality may be associated with the relationship with the Divine, a deep sense of belonging to a greater whole or of participating in the universe, and healing experiences (Lauver, 2000). The dimension of spirituality includes the characteristics of relationship, unity, honor, balance, and healing (Lowe & Struthers, 2001). Spirituality is evident in both common experiences of daily living and special times shared with others, times of joy, sorrow, ritual, loving sexuality, prayer, play, encouragement, anger, reconciliation, and concern (Dossey et al., 2000, p., 95).

Nursing literature has been inconsistent in defining spirituality and religiousness (Burkhart & Solari-Twadell, 2001). For the most part, the treatment of spirituality in nursing texts dealt with the spiritual needs of the patients, particularly as these needs related to the religious preferences of patients (Catanzaro & McMullen, 2001). Nursing literature published from 1963 to 1989 was screened for definitions to distinguish the concept of religion from that of spirituality. Following concept analysis procedures, definitions were selected from journal articles and textbooks and the key words in the definitions were listed in order of frequency. In definitions of religion, six words appeared most frequently -- system, beliefs, organized, person, worship, practices. In definitions of spirituality, nine words appeared most frequently -- personal, life, principle, animator, being, God (god), quality, relationship, and transcendent. Only the word person (al) appeared on both lists. The distinction between spirituality and religion is an important one, because the concepts are sometimes used interchangeably in the nursing community (Emblen, 1992; O'Brien, 2001, p. 6).

In exploring the meaning of spirituality, there needs to be a consideration of the concept outside the commonly held view that it is in some way exclusively related to religion. For some individuals it may be, for others it may not. If the profession is to establish a definition and conceptual framework of spirituality that encompasses the needs of all clients, this narrow and restrictive view of relating the concept to religion must be challenged and expanded (Dyson, Cobb, & Forman, 1997).

Spirituality is a distinct construct that acknowledges that individuals may have faith in a divine being or forces. In addition, spirituality provides a personal sense of meaning and life purpose, separate from beliefs and practices of a particular religion (Mansfield, Mitchell & King, 2002). Spirituality is a way of life, informed by moral norms of one or more religious traditions, through which the person relates to other persons, the universe, and the transcendent in ways that promote human fulfillment (of self and others), and universal harmony (Catanzaro & McMullen, 2001). When people are together on the same level of spirituality, they meet on the same level of the heart (Carson, 1989).

Spiritual orientation refers to the individual's attitudes and outlook about the non-physical aspects of life--the "spirit." It is often reflected in belonging to a church, following a religion, or holding specific religious beliefs (Joint Commission on Accreditation of Healthcare Organizations, 2001). Although many people reflect particular understanding of spirituality, there are many ways of understanding and assessing spirituality that transcend religion (Burkhardt & Nagai-Jacobsen, 2002, p. 13). Spirituality is currently the broader term and may subsume aspects of religion. If these concepts are not clearly defined, the care related to personal life principles, relationships,

and transcendent experiences may be confused with care for personal beliefs and worship practices (Emblen, 1992).

Using clinical knowledge in nursing as well as empirical work as a background, a research study focused on identification of specific nursing interventions regarded by adults as facilitative of their spirituality during hospitalization. A cross-sectional sample consisted of 300 adults distributed into three groups: Group 1, terminally ill hospitalized cancer patients who were aware of the terminal nature of their illness; Group 2, nonterminally ill hospitalized patients; and Group 3, healthy nonhospitalized well adults (Reed, 1991a). The cross-sectional sample participated in the study by responding to structured and open-ended questions about specific nursing interventions that they thought would help meet their spiritual needs. Significant differences were found across the groups, including a higher preference for more direct, spiritually related nursing interventions and more negativity about the nurse's role in caregiving as expressed by the nonterminally ill group. Also, the participants identified several key interventions for spiritual needs that fall within the domain of nursing (Reed, 1991a).

Spirituality is an integral and determining force for people especially when they are facing health challenges. It is important for the nursing student to know about client spirituality (Taylor, 2002, p. 117). The nursing student's degree of comfort in providing spiritual care is imperative to the problem-solving process, which is a valuable component of nursing practice (Simsen, 1985). Nursing students are in a significant position to help patients facilitate health and meet the crisis of illness, hospitalization, and loss through spiritual care (Simsen, 1985). The key to spiritual care is the establishment of a balance between control and spirituality that is tailored to an individual patient's

history, values and needs (Friedemann, Mouch, & Racey, 2002). If the nursing student encourages his patients to share their inner spiritual experiences, a wealth of valuable material could emerge from the silence (Macrae, 2001, p. 29).

The Internal Position Statements

There are many interventions available to the nurse for meeting spiritual needs. These interventions include the nurse's presence and touch, the use of prayer and religious reading material, facilitation of a client's participation in religious rituals while hospitalized, protection of the client's religious articles, use of the clergy, and advocating the client's position when his or her religious beliefs conflict with medical regimen (Carson, 1989). Theoretical support for spiritual caregiving is recognized by professional organizations that influence nursing practice and education. Some professional organizations have issued mandates that direct nurses to offer spiritual care to clients and to teach spiritual care to students (Taylor, 2002, p. 43).

The nursing process, an organized approach to caring, guides nurses to assess, identify client strengths and needs, determine appropriate outcomes, develop a plan to achieve them, implement interventions and evaluate their effectiveness (Bastable, 1997, p. 8). If the human being is deemed to be solely a biophyschosocial entity, excluding the existence and impact of spirituality, then it is arguable whether or not practitioners are assessing, planning, implementing and evaluating the individual's care correctly (Oldnall, 1995).

Many nurses are not comfortable with the spiritual when it comes to giving nursing care. They tend to define the spiritual role of the nursing as one of doing assessment and making a referral (Ackley, 2000). Assessment of the spiritual realm is

difficult because it is elusive. It is immensely easier to identify physiological needs, such as the needs for fluids or safety in which indicators are more readily evident, than to assess the evasive and enigmatic spiritual realm (Boutell & Bozett, 1990). While an initial spiritual assessment or history can provide baseline information regarding a patient's spirituality, it is important to remember that spiritual needs may change, or new spiritual concerns may arise during an illness experience (O'Brien, 1999, p.59).

Assessing spirituality goes beyond inquiring about a client's membership in a particular religion and taps deeper beliefs and feelings about the meaning of life, love, hope, forgiveness, and life after death (Pender, 1996, p. 132). Indicators of spiritual needs may be expressions of fear, doubt and despair, whether verbal or nonverbal. The nurse's response to even simple clues may determine whether a patient is willing to share deeper concerns of a spiritual nature. Another opportunity is listening if the patient indicates a fear of dying. Unless a patient talks openly about his or her relationship to God, which is rare, the nurse must ask for clarification of clues given (Piles, 1990).

In 1978, the Third National Conference on Classification of Nursing Diagnosis recognized the importance of spirituality by including "spiritual concerns," "spiritual distress, " and, "spiritual despair" in the approved list of approved nursing diagnoses (Ellerhorst-Ryan, 1985). In 1980, the Fourth National Conference combined these three categories into one, "spiritual distress," which they defined as "a disruption in the life principle which pervades a person's entire being and which integrates and transcends one's biological and psychosocial nature" (Ellerhorst-Ryan, 1985). In 1996, NANDA described spiritual well being as a process of an individual's developing/unfolding of mystery through harmonious interconnectedness that springs from inner strength. This

definition is specific to NANDA's nursing diagnosis (North American Nursing Diagnosis Association, 1996).

The American Nurses Association states that the professional nursing role is care, cure, and coordination (Bevis, 1989, p. 49). The American Nurses Association's Standards of Clinical Nursing Practice (1998) states that data collection for an assessment may include the following dimensions: physical, psychological, sociocultural, spiritual, cognitive, functional abilities, developmental, economics, and lifestyle. Some of the values and assumptions that undergird Nursing's Social Policy Statement are that humans manifest an essential unity of mind/body/spirit, human experience is contextually and culturally defined, health and illness are human experiences, and the presence of illness does not preclude health nor does optimal health preclude illness (The American Nurses Association, 1999, p. 3-4).

The American Nurses Association Code of Ethics specifies: "the nurse, in all professional relationships, practices with compassion and respect for the inherent dignity, worth and uniqueness of every individual, unrestricted by considerations of social or economic status, personal attributes, or the nature of health problems" (American Nurses Association, 2001). Provision 1.1 states that respect of human dignity, a fundamental principle that underlies all nursing practice, is respect for the inherent worth, dignity, and human rights of every individual (American Nurses Association, 2001). The measures nurses take to care for the patient enables the patient to live with as much physical, emotional, social, and spiritual well-being as possible (American Nurses Association, 2001). The American Nurses Association (ANA) Code of Ethics specified that the nurse,

in providing care, promotes an environment in which the values, customs, and beliefs of individuals are respected (Sumner, 1998).

American Association of Colleges of Nursing's (AACN) document *Older Adults: Recommended Baccalaureate Competencies and Curricular Guidelines for Geriatric Nursing Care* addresses spirituality in assessment (American Association of Colleges of Nursing, 1999b). The AACN Core Competency 5 states: assessment incorporates into daily practice valid and reliable tools to assess the functional, physical, cognitive, psychological, social, and spiritual status of older adults (American Association of Colleges of Nursing, 1999b).

The AACN competencies for care during the transition at the end of life address spirituality in two provisions: (a) Provision 4 relates to the nurse's own attitudes, feelings, values, and expectations about death; and (b) Provision 10 relates to spiritual diversity existing in these beliefs and customs (American Association of College Nurse, 1999b). Nurses are called upon to assess and treat multiple dimensions, including physical, psychological, social and spiritual needs, to improve quality at the end of life. The AACN recommends coursework for students that addresses psych-mental health and communication issues and provides multiple opportunities to discuss end of life issues, for example: (a) communication with the patient and family, (b) eliciting patient's and family's wishes for end-of-life care, and (c) recognition of the student's own attitudes, feelings, and expectations about death (American Association of College Nurse, 1999b).

External Position Statements

In 1946, the World Health Organization defined health as "a state of complete physical, mental, and social well-being, not merely the absence of disease or infirmity"

(Bevis, 1989, p. 107). Later in 1998, the World Health Organization proclaimed that the definition of health included four domains of well-being: physical, mental, social, and spiritual (Shih, Gau, Mao, Chen, & Kao Lo, 2001). The *World Health Organization's Fact Sheet 8 HIV Palliative and Terminal Care* defines palliative care as the combination of active and compassionate therapies to comfort and support individuals and families living with a life-threatening illness. Palliative care should start at the time of diagnosis and can be combined with therapies for treating opportunistic illness; or it may be the total focus of care. During the periods of illness and bereavement, palliative care strives to meet the physical, psychological, social and spiritual needs while remaining sensitive to the personal, cultural, and religious values, beliefs and practices (World Health Organization, 2000).

Over 30 years ago, the American Hospital Association addressed spiritual care of the patient. The 1973 American Hospital Association's *A Patient's Bill of Rights* states the hospitals should provide a base for understanding and for respecting the rights and responsibilities of patients, their families, doctors, and other caregivers; respect the role of patients in decision making about treatment choices and other care; and, be aware of cultural, racial, language, religious, age, gender, and other differences as well as the needs of persons with disabilities (American Hospital Association, 1973).

Presently, the Joint Commission on Accreditation of Hospital Organizations (JCAHO) requires procedures that reflect the need to recognize and meet the patient's spiritual needs, including those from diverse cultural and religious backgrounds (Vance, 2001). In the section titled Behavioral Health, the JCAHO states that an assessment of a client's spiritual orientation is necessary in order to determine any barriers that the client

might encounter in affiliating with certain types of self-help groups. The JCAHO (2001) Standard PE.1.21.4 states: assessment or reassessment of individuals receiving treatment for chemical dependency addresses spiritual orientation. The assessment gathers information about the individual that will help to match the individual's needs with appropriate setting and intervention. Spiritual orientation refers to the individual's attitudes and outlook about the non-physical aspects of life--the "spirit." It is often reflected in belonging to a church, following a religion, or holding specific religious beliefs. The assessment should, at a minimum, determine the patient's denomination, beliefs, and important spiritual practices, if any (Joint Commission on Accreditation of Healthcare Organizations, 2001).

Nursing Education

In the United States of America there are approximately 1,666 schools of nursing, educating more than half (52%) of all health profession students (Bartel, 2001). Of that total, 695 are educating at the baccalaureate and graduate level (Bartel, 2001). When undergraduate students select nursing as their major, their understanding of nursing may have been solely developed by how media portray nurses and nursing practice. Other times, students' understanding is based on personal experiences with professional nurses in a healthcare setting. The students are adults who are "learning to learn." Learning how to learn refers to the adult's having, or acquiring, the knowledge and skills essential to learning effectively in whatever (learning) situation he encounters. Each situation will make special demands on the learner, and each will impose special learning requirements (Smith & Haverkamp, 1977). An appreciation for nursing as a scholarly discipline is often absent in the mind of those beginning students. Fortunately, students' conceptions

of nursing practice can be continually broadened through their undergraduate educational experience (Welch, Jeffries, Lyon, Boland, Backer, 2001).

Nurses are aware that patients have spiritual needs but they may be unable to give spiritual care for two reasons: (a) nurse education did not adequately prepare nurses for spiritual care; and, (b) spiritual care was seen as a realm of the hospital (Narayanasamy, 1993). Several scholars have developed spiritual care/education models to help the incorporation of the concept of spirituality at clinical sites and nursing education (Shih, et al., 2001). Education may enhance students' capacity to be caring practitioners (Hoover, 2002). The overall objective of nursing education is to prepare student nurses for independent and critical judgment, and to enable them to solve problems independently (Lofmark, Carlsson, & Wikblad, 2001). Nurse educators should consider a renewed understanding of spirituality as a way of life. Spirituality cannot merely be taught. It must be incorporated into one's way of life and it must lead to personal growth (Catanzaro & McMullen, 2001).

Patient's concerns about soul and spirit must be heard (Dossey & Dossey, 1998). The integration of spirituality into the nursing curricula and the recognition of its transcendent, universal nature will prepare practitioners to recognize spiritual distress and plan for appropriate interventions. Importantly, the spiritual dimension is nurtured through activities such as prayer, spiritual rituals, listening, and reminiscence (Leetun & Saabye, 1996). The outcomes of this integration will facilitate the student's intra-professional understanding and communication (Goddard, 1995).

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independent and critical judgment, and to enable them to solve problems independently (Lofmark, Carlsson, & Wikblad, 2001). Nurse educators should consider a renewed understanding of spirituality as a way of life. Spirituality cannot merely be taught. It must be incorporated into one's way of life and it must lead to personal growth (Catanzaro & McMullen, 2001).

The education process has always been compared to the nursing process because the steps of each process run parallel to one another, but with a different slant. The education process, like the nursing process, consists of the basic elements of assessment, planning, implementing, and evaluation. The education process is a systematic, sequential, planned course of action consisting of two major interdependent operations, teaching and learning, which form a continuous cycle. The process also involves two interdependent players, the teacher and the learner (Bastable, 1997, p. 8). Using techniques for whole-person assessment, studying the body as metaphor, and using energy field principles for assessment need to be the foundation for nursing education (Dossey, et al., 2000, p. 223).

Nursing education, reflecting the need for change toward greater attention to both diversity and inclusiveness in practice, has moved simultaneously toward an emphasis on meaningful caring in lieu of purely technical care and increased valuation of transformative and experiential learning, oral inquiry, narrative, and stories. Nursing education has increased its appreciation of critical, inductive, and participatory method that challenge the discourse of risk and pathology to support understanding and building on real life experiences, strengths, and potentials. Nursing education is now at the point of putting its expertise in intercultural communication, care, and practice together with its

new approaches to pedagogy and participatory practice and research (Kavanagh, Absalom, Beil, & Schliessmann, 1999).

The importance of addressing spiritual needs has been acknowledged in British and international guidelines for nurse education (Greasley, Chiu, Gartland, 2001). Despite these policies and education guidelines, the subject of spirituality remains neglected and poorly understood (McSherry, 1998). Spirituality, in particular, was illuminated for the students as an important means of developing both themselves and their caring practices (Hoover, 2002).

The difficulty nursing students have in arriving at a definition of spirituality is due to of a lack of guidance from theorists and educationalists (Oldnall, 1996). Few nurse theorists have incorporated the spiritual dimension into their theoretical frameworks (Rassool, 2000) and most research dealing with spirituality has focused on religiosity (Ellerhorst-Ryan, 1985). Faculty members in many medical and nursing schools are prejudiced against world views other than empiricism, such as symbolic interactionism and its related philosophies, hermeneutics, ethnography, phenomenology, and grounded theory. As a result, health professionals who graduate from these schools of thought have learned little about client spiritual needs (Shih, et al., 2001).

Nurse educators have had a poor record in preparing nurses adequately for providing spiritual care (Greenstreet, 1999). Bush (1999) examined the development of a teaching format suitable for teaching spirituality and spiritual care to a group of mature age nurses, all of whom were older than the age of 25 years. A teacher's journal was kept that assisted in the identification of classroom activities that aided in relating the experiences to concepts and practices of adult learning. Whilst these precepts were

valuable as a means of resolving teaching concerns, it was the journal entries that identified the issues relating to the teaching process. Some of these issues were the use of student and educator experiences as a medium for reflection, the willingness of the educator to follow students' wishes to discuss apparently unrelated material, the facilitator being apart from the group as well as a part of the group, and the necessity for journal entries to be made as soon as possible after the completion of the class (Bush, 1999).

Filling the spiritual vacuum that exists in nursing education must begin with the nurse educators in order to integrate spirituality in the curricula (Catanzaro, & McMullen, 2001). The goal of the educator is not only to teach facts and information needed at the moment but also to develop capabilities and skills that will enable the learner to apply the learned information in future situations (DeYoung, 1990, p.31). Nurse educators are vital in giving support, direction, and encouragement during the process of learning. The educator can help the nursing student identify optimal learning approaches and then provide assistance in choosing learning activities that can both support and challenge the learner based on individual learning needs, readiness to learn, and learning style (Bastable, 1997, p. 57).

Baccalaureate Nursing Student

Students are the hub around which the educational wheel turns (Bevis, 1989, p. 74). The American Association of Colleges of Nursing found that the total enrollment in all nursing programs leading to the baccalaureate degree was 106,557 in 2001 (American Association of Colleges of Nursing, 2002c). Nursing students comprise more than half of all health professional students (American Association of Colleges of Nursing, 2000d)

and many nursing students go into health care out of a desire to help people get better and to minimize suffering (American Holistic Nurses' Association, 2002e).

According to March 2000 National Sample Survey of Registered Nurses, the average age of nursing program graduates is currently 30.5, and this average is increasing every year – indicating that more and more students are entering the field after having pursued another career (Freudenheim & Villarosa, 2001). Nursing schools enroll more diverse students than medical (10.5%) or dental colleges (11%). The overwhelming majority of students in today's baccalaureate nursing programs are female (91%) from non-minority backgrounds (73.5%) (American Association of Colleges of Nursing, 2001). Females comprise about 51% of the population and minority group representation is rapidly approaching 33%. Today's nursing students do not mirror the nation's population (American Association of Colleges of Nursing, 2001). Some students enter baccalaureate nursing programs as registered nurses having already completed their basic nursing education at diploma and associate degree programs. Students make the transition from the predominately technically focused role acquired in diploma and associate degree programs with varying degrees of success and at different rates (Garbin, 1991, p. 79).

Baccalaureate education is offered in university settings and provides students with a broad perspective and understanding of multiple content areas. The baccalaureate nursing program of study integrates approximately 60 hours from a variety of liberal arts and science courses and 60-70 hours of nursing courses (Board of Nurse Examiners for the State of Texas, 2001). The bachelor of science in nursing curriculum includes a broad spectrum of scientific, critical thinking, humanistic, communication, and leadership

skills (Bartel, 2001). It is in the clinical laboratory that many skills are perfected (p. 195), problem-solving and decision-making skills are refined, organization and time-management skills are gained, and the nursing student becomes professionally socialized (DeYoung, 1990, p. 196).

The goal of baccalaureate nursing education is to prepare nursing students to function as competent registered nurses in the health care work force (Letizia & Jennrich, 1998). The nursing profession has struggled for decades with concerns about educational preparation and skill levels necessary for providing safe and appropriate nursing care. Educators agree that nursing practice requires a strong background in the basic sciences -- biology, anatomy, chemistry, pharmacology, and pathophysiology. These basic sciences lay the foundation for the assessment skills that allow for the formulation of plans of care by nurses at the bedside. With patients in hospitals, long-term care settings, and the home care arena having complex multi-system illnesses, nurses must provide a critical level of assessment skills, employ highly complex forms of health interventions, and use advanced technology (Bartel, 2001). During the clinical component of the program, individual nursing faculty are placed with a group of students who provide direct nursing service to selected clients in the clinical setting (Letizia & Jennrich, 1998). The clinical setting is replete with affective learning experiences. The setting in which students are asked to effect behavior change is a complex one where values and expectations of participants are shared, competitive, and contradictory. The teacher comes to the setting with his or her own perceptions, values, and convictions about the world of nursing, student learning behavior in a practice setting, and how health care ought to be delivered in that setting. Likewise, the students bring to the setting their own

ideas and values, some of which will be altered in the process of learning (Reilly & Oermann, 1992, p.321).

Clinical experiences provide the means through which nursing students develop an understanding of the patient's problems, the nursing management, the psychomotor and technological skills, and the importance for caring for others (Oermann & Standfest, 1997, p. 115). Such skills are essential for today's professional nurse who must make quick, sometimes life-and-death decisions; design and manage a comprehensive plan of nursing care; understand a patient's treatment, symptoms, and danger signs; supervise other nursing personnel and support staff; master advanced technology; guide patients through the maze of health care resources in a community; and educate patients on health care options and how to adopt healthy lifestyles (American Association of Colleges of Nursing, 2002b).

Learning is a change in behavior, perceptions, insight, attitude, or a combination of these that can be repeated when the need is aroused. The change in behavior may or may not be directly observable; however, the effects of learning are always observable (Bevis, 1989, p. 78). In addition to the liberal learning and global perspective gained from a four-year baccalaureate education, the BSN curriculum includes clinical, scientific, decision-making, and humanistic skills, including preparation in community health, patient education, and nursing management and leadership (American Association of Colleges of Nursing, 2002b).

Baccalaureate nursing graduates are prepared to synthesize information from various disciplines, think logically, analyze critically, and communicate effectively with clients and other health care professionals (Board of Nurse Examiners for the State of

Texas, 2001). Also, the baccalaureate nurse is well-qualified to deliver care in private homes, outpatient centers, and neighborhood clinics where demand is fast expanding as hospitals focus increasingly on acute care and as health care moves beyond the hospital to more primary and preventive services throughout the community (Bartel, 2001).

The Patient

Faith factors in health and spirituality are believed to have a role in determining one's health and life span (Mansfield, Mitchell, & King, 2002). The average life span is increasing rapidly and it has been estimated by 2020 more than 20 percent of the population will be 65 and older, with those over 85 constituting the fastest growing age group (Heller et al., 2001). In seven years, there will be five million more people over 65 than there was seven years ago. Seven years after that, there will be 22 million more (Andersen, 1998).

Since the spiritual awakening emerged in the 1960s counter-culture, spiritual ethics has been widening its influence to the entire culture. Numerous writers have suggested the widespread use of psychedelic drugs brought about an unprecedented collective opening of the doors of perception. A significant segment of the 40 million people born between 1945 and 1955 who were raised middle class in traditional religious environments suddenly turned within and began having intense experiences that went far beyond anything that their culture up to that time could provide or explain (Taylor, 2001). The Gallup polls have consistently reported 95% of Americans believe in God and 42% said they attend church weekly (Astrow et al., 2001).

Spirituality has become an accepted part of contemporary American culture (Daaleman, Cobb, & Frey, 2001) and the role of spirituality in promoting health and

improving patients' response to illness is receiving increased attention (Vance, 2001). Social restraint has never been a major barrier to nurse/patient interaction. The very nature of a professional relationship gives the nurse a license to deal with some issues not normally discussed. The nurse/patient relationship, unlike social relationships, is bound to respect and confidentiality. Spirituality could certainly be considered one of the socially taboo topics that become acceptable within the nurse/patient relationship (Dettmore, 1984).

An extraordinary amount of evidence suggests the conception of spirituality is undergoing enormous change. Books and magazine articles, weekend retreats, seminars, spiritual enlightenment, communication with angels, and conversations with God are vogue. Personal testimonies to belief in a higher power are now regularly proclaimed, not from the church pew, but in cancer support groups, meditation centers, wellness treks, Alcoholic Anonymous, and other 12-step programs (Taylor, 1994). While acknowledging the importance of 12-Step Programs of Alcoholic /Narcotic Anonymous, it is also acknowledged that spirituality is a major aspect of addiction and recovery from addiction (Okundaye, Smith, & Lawrence-Webb, 2001).

Health promotion and illness prevention services parallel the specific needs and strengths of the church members across the life span (Leetun & Saabye, 1996). Religion and spirituality play vital roles in the lives of elderly individuals in time of crisis and chronic illness (Weaver, Flannelly, & Flannelly, 2001). Older adults, in particular, have been found to experience a deeper sense of spirituality as they age and rely on their beliefs in confronting their losses, suffering, illness, and even death (Leetun, 1996). Gerontological nurses are in a unique position among health professionals to make

contributions to the understanding of religion and spirituality in mental and physical health assessments and care (Weaver, et al., 2001).

A study was conducted that compared meaning-in-life and other related variables (Buchanan, 1993). The researcher used comparative survey design to examine relationships between spirituality, hope, health, social support, meaning-in-life, depression, and suicide. The sample consisted of 160 older adults with equal number of men and women who were depressed and not depressed. The model developed for the study assumed: in older adults that hope, spirituality, hope, health, and social support variables are essential concepts within which meaning-in-life occurs; the absence of clear meaning-in-life may contribute to the presence of depression; and depression is usually present in conjunction with thoughts of suicide. Findings showed there were few differences within the demographic variables; however there were statistically significant differences for the individual variables based on diagnosis. The finding showed: (a) higher levels of meaning-in-life were associated with higher level of spirituality, hope, health, and social support, (b) the nondepressed sample had higher level of meaning-in-life, spirituality, hope, health, and social support, (c) there was an inverse relationship between meaning-in-life and depression, and (d) higher levels of meaning-in-life and lower levels of depression predicted lower levels of suicidality.

Lifetime theories on adult cognitive and personality development indicate there is the propensity in later life for a spiritual or transcendent perspective of reality (Reed, 1991b). The world of spirit becomes more important as a person grows and matures individually and as humans evolve collectively (Martsolf & Mickley, 1998). Nurturing body, mind, and spirit is part of holistic care, and yet often the primary focus of care in

the nursing home is physical needs. Nurses in nursing homes have the opportunity to establish relationships with residents over time, often substituting for family and friends no longer available. Because length of stay is long, more time is available to enter into spirit-sharing relationships with residents (Theris & Touhy, 2001).

In the West, it is acknowledged that not every individual who seeks self-awareness, self-empowerment and self actualization pursues a particular religious belief or faith (Rassool, 2000). The development of a spirituality unit for health education and lifetime wellness courses is an important curriculum issue today. The impact of this dimension on an individual's overall well-being needs to be fully understood in relationship to the entire wellness dimension. Spiritual awareness activities, journaling, mindfulness practice, meditation, and yoga provide opportunities to experience connectiveness, mindfulness, and/or spirituality as part of everyday life (Scandurra, 1999).

Patients consider the nurse talking to them about religion as an appropriate spiritual care intervention (Reed, 1991a) and spiritual care may be of greater value to the patient than it is to their primary caregiver (Stranahan, 2001). Patients often need a person who will allow them to address their problems about God in a non-threatening environment (Piles, 1990). Patients don't have grandiose expectations. Their requests are simple: that the nurse listens, the nurse recognize spiritual needs enough to call a chaplain, and that the nurse prays with or for them (Dettmore, 1984).

Each individual has a cultural background including spiritual beliefs and religious practices (Tongprateep, 2000) and must recognize that he is the spiritual expert about his life, that the journey of wholeness and healing requires his spiritual understanding, and,

that understanding is a developing process (Dossey, et al., 2000, p. 650). The pattern of personal knowing refers to the quality and authenticity of the interpersonal process between each nurse and each patient. This pattern is concerned with the knowing, encountering, and actualizing of the authentic self; it is focused on how nurses come to know how to be authentic in relationships with patients, and how nurses come to know how to express their concern and caring for other people. Personal knowing is not "knowing one's self" but rather knowing how to be authentic with others, knowing one's own "personal style" of "being with" another person. Personal knowing is what is meant by "therapeutic nurse-patient relationships." Personal knowing is developed by means of opening and centering the self to thinking about how one is or can be authentic, by listening to responses from others, and by reflecting on those thoughts and responses (Fawcett, Watson, Neuman, Walker, & Fitzpatrick, 2001).

In addition to physical, social, and psychosocial pain, religious and spiritual pain can add to the struggle for many patients. Religious pain is rooted in guilt leading to punishment and experienced as fear. Spiritual pain is rooted in shame leading a patient to abandon hope in God's love. Religious pain is resourced through the positive teaching of the patient's religious legacy while spiritual pain is resourced through bringing unconditional love to the patient's sense of self-hatred and inner criticism (Satterly, 2001).

Young adults between the ages of 18 and 24 are exploring topics in spirituality (Cavendish, et al., 2001). They question everything they have been told, dissect the truth, and the myths, and draw their own conclusions. Their questions about the physical world are answered sometimes by truth and sometimes by myth. Questions about the

metaphysical world cannot be addressed by science and rely on myth, great faith, logic, and reason to formulate the answer. Many questions arise in the struggle to cope with more complex changes and relationships. A plan that meets the young adults' spiritual needs is urgent. Nurses need to acknowledge the developmental process of young adults from diverse cultures so they can accurately assesses human responses in the spiritual domain and intervene appropriately; however, spirituality and its significance to well young adults have not been widely studied. Thus our understanding of the phenomenon in this age group is limited (Cavendish, et al., 2001).

Women's spirituality also honors the fundamental relationship among all life form. For example, Native Americans not only focus on the union of body, mind, and spirit and the immanence of the divine, but also on maintaining respectful relationships with all forms of creation. African American women's spirituality groups have focused on valuing personal experiences, interpersonal relationships, and establishment of community, as well as respect for connection with the natural world (Lauver, 2000).

The study of spirituality may contribute to knowledge about significant experiences among terminally ill individuals. A research study that was designed to extend initial research into the significance of spirituality among terminally ill adults was conducted. The sample consisted of 300 adults from the same geographical location in southeastern United States and who were more acutely ill than those in an earlier study (Reed, 1987). Two hypotheses were examined using three groups of 100 adults matched on age, gender, education, and religious backgrounds: (a) terminally ill hospitalized adults indicate a greater spiritual perspective than nonterminally ill hospitalized adults and healthy nonhospitalized adults, and (b) spiritual perspective is positively related to

well-being among terminally ill hospitalized adults. All 300 participants completed the Spiritual Perspective Scale, Index of Well-Being, and other information. Results found the terminally ill hospitalized indicated greater spiritual perspective than either nonterminally ill hospitalized adults or healthy nonhospitalized adults. Also, the results supported a positive relationship between spiritual perspective and well-being in the terminally ill hospitalized and group.

Approaching the topic of spirituality in nursing in a contemporary society is both difficult and critically important (O'Brien, 2001, p. 5). The focus of care includes not only the individual with family as clients, but also extends to the aggregates, community, and society within the context of the environment, available resources, and technology (Board of Nurse Examiners for the State of Texas of Texas, 2001). Both cultural and family traditions contribute to the many aspects of an individual life; often providing the purpose of life, the spiritual beliefs, and, the role expectations for each age group (Buchanan, 1993, p.13).

The importance of spiritual issues to the patient with acquired immuno-deficiency syndrome is apparent in the wide variety of publications written by and for them (Carson & Green, 1992). An investigation was conducted to examine the relationship among spirituality, perceived social support, death anxiety, and nurse willingness to care for patients with Acquired Immunodeficiency Syndrome (AIDS). The study involved a volunteer sample of 220 female registered nurses who chose to work on an AIDS-dedicated unit or a Medical-Surgical unit with a daily census of 5 to 50 percent patients with AIDS (Sherman, 1994). Hierarchical analyses were conducted to test the hypotheses. First, there is an inverse relationship between spirituality and death anxiety,

independent of perceived support. The hypothesis was supported with spirituality contributing to 3% of the variance in death anxiety. Second, there is an inverse relationship between perceived social support and death anxiety, independent of spirituality. The hypothesis was not supported. Third, there is a positive relationship between spirituality and nurses' willingness to care for AIDS patients, independent and perceived social support and death anxiety. The hypothesis was supported and spirituality uniquely contributed to 2% of the variance in nurses willing to care for AIDS patients. Fourth, there is a positive relationship between perceived social support and nurses' willingness to care for patients, independent of spirituality and death anxiety. This hypothesis was supported and perceived social support uniquely contributed 5% to the variance in nurses' willingness to care for AIDS patients. And finally there is inverse relationship between death anxiety and nurses' willingness to care for AIDS patients, independent of spirituality and social support. The hypothesis was supported and death anxiety uniquely contributed 4% to the variance in nurses' willingness to care for AIDS patients. Based on the results of t-test, AIDS-dedicated nurses were found to have statistically significant ($p<.05$) higher mean scores on willingness to care for AIDS patients and spirituality. Yet there were no significant differences in group means on perceived social support and death anxiety (Sherman, 1993).

Positive spirituality preserved through religiosity can be a useful tool in the care of people who are dying. Spirituality concerns the connectedness with self, others, environment. Religiosity described postures and acts done alone or in company with others that preserve practices and spiritual understandings for the good of the terminally

ill. The home care and the hospice nurse must understand these principles and act in concert with the care team to accomplish care goals (Cairns, 1999).

Often, a nursing student's first experiences with client care are in an extended care facility where the environment allows for skill development without demanding a higher level of knowledge than the students have attained (Moll, Cook, & Saul, 2001). Students find themselves caring for patients and families enduring the effects of devastating illnesses. Healthcare restructuring and downsizing can place nursing students on the "frontline" caring for patients and families during episodes of pain, suffering, and death (Clingerman, 1996). The student should allow the patient to express his feeling toward God and determine the basis for those feelings in order for him to receive appropriate help. The assessment skills necessary to identify spiritual needs include a "listening ear" and sensitivity to tiny clues such as noticing if any religious articles are in the room and asking about their significance (Piles, 1996).

Nurses are often not educated about spiritual care and those nurses who do receive education are taught to use psychosocial interventions, rather than spiritual care interventions (Cross, 1996). One of the many ways to teach spiritual care is presented in the course "Spiritual Dimension of Nursing Care" designed by Joanne Cross (1996). The course was designed for professional nursing students, practitioners, and educators to facilitate the teaching and practice of spiritual needing care based on foundations of nursing theory and within the framework of the contemporary nursing process (Cross, 1996). Sessions one through four focused on foundations and the essence of spiritual care, the developmental aspects, and the importance of considering cultural diversity.

Independent nursing interventions were defined as actions performed by a nurse that will help achieve a patient outcome that falls within the realm of nursing (Cross, 1996).

The Call

The concept of the "calling" is traced throughout the development of nursing education, service, organization, and the profession. Many of the predominant professional values are held today drawn from once dominant religious forces. From the time of Jesus, Christian nursing of the sick has been guided by a spiritual call to care (O'Brien, 2001, p. 4). Historically, nursing was viewed in large part as a vocation of service. The nurse's mission was considered to be driven by altruism and empathy for the sick, especially the sick poor. The practicing nurse of the early and middle 20th century did not expect much in terms of worldly rewards for her efforts (O'Brien, 1999, p. 2). From the middle Ages, the old, sick, and dying looked to religious practitioners for comfort. Thus when the nuns opened hospitals, those institutions became training grounds for students (Taylor, 2002, p. 36). Although Nightingale viewed nursing as a calling, her nonsectarian model did not advocate one religion over another but considered religion essential to the spiritual and moral development of the nursing student (Catanzaro & McMullen, 2001).

During the period of 1915 to 1929, nursing began taking control of its own destiny (Waring, 1983). The educational system was moving in the direction of standardization and more nurses than others outside nursing were contributing to the nursing literature. The calling in the form of ethics and expressed idealism entered into the curriculum. Duty was upholding traditions and ideals (Waring, 1983). During the 1930s and 1940s nurses were still drawn to the profession by the greater opportunity for

social service (Waring, 1983). The conflict between the real and ideal continued. Student recruitment in 1940 was difficult and those who did enter came filled with zeal and enthusiasm that was often squelched during training (Waring, 1983).

With the development of modern science, medicine and religion took separate paths. Gradually, nursing preparation moved into university settings and government agencies assumed responsibility for licensing and oversight (O'Brien, 2001). By the mid-twentieth century, religion became less visible as a component of nursing. The development of modern scientific methods and technological advances in health care served to devalue interventions that could not be easily controlled or quantified, including those essential to spiritual care giving (Taylor, 2002, p. 36).

Across the country some nursing school deans and hospital administrators are concerned about a possible increase in students who seem to be interested in nursing only because they want a guaranteed job. People in the fields of engineering to psychology, English to computer technology, are taking another look–sometimes a first look at a career in nursing (Domrose, 2001). Future students will be (arguably, already are) motivated to enter nursing school part time, will attend school part time, and will have family responsibilities, such as caring for elderly grandparents or an unemployed spouse. Nontraditional students will be the norm (Wilkinson, 1996). These nontraditional students are entering schools of nursing at an older age and are bringing varying college and work experiences, as well as more sophisticated expectations for their education (Heller, et al., 2001). Students are entering nursing schools with increased ethnic and racial diversity, at an older age, with full time careers, and may be raising families (Heller et al., 2001).

Helping the nursing student learn is the purpose of education (Smith & Haverkamp, 1977). Without preparation and self awareness, the nursing student may feel inadequately prepared to address spiritual needs or may be embarrassed to address subjects which are often considered to be highly personal (Goddard, 1995; & Shih et al., 2001). American nurses are leading the way in exploring the concepts of spirituality and establishing its importance in holistic care (Oldnall, 1995). The degree to which the nursing student is self-aware influences nursing care, especially spiritual caregiving (Taylor, 2002, p. 66).

Spirituality in Research

Nurses and administrators have always been interested in identifying what nurses do, perhaps for different reasons. At various points in time, even industrial task analysis was common. Assessing and monitoring medical treatments and technology, administering medications, and assisting the patient to carry out the physician's orders were high priority in the traditional typology of nursing interventions. This situation changed with the publication of nursing theories and philosophies beginning at mid-twentieth century and the introduction of nursing diagnosis and clinical judgment. "Independent" nursing interventions that were nurse-initiated were given increased emphasis in curricula and in practice (American Nurses Association, 2000a).

Although a number of studies have examined the concept of spirituality and its impact on illness and health outcomes with individuals, there is little research related to spirituality in nursing education and in nurse educators' perspective of spirituality (Miklancie, 2001). Nursing research related to spiritual issues has been hampered by a variety of factors, including discomfort among nurses who believe that spirituality and

spiritual needs are a private matter, difficulty in distinguishing psychosocial needs from spiritual needs, lack of valid and reliable measurement tools that address spiritual concerns, and confusion about differences between spiritual concerns and religiosity. In light of nursing's focus on the total person, a cause of concern is the noticeable absence of the spiritual dimension in nursing theory and research (Ellerhorst-Ryan, 1985). Many nursing theorists recognize clients as bio-psycho-social-spiritual beings, and while most developed ways to categorize various human dimensions, all recognize multiple aspects of being human and advocate the provision of holistic care (Barnum, 1996; Dossey, et al., 2000; Taylor, 2002, p. 38).

Spirituality is the focus of discussion in nursing and other health professions in the United States of America, but whether or not it should be generally included in patient care is heavily debated. Also unanswered is the question about how spirituality should be addressed (Friedemann, Mouch, & Racey, 2002). When the nursing profession was first establishing itself as a science, words like biophysical and psychosocial were dominant. Subjective terms like spirit, spirituality, and spiritual needs were avoided and viewed as unscientific. In fact, nursing has had a strong tradition in the spiritual dimension of health care (Sumner, 1998).

In the caring professions a focus on individuals as bio-psychological-spiritual beings is gaining recognition and this notion is based on the premise that there should be a balance of mind, body, and spirit for the maintenance of health in a person. Emerging research highlights the spiritual care in nursing and suggests that there is scope for improving this dimension of care in order to improve the quality of life for many patients;

however there is little evidence about how nurses respond to the spiritual needs of their patients (Narayanasamy & Owens, 2001).

In central Massachusetts a large parish asked the University of Massachusetts, Amherst School of Nursing to conduct a community assessment of the church and newly employed parish nurses (Swinney, Anson-Wonkka, Maki, & Corneau, 2001). The aims of the assessment were to: determine the health status of the parishioners, identify their perceived health needs and perceived barriers in meeting those needs, and to assist the church and parish nurse in developing a health program for their faith community. Four hundred and twenty-one questionnaires were completed and six focus groups were held to validate the data (Swinney et al., 2001). Results showed that 93% of parishioners felt that they were in good health, 91% believed faith and spiritual belief were important in maintaining health and well-being, and 70% thought that the church should play a role in helping parishioners meet their health needs (Swinney et al., 2001).

A critical incident study was conducted to: (a) describe what nurses consider to be spiritual needs; (b) explore how nurses respond to the spiritual needs of their patients; (c) typify nurses' involvement in spiritual dimension of care; and (d) describe the effects of nurses' intervention related to spiritual care. Critical incident questionnaires were completed by 115 nurses who attended a post-registration modular course at a university (Narayanasamy & Owens, 2001). The data from these incidents were subjected to content analysis and categories were developed and described. There was an overwhelming consensus that patients' faith and trust in nurses produces a positive effect on patients and families. In addition, nurses derived satisfaction from the experience of giving spiritual care. In this respect, spiritual care interventions promote a sense of well-

being in nurses as well as being a valuable part of total care. The study findings suggested that there is confusion over the notion of spirituality and the nurse's role to spiritual care (Narayanasamy & Owens, 2001).

While research has supported the association between a nurse's own spirituality and the perceptions of its importance to patients, how nursing students intervene spiritually has received little attention (Vance, 2001). Very little research has been done in America and the United Kingdom into the preparation of nurses to meet the spiritual needs of patients during their formal education (Oldnall, 1996). The definitions for spirituality lack uniformity and clarity within the health care research (Daaleman, Cobb, & Frey, 2001; Strang, Strang, & Ternestedt, 2002). Rhetoric about spirituality and nursing has greatly increased as scientific-based approaches are not fully able to address many human problems, such as persistent pain. Despite the renewed interest and growing literature on spirituality, there is no consensus on a definition of this concept.

Without a precise theoretical definition of spirituality, it will remain difficult to recognize or appreciate spiritual meanings or distress, much less to meet spiritual needs in professional nursing practice (Goddard, 1995). There is also ambiguity on how this concept is incorporated into nursing practice, research, and education (Tanyi, 2002). One of the biggest obstacles for nursing research and practice has been the lack of conceptual clarity of the term "spirituality." Nurses, as well as professional in other disciplines, have struggled to define spirituality. One of the reasons for this confusion is that most nursing models and theories do not specifically address spirituality (Martsolf & Mickley, 1998).

The relationship of spiritual well-being of 29 senior-year baccalaureate nursing students and 24 graduate nursing students enrolled in a public institution was examined

(Soeken & Carson, 1986). The sample used two research instruments: the Spiritual Well-Being Scale, which measured an individual's religious and existential welfare; and the Health Professional's Spiritual Role Scale, which measures attitudes regarding the part that care providers should play in patients' spiritual care. The study confirmed the correlation between a nurse's spiritual well-being and his or her views about the provision of spiritual care by health professionals (Soeken & Carson, 1986).

From this study, four possible reasons were offered for the virtual exclusion of spiritual care from nursing. The first three factors were: nursing has become biologically oriented, nurses believe spiritual issues are not a nursing concern and should be delegated to a chaplain, and the nurses lack training to meet patient's spiritual needs. The fourth factor in the lack of attention to spirituality is the inadequacy of the nurse's own spiritual resources or spiritual well-being. The results of the study do not necessarily guarantee nurses will use spiritual care interventions in their practice, and therefore the educational process should be directed toward knowing and practicing the implementation of activities involved in spiritual care (Soeken & Carson, 1986). The individual with high spiritual well-being has a motivating sense of direction and order that can be used to assist another. Such harmony with the self is necessary before the nurse can assist the patient spiritually (Soeken & Carson, 1986).

Sixty-three registered nurses with a minimum of two years of clinical experience were surveyed to identify the nurse's conception of practice in the spiritual dimension of nursing (Dettmore, 1986). The subjects participated in half-hour interviews conducted by the investigators. When subjects described the spiritual aspects of nursing education, the majority reported minimal to no curricular input and a minority reported maximal input

that was characterized by consistent emphasis on spiritual care in both classroom and clinical setting. The majority of subjects professed greater proficiency in psychosocial rather than spiritual care. Dettmore suggested it was inherently important that nursing education include measures that enhance the spiritual awareness and spiritual well-being of nursing students. She also noted spiritual care in the curriculum will provide knowledge and experience for providing adequate spiritual nursing care. Nurses who have a sense of their own spirituality are more likely to feel comfortable addressing the spiritual needs of others (Catanzaro & McMullen, 2001).

The concepts of faith and values are useful in building a conceptual framework for teaching spiritual care (Hitchens, 1988). A descriptive study examined faith, values, and spiritual care in a group of nursing students in a sectarian university. The data was collected from an elective class taught by the researcher. The sample included baccalaureate nursing students (n=11) and registered nurses (n=9) (Hitchens, 1988). Data collection tools included: (a) two spiritual care case studies, (b) a faith development interview, and (c) the Personal Discernment Inventory. The researcher found that majority of the 20 subjects' faith and values stages were congruent and that the major issues in these stages could also be found in the projected interaction with the patients in the case studies. The researcher concluded that nursing educators need to: (a) focus on raising therapeutic communication skill levels, (b) use a consistent format for nursing diagnosis and goal statement, (c) nourish the interpersonal values, (d) foster imaginable skills, and (e) provide ways of integrating the concept of "faith journey" in both theory and practice (Hitchens, 1988).

Thirty-one nursing students enrolled in an elective course on spirituality and 145 nursing students taking other elective courses participated in a study that was conducted to study attitudes and self-reported religiosity (Carson, Winkelstein, Soeken, & Brunins, 1986). A demographic data sheet and the Religious Belief Questionnaire by M. Apfeldorf were administered to the subjects at the beginning and the end of term. Although pretest results indicated significant demographic differences between the two groups, their religious attitudes were positive, with all subscale means above the midpoint. Analysis of covariance revealed that posttest scores differed significantly on the God, Bible, Religious Practices, and Organized Religion subscales. Students in the spirituality elective courses showed an increase in pretest and posttest means, while those in other electives evidenced no change (Carson et al., 1986).

A study was conducted to determine the extent to which nurses assessed their patients' spiritual needs (Boutell & Bozett, 1990). The Boutell's Inventory for Identifying Nurses' Assessment of Patients' Spiritual Need was utilized to survey 238 practicing nurses in Oklahoma (Boutell & Bozett, 1990). Test–retest indicated an acceptable level of reliability. Findings indicated that the majority of nurses assessed their patients' spiritual needs from moderate to considerable extent. The participants most frequently assessed for fear, source of strength, and feeling of hope. Least frequently assessed were integrations, giving love to God, meaning in suffering, and transcendence. Moreover, the nurses ages 50 to 59 and psychiatric nurses were more likely than other nurses to assess the spiritual realm. The nurses' basic education was not found to influence assessment (Boutell & Bozett, 1990).

A research study was conducted to study the spiritual well-being of baccalaureate nursing students, faculty, and their responses about spiritual well-being of the person. The purposive sample of 225 students and 41 faculty members from four National League of Nursing accredited baccalaureate nursing schools in Pennsylvania participated in a research study. Instruments used were the 21-item JAREL Spiritual Well-Being Scale and a demographic questionnaire with three open-ended questions about spiritual well-being of persons. The descriptive–comparative study found that students provided spiritual care to their patients because their nursing curricula had spirituality integrated in all courses. A t-test resulted in a significant difference between students and faculty JAREL Scores. The Cronbach's Alpha for the group was .81 (Fulton, 1992).

A descriptive survey was conducted to determine if a positive correlation existed between (a) nurses' spiritual well-being, religious well-being, existential well-being, and nurses' attitudes; and (b) nurse spiritual well-being and degree of comfort in providing spiritual care, religious and existential care for patients (Cimino, 1992). Study participants were 272 randomly selected registered nurses from the Commonwealth of Massachusetts (Cimino, 1992). The subjects completed a four part questionnaire: (a) the Health Professional Spiritual Role (HSPR) Scale, (b) the Spiritual Intervention Comfort (SIC) Scale designed by the researcher, (c) the Spiritual Well-Being (SWB) Scale, and (d) a background data form with three open ended questions. The analysis of the questionnaires indicated that the nurses had a high level of spiritual well-being and positive attitudes toward providing spiritual care ($p<.001$). In addition, nurses were found to have a high level of spiritual well-being and a high degree of comfort in providing spiritual care, religious, and existential care ($p<.001$) (Cimino, 1992).

Lastly, a study to compare and contrast why women and men choose nursing found male and female subjects did not differ in their desire to care for others (Boughn, 2001). Presumably this was due to the influence of a curriculum emphasizing the caring model. Over a two-year period, the investigators interviewed 12 males and a cohort of 16 female nursing students enrolled in a baccalaureate nursing program (Boughn, 2001). The responses by female and male students were positively correlated around the construct of caring and both groups were clearly motivated by their desire to care for others. Findings showed both groups' usage of caring language and concepts increased as their class level increased. Also, the men and women revealed the evolution in their ability to elaborate on the context and actions of caring in nursing practice as they advanced from the freshman to the senior level (Boughn, 2001).

Summary

Religion refers to a system of beliefs and practices that ideally serve to enhance and express the experience of spirituality. Religion involves mutually interacting systems whereby symbol, myth and ritual. The definition of spirituality is broad and variable. In today's multicultural environment, its implications for both patient and nurse differ from case to case. To many, spirituality is a sense of connectedness to a Divine Other, to God. Spirituality is what connects us to others and is a sense that we are not alone and there is meaning beyond our own actions. As a caregiver, a nursing student needs to remember his role is to understand the patient's spirituality and help the individual to access and utilize his own spirituality. A nursing student lacking personal spiritual awareness might demonstrate avoidance of or failure to identify spiritual distress or needs in others.

CHAPTER III

Methodology

This chapter reports the methods used to seek answers to the research questions to accomplish the purpose of the study. Sections included are the design, description of the setting and sample, the instruments, description of the data collection method and procedure, ethical considerations, risk, benefits, and potential problems. Lastly, the methods of data analysis are described.

Research Design

The purpose of this pilot research study was to investigate whether spiritual education is a part of one baccalaureate nursing curriculum. A pilot study is a small-scale version, or trial run, done in preparation for a major study (Polit & Hungler, 1998, p.710). The pilot study was carried out with as much care as the major study so the detected weaknesses will be truly representative of inadequacies inherent in the major study (Polit & Hungler, 1998, p.39). The primary goal of this pilot research study was to gain a greater understanding of the social realities as observable measurable entities or phenomena (Simsen, 1985).

This pilot study replicated the work of Soeken and Carson (1986) and Cimino (1992) who studied nurses' spiritual well-being and attitudes toward providing spiritual care for patients. In addition, this pilot study assessed the subjects' spiritual involvement

and activity. A nonexperimental, cross-sectional, comparative descriptive, quantitative design was chosen for the investigation. The nonexperimental quantitative approach was chosen because there is no human manipulation, the primary interest is the human behavior, it was not practical to conduct a true experiment, and, the hypotheses embody the nature of comparison to be tested (Polit & Hungler, 1998, p. 193). The cross-sectional design was chosen because the groups compared involved different people and its measurements captured the process of spirituality at different levels of evolution (Polit & Hungler, 1998, p. 478).

The comparative descriptive design was chosen to examine and describe difference in variables in two groups that occurs naturally in the setting (Burns & Grove, 2001, p. 249). Two groups of subjects in various stages of development were examined simultaneously. The assumption was that stages are part of the process that progress over time. Selecting subjects at various points in the process provided important information about the totality of the process, even though the same subjects were not monitored during the entire process (Burn & Grove, 2001, p.252).

Descriptive statistics were used to describe and synthesize the data (Polit & Hungler, p. 439). Quantitative research was utilized for the data collection to address the research objectives, questions, and hypotheses, and variables were measured through the use of questionnaires (Burns & Grove, 2001, p. 50). The quantitative research was used for data collection of numerical data (Polit & Hungler, 1998, p. 478).

Setting and Sample

In September 2002, the investigator conducted the data collection in a comprehensive regional university classroom in southern Texas. Comprehensive institutions focus on

undergraduate education and offer a range of degree programs in the liberal arts, which account for fewer than half of their bachelor's degrees, and in professional fields such as business, nursing, and education (U.S. News & World Report, 2003). Two standardized scales and one demographic questionnaire were hand distributed to a group of volunteers. Then subjects were asked to complete the informed consent form, one demographic questionnaire and two standardized scales. After completion of the tools, each subject was instructed to return the tools inside an envelope to the investigator.

The target population was chosen because they have experienced different levels of spiritual education in the baccalaureate nursing program. A cross-sectional sampling of approximately 97 pre-nursing students and 50 senior baccalaureate nursing students were asked to participate in the study. Findings of this study can be generalized only to nursing students in southern Texas. In cross-sectional sampling, the subject is included in the study because they happen to be in the right place at the right time. A cross-sectional sample is accessible and inexpensive (Burns & Grove, 2001, p. 374-375).

The university classified the nursing students as generic and alternate pathway. The generic student is not a registered nurse. The alternate pathway subject is a registered nurse with an associate degree in nursing. The sample criteria were nonexclusive to gender or ethnic background. The sample inclusion criteria consisted of being: (a) a student enrolled in the baccalaureate nursing classes, (b) an adult over 18 years of age, (c) able to speak, read and write English, and (d) enrolled in the Wellness Class (pre-nursing students) or enrolled in the Leadership Class (senior nursing students).

The pre-nursing subject is pre-apprentice to the entry level of nursing. Their learning environment is the classroom where the depository-repository approach is

commonly used (O'Connor, 2001, p. 104). In contrast, the senior nursing subject is in the last semester of the nursing curriculum. The subject has progressed from the entry level. Some are licensed vocational nurses and registered nurses. Their learning takes place in both the classroom and the clinical setting.

The clinical part of the baccalaureate nursing curriculum offers students opportunities to apply the knowledge they have gained during the theoretical part of their education (Lofmark, et al., 2001). The clinical setting presents the subject with experiential and practical learning opportunities. The clinical setting environment involves a different process from the depository-repository approach that is common to classroom teaching and learning (O'Connor, 2001, p. 104). Provision for experiential learning in addressing ethical, moral and value conflict is essential if affective skills are to be acquired, however, experiential methods without disciplined cognitive skills are not sufficient (Reilly & Oermann, 1992, p. 321).

Instruments

In this pilot study, the two instruments are designed in the Likert scale format. The Likert scale was chosen because it is the most commonly used of the scaling techniques and is designed to determine the opinion or attitude of a subject. It contains a number of declarative statements with a scale after each statement. Response choices in a Likert scale most commonly address agreement, evaluation, and frequency (Burns & Grove, 2001, p. 431). Two standardized scales and a demographic questionnaire were utilized to measure the spiritual attitudes of the subjects. Any survey of student characteristics begins with demography (Bevis, 1989, p. 76). The demographic scale, developed by the investigator, gathers the subject's demographic information pertaining

to age, gender, marital status, educational level, and religious affiliation (Appendix A). The standardized scales were the: "Health Professional's Spiritual Role Scale" (APPENDIX B) developed by Soeken and Carson (1986) and the "Spiritual Involvement and Belief Scale –Revised" (APPENDIX C) developed by Hatch, Burg, Naberhaus, & Hellmich (Hatch, 2002).

Soeken and Carson (1986) developed the Health Professional's Spiritual Role Scale (HPSR) to measure nurses' attitudes toward providing spiritual care. The investigator chose the HPSR Scale to measure attitudes regarding the part each healthcare provider should play in the patient's spiritual care. The Health Professional's Spiritual Role Scale (HPSRS) was utilized to assess the samples' attitudes and to provide the answer to research question number one. The HPSR scale had a 6-point Likert-type response format (1 = strongly disagree; 6 = strongly agree). One critique of the 6-point Likert-type scale is that there was no midpoint. The respondents may have been forced to choose either "3" or "4" for which the response was neutral. Three were chosen when the overall opinions are not so strongly favorable and four were chosen when the overall opinion was strongly favorable (Gaur & Eckert, 1997).

The items were developed from the nursing literature which discussed the spiritual dimension of nursing practice. Both negatively and positively worded items were used to avoid a potential for response bias. Two nurses who teach an elective course entitled Spirituality in Nursing Practice reviewed the items for content (Soeken & Carson, 1986).

The scores can range from 25 to 150, with the higher scores representing more positive attitudes. Pilot testing results found the HPSR scale reliable for research

purposes (Soeken & Carson, 1986). The HPRS scale correlated positively with Ellison's Spiritual Well-Being Scale (r = .43, n = 53; r = .57, n = 93) and with the Religious Well-Being Scale (r = .46; n = 53) (Soeken & Carson, 2002). Comparison of the scores between students in religiously affiliated schools with those in public institutions found a significant difference (Soeken & Carson, 2002). Further work is continuing with the Health Professional's Spiritual Role Scale to factor analyze items for further evidence of construct validity.

The original Spiritual Involvement and Belief Scale (SIBS) was found to be a unique and valid measure of spirituality and it was selected to assess spiritual beliefs and actions that are free from traditional and cultural bias (Hatch, et al., 1998; Vance, 2001). Moreover, the SIBS scale assesses spiritual involvement and activity, not just belief (Hatch et al., 1998). Compared with other available instruments, the SIBS Scale appears to have certain advantages as it is inclusive for assessing aspects of spirituality not covered by other instruments, yet it is easily administered and scored. The reading skill level of SIBS ranges from approximately fourth grade level on some items to high school level on others (Hatch, et al., 1998). Test-retest reliability and internal consistency was published as r=.92 and Cronbach alpha=.92 (Hatch, et al., 1998).

The original SIBS had clusters that shared common contents and each factor was given a name that captured part or all of this common content. Item 1 clustering under factor 1 (labeled External/Rituals) typically addresses spiritual activities/ or were consistent with belief in an external power. Factor 2 (labeled Internal/Fluid) included items that refer to evolving beliefs and many items that focus on internal belief and growth. Both items dealing with meditation clustered under factor 3

Existential/Meditative), as did many items addressing more existential items. Finally, dealing with humility and application of spiritual principles in daily activities clustered under factor 4 (labeled Humility/Personal Application) (Hatch, et al., 1998).

The SIBS demonstrated excellent stability over time with a test-retest reliability coefficient of .92 over a seven to nine month interval, suggesting that an individual's score on the SIBS is highly reproducible (Hatch, et al., 1998). That the scores were stable over such a long interval suggests that most individuals' spiritual belief remained relatively constant over this time. In the authors' experience, most change in spiritual belief comes in infrequent but relatively dramatic bursts ("spiritual moments" or "awakenings"), superimposed on a background of gradual drift. If this is the case most individuals' scores would be quite constant over 7- to- 9 month period (Hatch, et al., 1998).

The Spiritual Involvement and Belief Scale's average scores and distribution of scores was very similar in Muslem, Christian, and Baha'i subjects, all of whom were very involved in their faith, however, scores were substantially lower in the Humanistic group, and much lower in the Atheist group. Despite these positive findings, the developers decided to revise the scale because of their concern for the wording of certain items (especially negatively worded ones) and concern that the scale missed certain domains of spirituality (Hatch, Burg, Naberhaus, & Hellmich, 2001). In 2001, Hatch, Naberhaus, Hellmich, and Burg revised the scale and re-named it the Spiritual Involvement and Belief Scale – Revised (SIBS - R) (Hatch, Burg, Naberhaus, & Hellmich, 2001). Data from medical students, nurses and elderly subjects were reanalyzed to select the best 22 items.

The mean scores of these pooled groups was 113.1 $\pm$ 20.9 with a range of 53 to 153 (Hatch, Burg, Naberhaus, & Hellmich, 2001). A very wide range of total score was observed (46 to 147) (Hatch, et al, 2001). The coefficient alpha for the 22 items was .92 (Hatch, et al, 2001). Correlation for the sum of 22 items was .984, indicating virtual replication of total score and retention of all four factors. Correlation of the scale sum with the five religiosity items from the Duke Religiosity Scale (DUREL) was .66 to .80(Hatch, et al, 2001). This indicates that the scale captures something strongly related to religiosity, yet significantly distinct (Hatch, et al, 2001).

The Spiritual Involvement and Belief Scales –Revised (SIBS-R) had a 7-point Likert type response (1= strongly disagree; 7 =strongly agree) (Hatch, et al., 2001). The developers stated pilot testing has been done only with a sample of recovering alcoholics. A very wide range of total score was observed (46 to 147) (Hatch, et al., 2001). The adult respondents required approximately 10 minutes to complete the instrument, while adolescents required twice as long (Hatch, et al., 2001). One subset completed a retest of the study instrument after the initial administration. The test-retest reliability was .93 for the SIBS – R (N=17) (Hatch, et al. 2001). Feedback from the pilot test subjects indicated the instrument was straightforward, easy to complete, and no one objected to the wording of the items (Hatch, et al, 2001).

The SIBS-R presents a factor structure which contains Factor Eigen Values and Preliminary Factors. The factors measured four distinct aspects of spirituality (Hatch, et al., 2001). Also, the instrument developers retained items that showed consistent factor loading in the different groups. The Factor Eigen Values and Preliminary Factor Labels were: Factor 1:15.0; Core spirituality (connection, meaning, faith, involvement and

experience), Factor 2:4.1; Spiritual perspective/existential, Factor 3:1.7; existential/ meditative, and Factor 4:1.2; Acceptance/insight (insight into futility of focusing attention on things which cannot change (Hatch, et al., 2001). The validity of factors 1, 2, and 3 is supported by high test-retest correlations and Cronbach's alpha correlation for each. Factor 4 had lower test-retest reliability and combined with a lower Cronbach's alpha coefficient, raises some concern about its validity.

Data Collection Methods and Procedures

The description of the data collection process details the data, the procedure for collecting data, and the type and frequency of measurement obtained (Burns & Grove, 2001, p. 637). After distributing the tools, each participant was asked to read the informed consent form. Next each subject was instructed to sign and date the informed consent form, read each item on the survey, and place a check mark in the box or circle for each item that matches his or her view. Subjects were asked to complete a two part survey: the first part measured the subject's attitude toward providing spiritual care for patients and the second part assessed the subject's spiritual beliefs and actions. The subject was allowed 20-30 minutes to complete the questionnaire. Upon completion of all of the questionnaires, the subjects placed all questionnaires in an envelope and returned it to the investigator.

Ethical Considerations

The investigator completed the graduate nursing research class, read and obtained a certificate of completion for the Belmont Report, "Ethical Principles and Guidelines for the protection of Human Subjects of Research", and subscribes to the principals it contains. Before conducting the survey, the University of Texas Pan-American's

Institutional Review Board (IRB) examined the submitted pilot review study for ethical concerns (Burns & Grove, 2001, p. 213). The investigator requested exemption from full IRB Review and an expedited review because the pilot study is on a group perception, the investigator does not manipulate subject's behavior, and research does not involve stress to subjects (Burns & Grove, 2001, p. 215). To receive copyright permission, the investigator contacted the instrument developers via postal, telephonic, and electronic mail (APPENDIX D). Written approval was granted by the University of Texas Pan-American's Institutional Review Board and by the developers (APPENDIX E).

Risk, Benefits, and Potential Problems

The purpose of this pilot research study proposal was to investigate whether spiritual care education is a part of one baccalaureate nursing curriculum. There were no direct benefits associated with this research investigation for each subject; however, nursing students and educators may indirectly benefit from this study because it evaluates the current educational curriculum.

Each subject was expected to sign an informed consent form (Appendix F) before participating in the study. In addition, each subject was informed (verbally and in writing) that the investigator will maintain confidentiality and anonymity. The health risks associated with this survey were non-existent as all that was required of each subject was answering questions. Every effort was made to maintain confidentiality and all survey responses were kept in a locked cabinet in the Master of Science in Nursing office. Also, the gatekeeper for handling, transcribing, and analyzing the data is the investigator.

Data Analysis

After completing the task of organizing individual pieces of the data from the demographic form and the two questionnaires, the investigator classified the data in the nominal, ordinal, and ratio measurement level. The ordinal measurement permits the sorting of objects on the basis of their standing and the ratio will measures information concerning the rank-ordering between objects on the critical attribute (Polit & Hungler, 1998, p. 440-441). To organize, summarize, and describe data, the investigator used the standard computer program titled Statistical Package for the Social Science (SPSS) 11.0. Computation of the data analysis was accomplished by using the SPSS 11.0 software program. The SPSS has a data entry module that can be used to design and customize self-report forms, automatically define variables to be used in statistical analyses, and data rules to check the accuracy of entered data and to deal with skipped patterns (Polit & Hungler, 1998, p. 549).

Descriptive statistics was used to reduce, summarize, organize, evaluate, interpret, describe, and communicate numeric information (Polit & Hungler, 1998, p. 469). Univariate descriptive statistics were utilized to describe the characteristics of the sample because the study does not necessarily focus on only one variable (Polit & Hungler, 1998, p. 196). Univariate analysis is also helpful in examining the variability of data, describing the sample, and checking statistical assumptions prior to more complex analysis (Munro, 1997, p. 6).

Inferential statistics was used to provide a means for drawing conclusions about the population. Parametric tests are more powerful, more flexible than nonparametric techniques, allow the researcher to study the effects of many independent variables on the

dependent variable, and also make possible the study of their interactions (Munro, 1997, p. 100). Parametric tests are characterized by three attributes: (a) they involve the estimation of at least parameter; (b) they require measurement on at least an interval scale; and (c) they involve several underlying assumptions about the variables under consideration, such as the assumption that the variables are normally distributed in the population (Polit & Hungler, 1998, p. 477). The *t* test is a popular test of statistical significance most popularly used in studies requiring comparison between two groups on a measure or a comparison of measures taken at two different times (Gillis & Jackson, 2002, p. 403). It is the one of the most popular statistical tests.

For this pilot study, the *t* test is selected to analyze the difference between two means (Polit & Hungler, 1998, p. 717). The *t* test which is a basic parametric procedure was selected to test the difference between two group means (Polit & Hungler, 1998, p. 717). The *t* test, or Student's *t* test, is named after its inventor, William Gossett, who published under the pseudonym of Student. Gossett invented the *t* test as a more precise method of comparing groups. He described a set of distributions of means of randomly drawn samples for a normally distributed population. The *t* test involves an evaluation and distribution of each group (Munro, 1997, p. 122). Because the *t* test compares means interval and ratio data are required (Nieswiadomy, 1998, p. 283).

The utilization of the *t* test involves the following assumptions: (a) sample means from the population are normally distributed, (b) the dependent variable is measured at the interval level, (c) the two samples have equal variance, and (d) all observations within each sample are independent. The *t* test is robust to moderate violation of its assumptions and the *t* statistics are relatively easy to calculate (Burns & Grove, 2001, p.581).

Comparing the two groups of subjects with respect to mean values on a dependent variable is a common research situation (Polit & Hungler, 1998, p. 717). The likelihood of finding statistics high enough to be statistically significant is increased as the sample size increases (LoBiondo-Wood & Haber, 2002, p. 354).

Summary

The purpose of this pilot research study proposal was to investigate whether spiritual care education is a part of the baccalaureate nursing curriculum at a southern Texas University. This study used two standardized scales to compare and measure the pre-nursing and senior baccalaureate nursing students' attitude about spirituality at different levels in the nursing program.

CHAPTER IV

Results

The purpose of this two-group comparative pilot research study was to investigate whether spiritual care education is a part of the baccalaureate nursing curriculum at a southern Texas university. Two standardized scales were utilized to compare the senior baccalaureate nursing students' and pre-nursing students' attitude about spirituality and attitudes toward providing spiritual care. First, the characteristics of the sample are summarized using descriptive statistics. Next, analysis of the scaling scores from the Health Professional Spiritual Role Scale (HPSRS) and the Spiritual Involvement and Belief Scale–Revised (SIBS-R) are reported. Lastly, results from the inferential statistics *t* test assuming unequal variance were utilized to answer the two research questions and the four hypotheses.

After collecting the questionnaires, the Microsoft XP Professional Excel computer program was used for data entry and for the transformation of the raw data into the nominal and ordinal levels. Frequency distributions included the subjects' ages, gender, marital status, race/ethnic group, highest educational level, and religious affiliation. Scaling results from the Health Professional Spiritual Role Scale (HPSRS) and the Spiritual Involvement and Belief Scale–Revised (SIBS-R) were also examined through frequency distribution.

Data analysis was conducted to examine the data more closely for differences and to provide answers to the pilot study's research questions and hypotheses. The between subject designs and the within subject design results were reported. The two-tailed *t* tests assuming unequal variance was used to determine whether spiritual care education is a part of the baccalaureate nursing curriculum. To infer significant differences the two-tailed probability test utilized the 0.05 significance levels. The $p = < 0.05$ values denoted that the results fall into the 2.5 percent right tail or the 2.5 percent left tail.

Quantitative Results

Descriptive Statistics of the Sample Profile

In September 2002, 147 students from a university in southern Texas volunteered to participate in this pilot study. In two classroom settings one week apart, the senior baccalaureate nursing students and the pre-nursing students completed questionnaires. Of the 147 returned questionnaires, 145 were appropriate for analysis. Two were eliminated due to missing data. Of the questionnaires (N = 145), 66 % (n = 95) were from pre-nursing students and 34% (n = 50) were from senior baccalaureate nursing students. Of the 145 respondents, 83% (n = 120) were females and 17% (n = 25) were males (See Table 1). Of the pre-nursing students, 84.2% (n = 80) were females and 16% (n = 15.8) were male. Of the senior baccalaureate nursing students, 80% (n = 40) were females and 20% (n = 10) were males.

The sample ages ranged from 18 years to 49 years and the mean age was 25.2 years. Of the pre-nursing students, the ages ranged from 18 years to 49 years, M = 23 years, mode = 21 years, and Mdn = 22 years. Of the senior baccalaureate nursing students, the ages ranged from 22 years to 46 years, *M* = 27 years, mode = 24 years, and

Mdn = 25.5 years (See Table 2). There was a significant difference in the two groups' ages ($p = < 0.05$).

TABLE 1. DEMOGRAPHICS – GENDER.

GROUPS	MALE n %	FEMALE n %	TOTAL N %
Pre-nursing students (n =95)	15 15.8%	80 84.2%	95 100
Seniors baccalaureate Nursing Students (n =50)	10 20%	40 80%	50 100
Total	25 17%	120 83%	145 100

TABLE 2. DEMOGRAPHICS – AGE.

GROUPS	M	RANGE	MODE	MDN
Pre-nursing students (n=95)	23	18 to 49	21	22
Senior Baccalaureate Nursing Students (n=50)	27	22 to 46	24	25.5

The sample identified their racial and ethnic designation as: 81.3 % (n = 118) white (of Hispanic origin), .7% (n = 1) were American Indian, 7.6% (n = 11) Asian or Pacific Islanders, 9% (n = 13) white (not of Hispanic Origin), and 1.4% (n = 2) black (not of Hispanic origin). Of the pre-nursing students, 81.05 % (n = 77) were white (of Hispanic origin), 10.52 % (n = 10) were Asian or Pacific Islanders, 7.4 % (n = 7) were white (not of Hispanic origin), and 1.05 % (n = 1) was black (not of Hispanic Origin). Of the senior baccalaureate nursing students, 82 % (n = 41) were white (of Hispanic origin),

12 % (n = 6) were white (not of Hispanic origin), 2 % (n = 1) was American Indian, 2 % (n = 1) was Asian or Pacific Islanders, and 2 % (n = 1) was black (not of Hispanic origin) (See Table 3). There was significant difference in the samples' racial/ethnic designations ($p < 0.05$).

TABLE 3. DEMOGRAPHIC CHARACTERISTICS – RACIAL/ ETHNIC GROUP, MARITAL STATUS, AND RELIGIOUS PREFERENCES (N = 145)

Characteristics		Pre-nursing Students (n = 95)		Senior Baccalaureate Nursing Students (n = 50)		General Population (N = 145)	
		n	%	n	%	N	%
Racial/Ethnic Group	White (of Hispanic origin)	77	81%	41	82%	118	81.3 %
	White (not of Hispanic origin)	7	7.4%	6	12%	13	9%
p (two tailed) significance level = 0.04	American Indian	0	0%	1	2%	1	0.7%
	Asian/Pacific Islander	10	10.5%	1	2%	11	7.6%
	Black (not of Hispanic origin)	1	1.1%	1	2%	2	1.4%
Marital Status	Single	71	73%	34	68%	105	72.4%
	Married	20	21 %	12	24%	32	22%
p (two-tailed) significance level = 0.3	Separated	1	1 %	4	8%	5	4%
	Divorced	3	3%	0	0%	3	2%
Religious Preference	Catholic	68	71.6%	31	62%	99	68%
	Protestant	17	17.9%	15	30%	32	22%
p (two-tailed) significance level = 0.8	Other	5	5.3%	1	2%	6	4%
	No preference	5	5.3%	5	10%	8	6%

More than half of the sample was unmarried (See Table 3). Of the 145 respondents, 72.4% (n = 105) were single, 22% (n = 32) were married, 4% (n = 5) were separated, and 2% (n = 3) were divorced. Of the pre-nursing students, 73% (n = 71) were single, 21 % (n = 20) were married, 1 % (n = 1) was separated, and 3% (3) were divorced. Of the senior baccalaureate nursing students, 68% (n = 34) were single, 24 % (n = 12) were married, and 8 % (n = 4) were separated. There was no significant difference in the samples' marital status ($p > 0.05$) (See Table 3).

The majority of the sample identified themselves to be a member of a religious group (See Table 3). Of the 145 respondents, 68% (n = 99) were Catholic, 22% (n = 32) were Protestant, 4% (n = 6) selected other for a religion not on the form, and 6% (n = 8) reported no religious preferences. Of the pre-nursing students, 71.6% (n = 68) were Catholics, 17.9% (n = 17) were Protestants, 5.3% (n = 5) selected other for a religion not shown on the form, and 5.3% (n = 5) reported no religious preferences. Of the senior baccalaureate nursing students, 62 % (n = 31) were Catholics, 30 % (n = 15) were Protestants, 2% (n = 1) selected other for a religion not shown on the form, and 6 % (n = 3) reported no religious preferences. There was no significant difference in the samples' religious preferences ($p > 0.05$) (See Table 3).

Over a quarter of the sample (N=145), 26.2% (38) reported they had participated in post-secondary education (See Table 4). Of the 38 respondents, 18% (n = 17) were pre-nursing students, 42% (n = 21) were senior baccalaureate nursing students, 9.7% (n = 14) nursing assistants, 8.3% (n = 12) had associate degrees in nursing, 4.8% (n = 7) had associate degrees in non-nursing, and 3.4% (n = 5) had bachelor degrees in other fields. Of the pre-nursing students (n = 24), 5.3% (n = 5) were nursing assistants, 7.4% (n = 7)

had associate degrees in other fields, and 5.3% (n = 5) had bachelor degrees in other fields. Of the senior baccalaureate nursing students (n = 21), 18% (n = 9) were nursing assistants and 24 % (n = 12) had associate degrees in nursing. There was no significant difference in the samples' post-secondary education levels ($p > 0.05$) (See Table 4).

TABLE 4. DEMOGRAPHICS –POST SECONDARY EDUCATION LEVELS.

Education Levels	Pre-nursing Students (n=95)		Senior Baccalaureate Nursing Students (n=50)		Total (N=145)	
	n	%	*n*	%	*N*	%
Nursing Assistant	5	5.3%	9	18%	14	9.7%
Associate Degree in Nursing	0	0%	12	24%	12	8.3%
Associate Degree(non-nursing)	7	7.2%	0	0%	7	4.8%
Bachelor (other field)	5	5.3%	0	0%	5	3.4%
Total	17	18%	21	42%	38	26.2%

To determine whether the samples were demographically different, the group was examined statistically using a *t* test. Statistically significant differences were found in the two groups ages and race/ethnicity. No statistical differences were noted in the two groups' marital status, religious preferences, and education levels (See Table 3 and Table 4).

Findings

Health Professional's Spiritual Role Scale (HPSRS)

The Health Professional's Spiritual Role Scale (HPSRS) scale was used to assess the pre-nursing students' and the senior baccalaureate nursing students' attitudes toward providing spiritual care. The 16 statements were presented in a Likert type format and measured response options that ranged from 1 "strongly disagree" to 6 "strongly agree" (Soeken & Carson, 1986; Soeken, 2002). The use of the six-item scale permitted much finer gradation from a minimum possible score of 6 (6 X 1) to a maximum possible score of 30 (6 X 5). The mean score was 113.3 out of the range of 45 to 129 (N=145), indicating an overall positive attitude toward providing spiritual care.

A higher score on the HPSRS scaling results reflected a more positive attitude (Soeken, 2002). Five items had total mean scores that were less than three on a 6-point scale (See Table 6). Of the five items, the pre-nursing students had higher mean scores for three items, the senior baccalaureate nursing students had higher mean scores for two items, three items had statistically significant findings ($p = < 0.05$), and two items had no statistically significant findings ($p = > 0.05$)..

Results showed six items with total mean scores of 3 (midpoint) on a 6-point Likert scale (See Table 5). Of these six items, the pre-nursing students had higher scores for three items, the senior baccalaureate nursing students had higher mean scores for two items, three items had statistically significant findings ($p = < 0.05$), and two items did not have statistically significant findings ($p = > 0.05$).

TABLE 5. HEALTH PROFESSIONAL'S SPIRITUAL ROLE SCALE RANKINGS OF BEHAVIORS				
HPSRS Behaviors	**Pre-nursing Students (n = 95)**	**Senior Baccalaureate Nursing Students (n =50)**	**Total Mean Score**	**P Two-Tailed Significance**
Listening to patient concerns is providing spiritual care.	5.1	5.1	5.1	0.8
Should have no preconceived ideas about a patient's relationship with God	4.2	4.9	4.7	0.009**
Can give professional spiritual care by being concerned and kind	4.7	4.5	4.6	0.3
Can assess a patient's spiritual needs by being observant.	4.5	4.5	4.5	0.94
Should ask every patient if she/he wants to see clergyman	4.3	4.5	4.4	0.25
Uncomfortable discussing spiritual matters with patients.	4.2	3.8	3.95	0.06
Are aware of the need to assess the spirituality of a patient.	3.6	3.4	3.5	0. 5
Are not qualified to help patient with their spiritual needs.	3.6	3.3	3.45	0.2
Using scripture with a patient is appropriate.	3.5	3.3	3.4	0.6
Are too busy to help patient with their spiritual needs.	3.3	3.2	3.25	0.6
Being able to assess a patient's spiritual needs requires special training	3.6	2.7	3.15	0.000025**
The health professionals need to have a strong relationship with God.	3.2	2.5	2.85	0.008**
Asking religious preference is sufficient for assessing spiritual needs.	3	2.7	2.85	0.1
Discussing a patient's religious beliefs is too personal. *	2.9	2.6	2.75	0.17
Offering spiritual assistance is the clergyman's role not health professional*	2.83	2.3	2.6	0.008**
Talking with patient about religion is trying to convert patient.*	1.9	1.5	1.7	0.011**

- * Items have reversed scores
- ** $p = < 0.05$

Five of the items had mean scores less than 4 (See Table 5). Items with scaling scores in the upper range indicated positive religious and existential well-being and a more positive attitude (Soeken & Carson, 1986; Soeken, 2002). Of the five items, the pre-nursing students had a higher mean score for one item, the senior baccalaureate nursing students had a higher mean score for one item, three items had homogenous mean scores, one item had statistically significant findings ($p = < 0.05$), and four items did not have statistically significant findings ($p = > 0.05$). The Health Professional's Spiritual Role Scale (HPSRS) scale contained both negative and positive worded items in random order to assess the samples attitudes (Soeken & Carson, 1986).

The Spiritual Involvement and Belief Scales –Revised (SIBS-R)

The Spiritual Involvement and Belief Scales –Revised (SIBS-R) was utilized to assess the respondents' spiritual beliefs and activities (See Table 6). The SIBS-R scale contains statements in a Likert type format with response options ranging from 1 "strongly disagree" to 7 "strongly agree" (Hatch, 2002). In this pilot study, the samples' mean score tended to be in the upper range, indicating positive religious and existential well-being. The SIBS-R Factor Structure variables were separated into four linear combinations that measured four distinct aspects of spirituality. The preliminary factor labels were: Factor 1: core spirituality (connection, meaning, faith, involvement and experience), Factor 2: spiritual perspective/existential, Factor 3: existential/ meditative, and Factor 4: acceptance/insight (insight into futility of focusing attention on things which cannot change (Hatch, et al, 2001). The two-tailed *t* test of unequal variance results showed no statistically significance difference in the pre-nursing students' and the senior baccalaureate nursing students' beliefs and activities ($p = > 0.05$).

Factor 1: Core Spirituality

Sixteen items measured core spirituality (connection, meaning, faith, involvement and experience) (Hatch, 2002). There was minimal difference in the two groups' mean scores results that ranked high (5 on the 7-point scale). Of the pre-nursing students, M = 5.1, Mdn = 5.2, SD = .83. Of the senior baccalaureate nursing students, M = 5.2, Mdn = 5.4, SD= .77. No statistically significant difference was found in the pre-nursing students' and the senior baccalaureate nursing students' core spirituality (See Table 6).

TABLE 6. FACTOR STRUCTURES RESULTS FROM THE SPIRITUAL INVOLVEMENT AND BELIEF SCALES –REVISED (SIBS-R)

SIBS-R FACTORS	Pre-nursing Students (n = 95)			Seniors Baccalaureate Nursing Students (n = 50)			
	M	Mdn	SD	M	Mdn	SD	*P* Two- tailed Significance
Factor 1	5.1	5.2	0.83	5.2	5.35	0.77	0.6
Factor 2	3.65	3.6	1.2	3.6	3.3	1.2	0.86
Factor 3	5.8	5.8	0.52	5.8	5.8	0.48	0.98
Factor 4	5.3			4.6			

- the upper range mean scores indicate positive religious and existential well-being

Factor 2: Spiritual Perspective/ Existential

Seven items measured spiritual perspective/ existential (Hatch, 2002). The mean scores were homogenous and ranked mid-point (3 on a 7-point scale). Of the pre-nursing students, the M = 3.7, Mdn = 3.6, and SD = 1.2. Of the senior baccalaureate nursing

students, the M = 3.6, Mdn =3.3, and SD = 1.2. No statistically significant difference was found in the pre-nursing students and the senior baccalaureate nursing students' spiritual perspectives/ existential behaviors (See Table 6).

Factor 3: Personal Application/humility

Two items measured application/humility (Hatch, 2002). Once again the mean scores were homogeneous and ranked high (5 on a 7-point scale). Of the pre-nursing students, the M = 5.8, Mdn = 5.8, and SD = .5. Of the senior baccalaureate nursing students, the M = 5.8, Mdn = 5.8, and SD = .5. No statistically significant difference was found in the pre-nursing students' and the senior baccalaureate nursing students' application/ humility behaviors (See Table 6).

Factor 4: Acceptance/insight

Factor 4 had one item that measured acceptance and insight (i.e. insight into futility of focusing attention on things which cannot be changed) (Hatch, 2002). The two groups' responses had mean scores that were above average to high (4 and 5 on a 7-point scale). The pre-nursing students' mean score (M = 5.3) was higher than the senior baccalaureate nursing students' (M = 4.6). A *t* test was not performed on the single item (See Table 6).

Quantitative Research Questions

Quantitative Research Question Number One:

Research question one was stated as: Is there a difference between pre-nursing students' and senior baccalaureate nursing students' personal spiritual involvement and beliefs? Analysis of the Spiritual Involvement and Belief Scales–Revised (SIBS–R) items revealed no statistical significant difference between pre-nursing students' and

senior baccalaureate nursing students' personal spiritual involvement and beliefs (See Table 6). Of the pre-nursing students, the four factors' mean scores were 5.06, 2.65, 5.8, and 5.26, respectively. Of the senior baccalaureate nursing students, the four factors' mean scores were 5.2, 3.56, 5.8, and 4.6, respectively. The participants' responses to Factors 1, 3, and 4 revealed mean scores that were high. Factor 2 had different mean scores that were midpoint. From these results, the investigator concluded that the answer to question one was that there were no statistically significant differences between the pre-nursing students' and the senior baccalaureate nursing students' personal spiritual involvement and beliefs ($p = > 0.05$).

Quantitative Research Questions Two:

Research question number two was stated as: Is there a difference between pre-nursing students' and senior baccalaureate nursing students' opinions about the spiritual role of the nurse in meeting patient spiritual needs? Results from the Health Professional's Spiritual Role Scale (HPSRS) scale found five items with results that showed a statistically significant difference (See Table 5). These results lead the investigator to conclude that the answer to research question two was that there was a statistically significant differences between the pre-nursing students' and the senior baccalaureate nursing students' opinions about the spiritual role of the nurse in meeting patient spiritual needs. These results were:

1. "Being able to assess a patient's spiritual needs requires special training", p (two-tailed) significance value = 0.000025. The pre-nursing students' total mean score was 3.6 and the senior baccalaureate nursing students' total mean score was 2.7.

2. "Offering spiritual assistance is the clergyman's role not health professional" p (two-tailed) significance value = 0.008. The pre-nursing students' total mean score was 2.85 and the senior baccalaureate nursing students' total mean score was 2.3.
3. "A health professional needs to have a strong relationship with God" p (two-tailed) significance value =0.008. The pre-nursing students' total mean score was 3.2 and the senior baccalaureate nursing students' total mean score was 2.5.
4. "Should have no preconceived ideas about a patient's relationship with God" p (two-tailed) significance value =0.009. The pre-nursing students' total mean score = 4.2 and the senior baccalaureate nursing students' total mean score = 4.9.
5. "Talking with patient about religion is trying to convert patient" p (two-tailed) significance value = 0.011. The pre-nursing students' total mean score was 1.9 and the senior baccalaureate nursing students' total mean score was 1.5

Hypotheses

Hypothesis number one: There are differences between the pre-nursing students' and senior baccalaureate nursing students' spiritual involvement and belief. Statistical analysis of the Spiritual Involvement and Belief Scales –Revised (SIBS-R) results found no statistically significant differences between the pre-nursing students' and senior baccalaureate nursing students' spiritual involvement and beliefs (See Table 6). The majority of the Spiritual Involvement and Belief Scales–Revised (SIBS-R) scale items addressed actions that focused on either the internal effects of these actions or the applications of spiritual principles in daily life. From these results, the investigator concluded that there were no statistically significant differences between the pre-nursing

students' and the senior baccalaureate nursing students' personal spiritual involvement and beliefs (p = > 0.05).

Hypothesis number two: There are higher levels of spiritual involvement and belief in senior baccalaureate nursing students. The Spiritual Involvement and Belief Scales–Revised (SIBS-R) scaling results did not show a statistically significant difference between the pre-nursing students' and senior baccalaureate nursing students' spiritual involvement and belief (p = > 0.05). There was no statistically significant difference between the pre-nursing students' and the senior baccalaureate nursing students' levels of spiritual involvement and belief (p = > 0.05) (See Table 6).

TABLE 7. HEALTH PROFESSIONAL'S SPIRITUAL ROLE SCALE SUMMATION RATING SCORES

	M	MDN	MODE	SD	SUMMATION SCORES
Pre-nursing students (N = 95)	3.64	3.6	3.6	0.813566	58.2
Senior Baccalaureate Nursing Students (N = 50)	3.44	3.3	4.5	1.03765	55.1
o P = > 0.05					

Hypothesis number three: There are differences between pre-nursing students and senior baccalaureate nursing students' conception of the spiritual role of the nurse in meeting patients' spiritual needs. Five items from the Health Professional's Spiritual Role Scale (HPSRS) had scaling results that indicated that there were statistically significant differences between the pre-nursing students and senior baccalaureate nursing students' conception of the spiritual role of the nurse in meeting patients' spiritual needs (p = < 0.05). The investigator concluded there were indeed differences between pre-nursing students and senior baccalaureate nursing students' conception of the spiritual

role of the nurse in meeting patients' spiritual needs (See Table 5). One item's significance value results that ranked beyond the table value lead the investigator to reject the null hypothesis for the item "being able to assess a patient's spiritual needs requires special training" results (Polit & Hungler, 1998, p. 474; LoBiondo-Woods & Haber, 2002, p. 356).

Hypothesis number four: The pre-nursing students have a lower level of perception about the spiritual role of the nurse meeting the patient's spiritual needs. In this pilot study the two groups answered the statement similarly. To reflect the true underlying variables a summation of the pre-nursing students' and the senior baccalaureate nursing students' scores was conducted (Gillis & Jackson, 2002, p. 457). The pre-nursing students summation score (n = 58.2) was higher than the senior baccalaureate nursing students' summation score (n = 55.1). In addition, the results showed the two groups possessed mid-level (average) perception about the spiritual role of the nurse meeting the patient's spiritual needs. Of the pre-nursing students, M = 3.64, Mdn = 3.55, mode = 3.6, and the SD = 0.813566. Of the senior baccalaureate nursing students, M = 3.44, Mdn = 3.3, SD = 1.03765. The investigator found no statistically significant difference in the pre-nursing students' and senior baccalaureate nursing students' level of perception about the spiritual role of the nurse in meeting the patient's spiritual needs.

Summary

This chapter presented information about the demographic characteristics of the samplepopulation, reported the analysis of scaling scores from the Health Professional Spiritual

Role Scale (HPSRS) and the Spiritual Involvement and Belief Scale –Revised (SIBS-R). and discussed inferential statistical result findings that provided answers to the research questions and hypotheses.

CHAPTER V

CONCLUSION, IMPLICATION, RECOMMENDATIONS

This pilot study investigated senior baccalaureate nursing students' and pre-nursing students' attitudes about spirituality at different levels in the nursing program within the nursing conceptual framework of the Theory of Human Caring. The pilot study was conducted in classrooms at a comprehensive regional university located in southern Texas. The study involved a volunteer sample of 95 pre-nursing students and 50 senior baccalaureate nursing students. The sample tended to be in their 20s, female, single, White (of Hispanic origin), unmarried, and Catholic. This was reflected in the survey participants: 83% were females, 81.3 % were White of Hispanic origin, 72.4% were unmarried, and 68% were Catholic. Seventeen percent (25) were males. 9.7% were certified nursing assistants, and 8.3% were associate degrees nurses.

Analysis of descriptive characteristics found statistically significant differences in the target populations' age and race/ethnicity. Data were drawn from a sample of primarily white (of Hispanic Origin), younger aged, Catholic, with a high percentage of male nursing students. The age and the racial/ethnicity of the sample can be considered a bias and limitation. This is compared to the nationally reported average graduating age of 30.5 (Freudenheim & Villarosa, 2001) and the overwhelming majority of female students (91%) from non-minority backgrounds (73.5%) (American Association of

Colleges of Nursing, 2001). The 17 percent male nursing student population in the sample is double in comparison to the nationally reported 9% (American Association of Colleges of Nursing, 2001).

The sample was typical for the undergraduate student population at the southern Texas university. Results from the cross-sectional sample are generalizeable to those with similar backgrounds; however, the sample is atypical of the population, homogeneous, and may be biased. The sample does not represent the current population of baccalaureate nursing students statewide or nationally. With the rapid increasing Hispanic population in the United States and the increasing number of males in nursing, this atypical population may possibly be the faces of the future profession of nursing. Also the sample was biased because the population was not a consecutive sample. A longitudinal study such as a trend study to examine the population's spiritual involvement and activity is recommended to eliminate the bias.

Attitudes toward Providing Spiritual Care

The participants' Health Professional's Spiritual Role Scale (HPSRS) mean score was 113.3 out of the possible range of 45 to 129. The mean score was similar to results of other studies that reported high levels of overall positive attitude toward providing spiritual care (Cimino, 1992; Soeken & Carson, 1986). Data analysis of the Health Professional's Spiritual Role scale (HPSRS) found statistical differences in five items that addressed the psychosocial and spiritual dimensions of holistic nursing care. These items were: talking with patient about religion is trying to convert patient, should have no preconceived ideas about a patient's relationship with God, needs to have a strong

relationship with God, offering spiritual assistance is the clergyman's role not health professional, and being able to assess a patient's spiritual needs requires special training.

The notable statistically significant findings were: (a) both groups moderately disagreed that offering spiritual assistance is the clergyman's role and not the health professional role; (b) the pre-nursing students disagreed and senior baccalaureate nursing students moderately disagreed that being able to assess a patient's spiritual needs required special training; (c) pre-nursing students agreed health professionals should have no preconceived ideas about a patient's relationship with God and senior baccalaureate nursing students moderately agreed; (d) pre-nursing students agreed and senior baccalaureate nursing students moderately agreed that a health professional needs to have a strong relationship with God; and (e) pre-nursing students moderately disagreed and senior baccalaureate strongly disagreed that talking with the patient about religion is trying to convert the patient.

It is the nurse educator's responsibility to assist nursing students in developing their spiritual self-awareness so they will be better able to determine approaches that will serve to promote client spiritual well-being. The outcomes of this integration will facilitate the student's intra-professional understanding and communication. The statistically significant differences are important indicators that the senior nursing students are not cognizant that their role is to understand the patient's spirituality and to help the individual to access and utilize his own spirituality. The senior nursing students' responses indicate they have high spirituality but do not feel rendering spiritual care to their patients is a critical aspect of providing care. Perhaps the nursing students avoid the spiritual dimension because they believe that inquiring about spirituality would

make the patient uncomfortable. If this perception is based not on fact but intuition, it can be altered through education. Nothing is known about the nursing faculty's perceptions of the spiritual role of the nurse. Their perceptions may play a critical role in the students' education.

The results of the study do not necessarily indicate that nurses will use spiritual care interventions in their practice, and therefore the educational process should be directed toward knowing and practicing the implementation of activities involved in spiritual care. Further exploration of the differences and similarities in the statistically significant items is clearly needed to chronicle the nursing students' spiritual well-being and attitudes toward providing spiritual care for patients over time. A trend study is recommended to examine the nursing student's overall positive attitude toward providing spiritual care. A correlation study is recommended that would examine the populations' age, spiritual well-being, attitudes toward role, and appropriateness of behaviors.

Spiritual Involvement and Activity

There was no significant difference found in the participants' spiritual involvement and activity. Spiritual Involvement and Belief Scale–Revised (SIBS-R) results from both groups were generally high level and mostly homogenous. They had rated themselves as moderately high spiritual people, (4.75 on a 7-point scale). The mostly homogenous responses showed the similarities in core spirituality, spiritual perspective/existential, and personal application/humility.

Although not statistically significant, pre-nursing students' scores were higher for Factor 4 (acceptance and insight) than the senior baccalaureate nursing students. In this pilot study the use of the cross-sectional design makes it questionable to assume

differences in behavior. It is possible that the homogeneity of spiritual involvement and activity may be independent of any experiences encountered in the nursing program. A longitudinal study would better explain the difference.

This study could be conducted using the Factor Eigen Values that were used in the original and revised studies. Because this was a pilot study, the investigator used a *t* test to determine if the mean score on some measures are more different than would be expected by chance. The paired *t* test was used to determine the differences between the two groups. The findings have practical importance because they recognize the patterns of relationships among the senior baccalaureate nursing students' and pre-nursing students' attitudes about spirituality at different levels in the nursing program.

Discussion

Watson's Theory of Human Caring provided the framework for this research by suggesting spiritual and religious awareness is one of the nurse's responsibilities and the nurse should appreciate and respect the spiritual meaning in a personal life (regardless of how unusual a person's belief is) since this is comforting to the individual (Oldnall, 1996; Watson, 1985; Watson, 1988). Research question one was stated as: Is there a difference between pre-nursing students' and senior baccalaureate nursing students' personal spiritual involvement and beliefs? There were no statistically significance differences in the pre-nursing's students' and senior baccalaureate nursing students' mid-level (average) personal spiritual involvement and beliefs. The sample had mostly homogenous and mid-level (average) to high levels of core spirituality, personal application and humility, and acceptance and insight. The four distinct aspects of spirituality findings indicate the population is entering and leaving the university with high levels of personal spiritual

involvement and beliefs. Nursing students are entering the nursing program with high levels of spirituality and are primed to be taught spiritual education that can influence their roles as nursing students and future healthcare providers.

Research question number two was stated as: Is there a difference between pre-nursing students' and senior baccalaureate nursing students' opinions about the spiritual role of the nurse in meeting patient spiritual needs? Results found there were statistically significant differences in the pre-nursing students' and senior baccalaureate nursing students' opinions about the spiritual role of the nurse in meeting patient spiritual need. The root of the differences may be found in the two groups' responses to the statement "being able to assess a patient's spiritual needs requires special training." It is possible that the population does not know that learning about spirituality in nursing is possible. The pre-nursing students have not been exposed to the baccalaureate nursing curriculum. An appreciation for nursing as a scholarly discipline is often absent in the mind of those beginning students (Welch, Jeffries, Lyon, Boland, Backer, 2001). Fortunately, their conceptions of nursing practice can be continually broadened through their undergraduate educational experience (Welch, et al., 2001).

Few nurse theorists have incorporated the spiritual dimension into their theoretical frameworks and most research dealing with spirituality has focused on religiosity. Dr. Watson, however strongly endorses the ideals/content/ theory of liberal arts education integration in the professional nursing education curriculum. She has proclaimed that a strong knowledge in the humanities expands the mind, thinking skills, and personal growth (Tracey et al., 1998, p. 144). The student sample was enrolled in a comprehensive university and the nursing program had integrated a basic the liberal arts

education into its nursing education curriculum. The baccalaureate nursing program did not follow any specific nursing theoretical conceptual framework. Perhaps the difficulty nursing students have in arriving at a definition of spirituality is due to of a lack of guidance from theory and educators. Also, it is possible that the nurse education community is comfortable with the status quo. Further studies are recommended to examine the nursing students' knowledge of humanities and the effects it has on their minds, thinking skills, and personal growth.

Institutions that seek to use a holistic approach to nursing care are using many aspects of Watson's theoretical commitment to caring (Bennett, et al., 1989, p. 169). The Human Caring model can be considered a philosophical and moral/ethical foundation for professional nursing and part of the central focus for the nursing discipline. The concept promotes the change in the role of the nurse from a technical assistant to a distinct health professional, who works side by side with other distinct health professionals. This transforms the nurse to a healer within a caring-healing profession (Watson, 1999).

Watson states that nurses should seek opportunities, as well as acknowledge an obligation, to become familiar with the religious and spiritual influences in a person's life at home or in the community (Oldnall, 1996). This item "being able to assess a patient's spiritual needs requires special training" results showed the $p = 0.000025$ (two-tailed). The statistically significance difference in these items may be an indicator that the current nursing education curriculum did not place its central emphasis on the core of nursing care (gentle and personal care). This would suggest that more emphasis was placed on the high priorities in traditional typology of nursing interventions such as assessing and monitoring medical treatments and technology (trim).

Watson incorporated spiritual concepts such as soul, spirit, and transcendence in her explication of the nature of a person and the goal of nursing. It is possible that participant responses would have been different if the population had been taught how to learn about assessing the spiritual need. For those values that have been developed, their expression in nursing may be different from what the students have experienced in their life encounters.

At a time when the nursing profession is attempting to develop its own body of knowledge as an academic discipline it becomes imperative that the language used to define theoretical concepts be precise, unambiguous, readily communicated and justifiable (Kyle, 1995). This pilot study found the senior baccalaureate nursing students appear to lack clarity in their religious and spiritual role as future health care providers. The results are similar to a previous research study that found that although the subjects described the spiritual aspects of nursing education, the majority reported minimal to no curricular input. Only a minority reported maximal input that was characterized by consistent emphasis on spiritual care in both classroom and clinical setting (Dettmore, 1986). More studies are recommended to examine how the curriculum objectives for spiritual education are addressed in the nursing classroom and clinical setting, in coursework that addresses psych-mental health and communication issues, and the American Association of Colleges of Nursing recommended core competencies. Additional research also is indicated that examines religious and spiritual influences on the nursing student.

Spirituality is broader than religiosity and it is possible for an individual to be spiritual and not religious (Hatch, et al, 1998). By relating to Watson's Theory of Human

Caring, the nurse will recognize the most important aspects of all nursing activities are those actions that promote professional, compassionate, and human-to-human interactions (Frisch, 2001; Watson, 2000a). The inferential analysis of the data rendered answers to hypothesis number one, two, and three. No statistically significance differences were found between the pre-nursing students' and senior baccalaureate nursing students' spiritual involvement and beliefs, levels of spiritual involvement and belief, and their levels of perception about the spiritual role of the nurse meeting the patient's spiritual needs. The population has a sense of their own spirituality and they are more likely to feel comfortable addressing the spiritual needs of others. Findings in this research study are important for future development of the nursing curriculum and will further the theory building research.

Learning is a change in behavior, perceptions, insight, attitude, or a combination of these that can be repeated when the need is aroused. The change in behavior may or may not be directly observable; however, the effects of learning are always observable (Bevis, 1989, p. 78). Without preparation and self awareness, the nursing student may feel inadequately prepared to address spiritual needs or may be embarrassed to address subjects which are often considered to be highly personal. Lifetime theories on adult cognitive and personality development indicate there is the propensity in later life for a spiritual or transcendent perspective of reality (Reed, 1991). Further research studies are needed to determine whether the demographic characteristics influence the spiritual involvement and activity.

Implications

The results of this pilot study can provide nursing educators in entry level and advanced level nursing education curriculums a better understanding of their students' perception about spirituality in nursing care. The nurse educator can enhance delivery of critical nursing knowledge by integrating spirituality into the nursing curriculum. The Theory of Human Caring elevates the importance of the healing presence to its rightful state in care and could be the conceptual framework for a comprehensive university baccalaureate nursing program. Nursing education should strive to be holistic, teaching students to provide clients with support and nurture for their physiologic, emotional and spiritual needs. The Theory of Human Caring is an appropriate platform for this education.

It would also be useful to survey nurse educators to establish a baseline of faculty perceptions about spirituality. Faculty knowledge and understanding of the spiritual role of the nurse is essential to spirituality education. The knowledge base about the student and instructor can be used in future course revisions. The southern Texas baccalaureate nursing student may be the representative of our future nursing profession statewide and nationally. A greater understanding of this populations' spirituality can help make teaching spiritual education more effective and meaningful.

Future research is needed on the atypical nursing student population found in this study in order to explore in greater depth their perceptions of spirituality and the effectiveness of spirituality education in the baccalaureate nursing curriculum. Also important is research that allows evaluation of nursing students longitudinally throughout the course of the nursing curriculum. Additionally, to evaluate the outcome

measurement, it would be beneficial to see how the nursing student adapts to the health professional role. A longitudinal study would be useful to determine if the differences in attitudes toward providing spiritual care are only differences between groups, or come as a result of the nursing education curriculum's focus on the technical aspects (the trim) rather than caring (the core).

Summary

The quintessence of nursing is caring. Nursing care strives to be holistic, providing clients with support and nurture for their physiologic, emotional and spiritual needs. Professional nursing practice must rest on a solid educational basis covering a broad range of physical, psychosocial, spiritual and cultural competencies; however, teaching and enhancing caring practice is not always included in the nursing curriculum. It is the nurse educator's responsibility to assist nursing students in developing their spiritual self-awareness so they will be better able to determine approaches that will serve to promote client spiritual well-being. The degree to which the nursing student is self-aware influences nursing care, especially spiritual caregiving.

REFERENCES

Abels, S. (2000). Spirituality in social work practice. Denver: Love Publishing Company.

Ackley, N. (2000). Spirituality and the nurse. *Texas Nursing, 74*(1):6.

All Nursing Schools. (2002). Nursing as a second career. Retrieved January 24, 2003, from http://www.allnursingschools.com/faqs/nursing_2nd_career.php

American Association of Colleges of Nursing. (1999a). Essential clinical resources for nursing's academic mission. Retrieved October 1, 2002, from http://www.aacn.nche.edu

American Association of Colleges of Nursing. (1999b). Older adults: Recommended baccalaureate competencies and curricular guidelines for geriatric nursing care. Retrieved August 4, 2002, from http://www.aacn.nche.edu/Education/gercomp.htm

American Association of Colleges of Nursing. (2001). Effective strategies for increasing diversity in nursing programs. Retrieved April 2, 2002, from http://www.aacn.nche.edu/Publications/issues/dec01.htm

American Association of Colleges of Nursing. (2002a). *AACN white paper: Hallmarks of the professional nursing practice environment*. Retrieved June 30, 2002, from http://www.aacn.nche.edu

American Association of Colleges of Nursing. (2002b). *The baccalaureate degree in nursing as minimal preparation for professional practice*. Retrieved September 5, 2002, from http://www.aacn.nche.edu/Publications/positions/baccmin.htm

American Association of Colleges of Nursing. (2002c). Enrollments rise at U.S. nursing colleges and universities: Ending a six-year period of decline. Retrieved September 5, 2002, from http://www.aacn.nche.edu/Media/NewsReleases/enrl01.htm

American Association of Colleges of Nursing. (2002d). Older Adults: Recommended Baccalaureate Competencies and Curricular Guidelines for Geriatric Nursing Care. Retrieved September 5, 2002, from http://www.aacn.nche.edu/Education/gercomp.htm

American Association of Colleges of Nursing. (2002e). Your nursing career: A look at the facts. Retrieved October 6, 2002, from http://www.aacn.nche.edu/education/Career.htm

American Holistic Nurses' Association. (2000). Philosophy. Retrieved September 24, 2002, from http://www.ahna.org

American Hospital Association (1973). Patient bill of rights. Retrieved September 25, 2002, from hospitalguide.mhcc.metro-data.com/patient_bill_of_rights.htm

American Nurses Association. (1997). ANA response to Pew Commission Report. NursingWorld. Retrieved October 12, 2002, from http://www.nursingworld.org/readroom/pew.htm

American Nurses Association. (1998). Standards of clinical nursing (2nd Ed.) Washington, DC: American Nurses Association.

American Nurses Association. (1999). Nurse's social policy statement (7th Ed.). Washington, DC: American Nurses Association.

American Nurses Association. (2000a). Intervention classification. Retrieved October 6, 2002, from http://www.nursingworld.org/mods/mod30/cec211.htm

American Nurses Association. (2000b). Definition and criteria for classification. Retrieved October 6, 2002, from http://www.nursingworld.org/mods/mod30/cec25.htm

American Nurses Association. (2001). Code of ethics for nurses with interpretive statements. Retrieved October 6, 2002, from http://nursingworld.org/ethics/chcode.htm

Andersen, G. (1998). As America ages: Assessing the older patient. RN/MCPHU Home Study Program CE Center. Retrieved January 25, 2002 from http://www.rnweb.com

Astrow, A., Puchalaski, C., & Sulmasy, D. (2001). Religion, spirituality, and health care: Social, ethical, and practical considerations. The American Journal of Medicine, 110, 283-287.

Baldacchino, D., & Draper, P. (2001). Spiritual coping strategies: A review of the nursing research literature. Journal of Advanced Nursing, 34(6), 833-841.

Barnum, B. (1996). Spirituality in nursing: From traditional to new age. New York: Springer.

Bastable, S. (1997). Nurses as educators: Principles of teaching and learning. Boston: Jones and Bartlett.

Bath, P. (1992). Spiritual dimension of nursing and patient care: Challenges and dilemmas for nursing education. Lancaster Theological Seminary.

Bennett, P., Porter, B., & Sloan, R. (1989). Jean Watson: Philosophy and science of caring. In A. Marriner-Tomey's Nursing theorists and their works (2nd Ed., pp.164-171), Baltimore: Mosby.

Bevis, E. (1989). Curriculum building in nursing: A process. Boston: Jones and Bartlett.

Board of Nurse Examiners for the State of Texas for the State of Texas. (2001). Essential Competencies of Texas, 1-24.

Boughn, S. (2001). Why women and men choose nursing. Nursing and Health Care Perspective, 22(1), 14-19).

Boutell, K., & Bozett, F. (1990). Nurse's assessment of patients' spirituality: Continuing education implications. The Journal of Continuing Education in Nursing, 21(4), 172-176.

Boyle, J., & Andrews, M. (1989). Transcultural concepts in nursing care. Boston: Scott Foresman/Little Brown College Division.

Brush, B., & Daly, P. (2000). Assessing spirituality in primary care practice: Is there time? Clinical Excellence for Nurse Practitioner, 2(2), 67-71.

Buchanan, D. (1993). Meaning-in-life, depression and suicide in older adults: A comparative survey study. Rush University. University Microfilm International, Ann Arbor, MI. (UMI No. 9400098)

Burkhardt, M., & Nagai-Jacobson, M. (2002). Spirituality: Living our connectedness. Albany: Delmar.

Burkhart, L., & Solari-Twadell, A. (2001). Spirituality and religiousness: Differentiating the diagnosis through a review of the nursing literature. *Nursing Diagnosis, 12(*2), 45-54.

Burns, N., & Grove, S. (2001). The practice of nursing research: Conduct, critique, & Utilization (4th Ed.) New York: Saunders.

Bush, T. (1999). Journaling and the teaching of spirituality. Nursing Education Today, 19(1), 20-28.

Butcher, H. (1998). Essential readings in holistic nursing. Nursing and Health Care Perspectives, 19(5), 238-239.

Cairns, A. (1999). Spirituality and religiosity in palliative care. Home Healthcare Nurse, 17(7), 450.

Carson, V. (1989). Spiritual dimensions of nursing practice. Philadelphia: W.B. Saunders Company.

Carson, V., & Green, H. (1992). Spiritual well-being: A predictor of hardiness in patients with acquired immunodefiency syndrome. Journal of Professional Nursing, 8(4), 209-220.

Carson, V., Winkelstein, M., Soeken, K., & Brunins, M. (1986). The effect of didactic teaching on spiritual attitudes. Image – the Journal of Nursing Scholarship, 18 (4), 161-164.

Castellaw, L., Wicks, M., & Martin, J. (1999). Spirituality in white older women with arthritis. Graduate Research in Nursing. Retrieved January 20, 2002 from http://www.graduateresearch.com/wicks.htm

Catanzaro, A., & McMullen, K. (2001). Increasing nursing student's spiritual sensitivity. Nurse Educator, 26(5), 221-226.

Cavendish, R., Luise, B., Bauer, M., Gallo, M., Medefindt, J., & Russo, D. (2001). Recognizing opportunities for spiritual enhancement in young adults. Nursing Diagnosis, 12(3), 77-91.

Center of Human Caring. (2000). Watson's theory of caring. Retrieved June 15, 2000, from http://www.uchsc.edu/ctrsinst/chs/jwtheory.htm

Chambers, M. (1998). Some issues in the assessment of clinical practice: A review of the literature. Journal of Clinical Nursing, 7(3), 201-208.

Chang, S. (2001). The conceptual structure of physical touch in caring. Journal of Advanced Nursing, 33(6), 820-827.

Chin, P., Jacobs, M., & Huerther, S. (1987). Theory of nursing-a systematic approach (2nd Ed.) Washington DC: The C.V. Mosby Company.

Cimino, S. (1992). Nurses' spiritual well-being as related to attitudes toward and degree of comfort in providing spiritual care. Boston College. University Microfilm International, Ann Arbor, MI. (UMI No. 9217438)

Clingerman, E. (1996). Bereavement tasks for nursing students. Nurse Educator, 21(3), 19-22.

Cotter, V., & Strumpf, N. (2001). Advanced practice geriatrics nursing. New York: McGraw-Hill/Appleton & Lange

Cross, J. (1996). The spiritual dimension of nursing practice. Wright State University. UMI Dissertation Services, Ann Arbor, MI. (UMI No. 9611438)

Daaleman, T., Cobb, A., & Frey, B. (2001). Spirituality and the well-being: An exploratory study of patient perspective. Social Science & Medicine, 53(11), 1503-1511.

Dettmore, D. (1984). Spiritual care: Remembering your patient's forgotten needs. Nursing84, 46.

Dettmore, D. (1986). Nurses' conceptions of and practices in the spiritual dimension. Teachers College, Columbia University. UMI Dissertation Services, Ann Arbor, MI. (UMI No.8620348)

DeYoung, S. (1990). Teaching nursing. New York: Addison-Wesley Nursing.

Dobrin, A. (2001). The self and Confucianism. Chinese American Forum, 17(2), 33-36.

Domrose, C. (2001). The RN route. NurseWeek, 6(25), 15-17.

Dossey, B., & Dossey, L. (1998). Body-mind-spirit: Attending to holistic care. American Journal of Nursing, 98(8), 35.

Dossey, B., Keegan, L., & Guzetta, C. (2000). Holistic nursing: A handbook for practice (3rd Ed.) Gaithersburg, MD: Aspen Publications.

Dunajski, B. (1994). Spirituality: The nurse's lived experience. Adelphi University. UMI, Ann Arbor, MI. (UMI No. PUZ9424347)

Dychkowski, L. (2002). The Future of Nursing. Paper presented at the meeting of the American Association of Colleges of Nursing.

Dyson, J., Cobb, M., & Forman, D. (1997). The meaning of spirituality: a literature review. Journal of Advanced Nursing, 26(6), 1183-1188.

Ellerhorst-Ryan, J. (1985). Selecting an instrument to measure spiritual distress. Oncology Nursing Forum, 12(2), 93-99.

Ellison, C. (1983). Spiritual well-being: Conceptualization and measurement. Journal of Psychology and Theology, 11(4), 330-340.

Emblen, JD. (1992). Religion and spirituality defined according to current use in nursing literature. Journal of Professional Nursing, 8(1), 41-47.

Fawcett, J. (2000). Teaching practice, community service, and research: An idea for putting it together. MAINE NURSE, 2(1), 5-6.

Fawcett, J., Watson, J., Neuman, B., Walker, P., & Fitzpatrick, J. (2001). On nursing theories and evidence. Journal of Nursing Scholarship, 33(2), 115-119

Freudenheim, M., & Villarosa, L. (2001). Nursing shortage is raising worries on patient's care: Problems may get worse more nurses join unions--complaints of long shifts and rising workloads. Maine Nurse, 3(2), 17.

Friedemann M., Mouch J. & Racey T. (2002) Nursing the spirit: the framework of systemic organization. Journal of Advanced Nursing, 39 (4), 325-332.

Frisch, N. (2001). Standards for holistic nursing practice: A way to think about our care that includes complementary and alternative modalities. Online Journal pf Issues in Nursing, 6(2), 1-7. Retrieved on January 20, 2002 from http://www.nursingworld.org/ojin/topic15/tpc_4.htm

Fulton, R. (1992). Spiritual well-being of baccalaureate nursing student and their responses about spiritual well-being of persons. Widener University School of Nursing. University Microfilm International, Ann Arbor, MI. (UMI No. PUZ9312416)

Garbin, M. (1991). Assessing educational outcomes. New York: National League of Nursing Press.

Gaur, K., & Eckert, W. (1997). Evaluating EDI participant's reactions via different response scales: A technical review. Retrieved on January 20, 2003 from http://wbln0018.worldbank.org/WBIES%5Cwbievalu.nsf/All/852568A900796A0F852568A200750E8A/$File/scaleskg.pdf?OpenElement

Geiter, H. (2002). The spiritual side of nursing. RN, 65(5), 43-44.

Gillis, A., & Jackson, W. (2002). Research for nurses: Methods and interpretation. Philadelphia: F.A. Davis Company.

Glaze, J. (2001). Reflection as transforming process: Student advanced nurse practitioner's experiences of developing reflective skills as part of an MSc programme. Journal of Advanced Nursing, 34(5), 639-647.

Goddard, N. (1995). 'Spirituality as integrative energy': a philosophical analysis as requisite precursor to holistic nursing practice. Journal of Advanced Nursing, 22(4), 808-815.

Goddard, N. (2000). A response to Dawson's critical analysis of spirituality as "integrative energy". Journal of Advanced Nursing, 31(4), 968-979.

Goldberg, J. (1998). Connection: An exploration of spirituality in nursing care. Journal of Advanced Nursing, 27(4), 836-842.

Greasley, P., Chiu, L., & Gartland, M. (2001). The spiritual concept of spiritual care in mental health nursing. Journal of Advanced Nursing, 33(5), 629-637.

Greenstreet, W. (1999). Teaching spirituality in nursing: A literature review. Nurse Education Today, 19(8), 649-658.

Harrison, J., & Burnard, P. (1993). Spirituality and nursing practice. Sydney: Ashgate.

Harrison, J., & Burnard, P. (1998). Spirituality and nursing practice. Aldershot: Ashgate.

Hatch, R., Burg, M., Naberhaus, D., & Hellmich, L. (1998). The spiritual involvement and belief scale: Development and testing of a new instrument. The Journal of Family Practice, 46(6), 476-486.

Hatch, R., Burg, M., Naberhaus, D., & Hellmich, L. (2001). Progress on revision and validation of SIBS scale since 6/98 JFP article (update as of 8/2001). University of Florida, 1-9.

Health Guide. (2002). Patient bill of rights. Retrieved September 12, 2002, from http://hospitalguide.mhcc.metro-data.com/patient_bill_of_rights.htm

Heller, B., Oros, M., & Durney-Crowley, J. (2001). The future of nursing education: Ten trends to watch. Retrieved January 29, 2001, from http://www.nln.org/nlnjournal/infotrends.htm

Hitchens, E. (1988). Stages of faith and values development and their implications for dealing with spiritual care in the student nurse-patient relationship. Seattle University. University Microfilm International, Ann Arbor, MI. (UMI Order # PUZ8819162)

Holt-Ashley, M. (2000). Nurses Pray: Use of prayer and spirituality as a complementary therapy in the intensive care setting. AACN Clinical Issues: Advanced Practice in Acute Critical Care, 11(1), 60-67.

Hoover, J. (2002). The personal and professional impact of undertaking an educational module on human caring. Journal of Advanced Nursing, 37(1), 79-86.

Howden, J. (1993). Development and psychometric characteristics of the spirituality assessment scale. Texas Woman's University. University Microfilm International, Ann Arbor, MI. (UMI No. PUZ9312917)

Hutchings, D. (1991). Spirituality in the face of death. The Canadian Nurse, 87(5), 30-31.

Johnson, E. (1998). Integrating healthcare and spirituality: Considerations for ethical and cultural sensitivity. Maryland Nurse, 17(5), 5.

Joint Commission of Accreditation of Healthcare Organization. (2001). Spiritual assessment. Retrieved September 13, 2002, from http://www.jcaho.org/accredited+organizations

Kavanagh, K., Absalom, K., Beil, W., & Schliessmann, L. (1999). Connecting and becoming culturally competent: A Lakota example. Advances in Nursing Science, 21(3), 9-31.

Keegan, L. (1996). Complementary therapies: Nurses are embracing holistic healing. RN, 59(4), 59-60.

Keighley, T. (2001). At the heart of nursing. Nursing Standard, 15(5), 24-25.

Kelly, D. (1998). Caring and cancer nursing: framing the reality using selected social science theory. Journal of Advanced Nursing, 28(4), 728-736.

Kendrick, D., & Robinson, S. (2000). Spirituality: Its relevance and purpose for clinical nursing in a new millennium. Journal of Clinical Nursing 2000, 9, 701-705.

Koswoski, M., Grams, K., Taylor, G., & Wilson, C. (2001). They took the time. They started to care: Stories of African-American Nursing students in intercultural caring groups. Advances in Nursing Sciences, 23(3), 11-27.

Kyle, T. (1995). The concept of caring: A review of literature. Journal of Advanced Nursing, 21(3), 506-514.

Lauver, D. (2000). Commonalities in women's spirituality and women health. Advances in Nursing Science, 22(3), 76-88.

Leetun, M. (1996). Wellness spirituality in the older adult: Assessment and intervention protocol. Nurse Practitioner, 21(8), 60-70.

Leetun, M., & Saabye, J. (1996). Bismark parish nurses: Respond to health reform. Prairie Rose, 65(2), 9.

Letizia, M., & Jennrich, J. (1998). Development and testing the clinical post-conference learning environment survey. Journal of Professional Nursing, 14(4), 206-213.

LoBiondo-Wood, G., & Haber, J. (1994). Nursing research: Methods, critical appraisal, and utilization, (3rd Ed.). Boston: Mosby.

LoBiondo-Wood, G., & Haber, J. (2002). Nursing research: Methods, critical appraisal, and utilization, (5th Ed.). Boston: Mosby

Lofmark, A., Carlsson, M., & Wikblad, K. (2001). Facilitating and obstructing factors for development of learning in clinical practice: A student perspective. Journal of Advanced Nursing, 34(1), 43-50.

Lowe, J., & Struthers, R. (2001). A conceptual framework of nursing in Native American culture. Journal of Nursing Scholarship, 33(3), 279-283.

Macrae, J. (2001). Nursing as s spiritual practice: A contemporary application of Florence Nightingale's view. New York: Springer publishing Company.

Maddox, M. (2001). Teaching spirituality to nurse practitioner students: The importance of interconnection of mind, body, and spirit. Journal of American Academy of Nurse Practitoners, 13(3), 134-139.

Malinski, V., & Barrett, E. (1994). Martha E. Rogers: Her life and work. Philadelphia: F. A. Davis.

Mansfield, C., Mitchell, J., & King, D. (2002). The doctor as God's mechanic? Beliefs in Southerneastern United States. Social Science & Medicine, 54(3), 399-409.

Marshall, E., & Wall, B. (1999). Religion, gender, and autonomy: A comparison of two religious women groups in nursing and hospitals in the late nineteenth and early twentieth century. Advances in Nursing Science, 22(1), 1-22.

Martsolf, D., & Mickley, J. (1998). The concept of spirituality in nursing theory: Differing world-views and extent of focus. Journal of Advanced Nursing, 27(2), 294-303.

Maryland Nurse. (2001). Colleagues in caring project releases final nursing student survey results. Maryland Nurse, 2(3), 5.

Matthew, D. (2000). Can every nurse give spiritual care? Kansas Nurse, 75(10), 4-5.

McCance, T., McKenna, H., & Boore, J. (1999). Caring: Theoretical perspectives of relevance of nursing. Journal of Advanced Nursing, 30(6), 1388-1395.

McNamara, C. (2002). Analyzing, interpreting and reporting basic research results. Retrieved April 9, 2002, from http://www.mapnp.org/library/research/analyze.htm

McSherry, W. (1998). Nurse's perceptions of spirituality and spiritual care. Nursing Standard, 13, 36-40.

McSherry, W., & Draper, P. (1998). The debates emerging from the literature surrounding the concept of spirituality as applied to nursing. Journal of Advanced Nursing, 27(4), 683-692.

Miklancie, M. (2001). The spiritual lived experience of nurse educators within the context of their teaching practice. George Mason University, 175.

Moll, R., Cook, L, & Saul, J. (2001). Church programs as a first clinical experience. Nurse Educator, 26(3), 122-124.

Moxley, R. (2000). Leadership and spirit: Breathing new vitality and energy into individuals and organizations. San Francisco: Jossey-Bass.

Munro, B. (1997). Statistical methods for health care research (3rd Ed.) New York: Lippincott.

Narayanasamy, A. (1993). Nurse's awareness and educational preparation in meeting the patient's spiritual needs. Nurse Education Today, 13, 196-201.

Narayanasamy, A., & Owens, J. (2001). A critical incident study of nurses' responses to the spiritual needs of their patients. Journal of Advanced Nursing, 33(4), 446-455.

New York College of Health Professions. (2002). Academics. Retrieved October 8, 2002, from http://www.nycollege.edu

Newman, M. (1991). Prevailing paradigms in nursing. Nursing Outlook, 40(1), 10-32.

Nicoll, L. (1997). Perspectives on nursing theory (3rd Ed.) Philadelphia: Lippincott.

Nieswiadomy, R. (1998). Foundations of nursing research. Stamford: Appleton & Lange.

North American Nursing Diagnosis Association. (1996). Potential for enhanced spiritual well being (NANDA). Nursing diagnosis: Definitions and classification, 1997-1998. Philadelphia: North American Nursing Diagnosis Association.

North American Nursing Diagnosis Association -International (NANDA). (2002). History and historical highlights 1973 through1998. Retrieved October 17, 2002, from http://www.nanda.org/html/history1.html#1973

O'Brien, M. (2001). The nurse's calling: A Christian spirituality of caring for the sick. New York: Paulist Press.

O'Brien, M. (1999). Spirituality in nursing: Standing on holy ground. Boston: Jones and Bartlett.

O'Connor, A. B. (2001). Clinical instructions & evaluation: A teaching resource. New York: National League of Nursing.

O'Connor, C. (2001). Characteristics of spirituality, assessment, and prayer in holistic nursing. The Nursing Clinics of North America, 36(1), 33-47.

Oermann, M., & Standfest, K. (1997). Differences in stress and challenge in clinical practice among ADN and BSN students in varying clinical courses. Journal of Nursing Education, 36(5), 228-233.

Okundaye, JN., Smith, P., Lawrence-Webb, C. (2001). Incorporating spirituality and the strengths perspectives into social work practice with addicted individuals. Journal of Social Work Practice in the Addictions, 1(1), 65-82.

Oldnall, A. (1995). On the absence of spirituality in nursing theories and models. Journal of Advanced Nursing, 21(3), 417-418.

Oldnall, A. (1996). A critical analysis of nursing: Meeting the spiritual needs of patients. Journal of Advanced Nursing, 23(1), 138-144.

Pender, N. (1996). Health promotion in nursing practice (3rd Ed.) Scranton: Appleton & Lange.

Peterson, J. (2000). Heart and soul of spiritual care: Should nurses provide spiritual care. Kansas Nurse, 75(10), 8-9.

Piles, C. (1990). Providing spiritual care. Nurse Educator, 15(1), 36-41.

Polit, H., & Hungler, B. (1998). Nursing research: Principles and methods (6th Ed.) New York: Lippincott.

Porter, D., & Sloan, R. (1996). Jean Watson: Philosophy and science of caring. In The nursing experience: Trends, challenges, and transitions (3rd Ed., pp. 160-168) New York: McGraw-Hill.

Puchalski, C., & Romer, A. (2000). Taking a spiritual history allows the clinician 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, 10, 335-344.

Reed, P. (1991a). Preferences for spirituality related nursing interventions among terminally ill and nonterminally ill hospitalized adults and well adults. Applied Nursing Research, 4(3), 122-128.

Reed, P. (1991b). Spirituality and mental health in adults: Extant knowledge for nursing. Community Health Nursing, 14(2), 14- 25).

Reilly, D., & Oermann, M. (1992). Clinical teaching in nursing education, (2nd Ed.) New York: National League of Nursing

Rassool, G. (2000). The crescent and Islam: Healing, nursing and spiritual dimension. Some considerations toward an understanding of the Islamic perspective on caring. Journal of Advanced Nursing, 32(6), 1476-1484.

Rolph, G. (2001). Clinical spiritual care with advanced illness patients--nurses and chaplains working together. Nursing News (New Hampshire), 25(3), 19.

Satterly, L. (2001). Guilt, shame, and religious and spiritual pain. Holistic Nursing Practice, 15(2), 30-39.

Scandurra, A. (1999). Everyday spirituality: A core unit in health education and lifetime wellness. Journal of Health Education, 30(2), 104-109.

Sherman, D. (1994). An investigation of the relationship among spirituality, perceived social support, death, anxiety, and nurses' willingness to care for AIDS patients. New York University. University Microfilm International, Ann Arbor, MI. (UMI No. 9423008)

Sherman, D. (1996). Nurses' willingness to care for AIDS patients and spirituality, social support, and death anxiety. Image-the Journal of Nursing Scholarship, 28(3), 205-213.

Shih, F., Gau, M., Mao, H., Chen, C., & Kao Lo, C. (2001). Empirical validation of a teaching course on spiritual care in Taiwan. Journal of Advanced Nursing, 36(3), 333-346.

Simsen, B. (1985). Spiritual needs and resources in illness and hospitalization. The University of Manchester: Azusa Pacific University, Azusa, CA.

Sitzman, K. (2002). Interbeing and mindfulness: A bridge to understanding Jean Watson's Theory of Human Caring. Nursing Education Perspective, 23(3), 118-123.

Smith, R., & Haverkamp, K. (1977). Toward a theory of learning how to learn for participants. Adult Education, 28 (1), 3-21.

Soeken, K., & Carson, V. (1986). Health Progress, 52-55.

Soeken, K., & Carson, V. (2002). Health Professional's Spiritual Role Scale (pp. 1-3). Baltimore: University of Maryland.

Sorensen, M., & Wall, B. (1999). Religion, gender, and autonomy: A comparison of two religious women groups in nursing and hospitals in the late nineteenth and early twentieth centuries. Advances in Nursing Science, 22(1), 1-22.

Sourial, S. (1996). An analysis and evaluation of Watson's theory of human care. Journal of Advanced Nursing, 24(2), 400-404.

Stoll, R. (1989). The essence of spirituality. In Carson, V. (1989). Spiritual dimensions of nursing practice. Philadelphia: W.B. Saunders Company.

Stranahan, S. (2001). Spiritual perceptions, attitudes about spiritual care, and spiritual care practices among nurse practitioners. Western Journal of Nursing Research, 23(1), 90-105.

Strang, S., Strang, P., & Ternestedt, B. (2002). Spiritual needs as defined by Swedish nursing staff. Journal of Clinical Nursing, 11(1), 48-57.

Struebert, H., & Carpenter, D. (1999). Qualitative research in nursing: Advancing the humanistic imperative (2nd Ed.) New York: Lippincott.

Sumner, C. (1998). Recognizing and responding to spiritual distress. American Journal of Nursing, 98(1), 26-32.

Swinney, J., Anson-Wonkka, C., Maki, E., & Corneau, J. (2001). Community assessment: A church community and the parish nurse. Public Health Nursing, 18(1), 40-44.

Tanyi, R. (2002). Towards clarification of the meaning of spirituality. Journal of Advanced Nursing, 39(5), 500-509.

Taylor, E. (1994). Desperately seeking spirituality. Psychology Today, 27(6), 54-65.

Taylor, E. (2002). Spiritual care: Nursing theory, research, and practice. Upper Saddle River, NJ: Prentice Hall.

Taylor, F. (2001). Spirituality, culture, and cancer care. Seminars in Oncology Nursing, 17(3), 197-205.

Taylor, H., Westcott, E., & Bartlett, H. (2001). Measuring the socialization of graduate and diplomate nurses using the Corwin role orientation scale. Journal of Advanced Nursing, 33(1), 20-28.

Theris, A., & Touhy, N. (2001). Nurturing hope and spirituality in the nursing home. Holistic Nursing Practice, 15(4), 45.

Thorpe, K., & Barsky, J. (2001). Healing with self-reflection. Journal of Advanced Nursing, 35(5), 760-768.

Tongprateep, T. (2000). The essential elements of spirituality among rural Thai elders. Journal of Advanced Nursing, 31(1), 197-203.

Tracey, J., Patton, D., Barnhart, P., Bennett, B., Porter, B., & Sloan, R. (1998). Jean Watson: Philosophy and science of caring. In A.M. Tomey & M.R. Alligood (Fourth Ed.), Nursing theorists and their work (pp. 142-156). Boston: Mosby.

Trussell, P., Brandt, A., & Knapp, S. (1981). Using nursing research: Discovery, analysis, and interpretation. Wakefield, MA: Nursing Resources.

Tuck, I., McCain, N., & Elswick, R. (2001). Spirituality and psychosocial factors in persons living with HIV. Journal of Advanced Nursing, 33(6), 776-783.

Tuck, I., Pullen, L., & Wallace, D. (2001). A comparative study of the spiritual perspectives and interventions of mental health and parish nursing. Issues in Mental Health Nursing, 22(6), 593-605.

U.S. News & World Report. (2003). American best colleges 2003. Retrieved March 6, 2003, from http://www.usnews.com/usnews/edu/college/rankings

Vance, D. (2001). Nurses' attitudes towards spirituality and patient care. MEDSURG Nursing, 10(5), 264-277.

Walker, C. (1996). Coalescing the theories of two nurse visionaries: Parson and Watson. Journal of Advanced Nursing, 24(5), 988-996.

Wall, B. (2002). The pin-striped habit: Balancing charity and business in Catholic hospitals, 1865-1915. Nursing Research, 51(1), 50-58.

Waring, L. (1983). American nursing and the concept of the calling: Selected period 1884-1945, an historical consideration. Teachers College, Columbia University. University Microfilm International, Ann Arbor, MI. (UMI No.2231657)

Watson, J. (1979). Nursing: The philosophy of science and caring. Boston: Little, Brown and Company.

Watson, J. (1985). Nursing: The philosophy of science of caring. Boulder: Colorado Associated University Press.

Watson, J. (1988). Nursing: Human science and human care, a theory of nursing. New York: National League of Nursing.

Watson, J. (1996). President's message: From discipline specific to "Inter" to "Multi" to "Transdisciplinary" health care education and practice. N & HC: Perspectives on Community, 17(2), 90-91.

Watson, J. (1999). Postmodern nursing and beyond. New York: Churchill Livingston.

Watson, J. (2000). Theory description. Retrieved June 23, 2000, from http://www.uchsc.edu/ctrsinst/chc/jwtheory.htm

Watson, J. (2001). Jean Watson: Theory of human caring. In Nursing theories and nursing practice, (pp. 343-351). Philadelphia: F.A. Davis Company.

Watson, J. (2002a). Intentionality and caring-healing consciousness: a practice of transpersonal nursing. Holistic Nursing Practice, 16(4):12-9.

Watson, J. (2002b). Jean Watson's theory. Retrieved August 6, 2002, from http://www2.uchsc.edu/son/caring/content/wct.asp

Weaver, A., Flannelly, L., & Flannelly, K. (2001). A review of research on religious and spiritual variables in two primary gerontological nursing journals 1991 to 1997. Journal of Gerontological Nursing, 27(9), 47-54.

Weinbach, R., & Grinnell, R. (1997). Statistics for social workers (4th Ed.) New York: Longman.

Weis, D., & Schank, M. (2000). An instrument to measure professional nursing values. Journal of Nursing Scholarship, 32(2), 201-204.

Welch, J., Jeffries, P., Lyon, B., Boland, D., & Backer, J. (2001). Experiential learning: Integrating theory and research into practice. Nurse Educator, 26(5), 240-243.

WholeHealthMD. (2002). Holistic nursing. Retrieved September 30, 2002, from http://www.wholehealthmd.com

Wilkinson, J. (1996). The C word: A curriculum for the future. N &HC: Perspective on Community, 17(2), 72-77.

World Health Organization. (2000). Fact sheet 8 HIV palliative and terminal care. Retrieved September 7, 2002, from http://www3.who.int/whosis/factsheets_hiv_nurses/ fact-sheet-8/ - 34k

Wright, S. (2001). Looking at the star. Nursing Standards, 15(52), 26-27.

APPENDIX A

Demographics

AGE	GENDER	MARITAL STATUS
*Please indicate your age*_____	Please place a (√) in the area that applies to you. _____Female	Please place a (√) in the area that applies to you. _____Single (never married) _____Married _____Separated _____Divorced _____Widowed
EDUATIONAL LEVEL	**RACE/ETHNIC GROUP**	**RELIGIOUS REFERENCE**
Please place a (√) in all areas of education you have completed. ____Nursing Assistant ____Licensed Practical/ Vocational Nurse ____Diploma Nurse ____Associate Degree in Nursing ____Associate Degree in other field ____Baccalaureate in other field ____Masters in other field Other (Specify) _____ _____	Please place a (√) in the area that applies to you. _____American Indian/ Native American _____ Asian or Pacific Islander _____Black (Not of Hispanic Origin) _____Black (Of Hispanic Origin) _____White (Not of Hispanic Origin) _____White (Of Hispanic Origin) Other (Specify) _____ _____	Please place a (√) in the area that applies to you. _____Buddhist _____Catholic _____Hindu _____Jewish _____Muslim _____Protestant _____None Other (Specify) _____ _____

APPENDIX B

HEALTH PROFESSIONAL'S SPIRITUAL ROLE SCALE

For each of the following, indicate how much you agree or disagree with the statement. There is no right or wrong answers. We are merely interested in your opinion as reflected by the statement. Please circle your response.

	Strongly Agree	Moderately Agree	Agree	Disagree	Moderately Disagree	Strongly Disagree
1. Health professionals give spiritual care to their patients by being concerned and kind.	6	5	4	3	2	1
2. A health professional should ask every patient if she/he wants to see a clergyman.	6	5	4	3	2	1
3. Most health professionals are not qualified to help patients with their spiritual needs.	6	5	4	3	2	1
4. A patient's religious beliefs are too personal to discuss with a health professional.	6	5	4	3	2	1
5. Health professionals are too busy to help patients with their spiritual needs.	6	5	4	3	2	1
6. Health professionals who talk with patients about religious beliefs are trying to convert them.	6	5	4	3	2	1

7. A health professional who listens to patient concerns and fears is providing spiritual care.	6	5	4	3	2	1
8. A health professional should have no preconceived ideas about a patient's relationship with God.	6	5	4	3	2	1
9. Using scripture with a patient is appropriate for a health professional.	6	5	4	3	2	1
10. A health professional can assess a patient's spiritual needs by being observant.	6	5	4	3	2	1
11. Offering spiritual assistance to a patient is the clergyman's role and not the health professional's role.	6	5	4	3	2	1
12. Being able to assess a patient's spiritual needs requires special training.	6	5	4	3	2	1
13. Asking a patient his/her religious preference is sufficient for assessing the spiritual needs of the patient.	6	5	4	3	2	1

14. Most health professionals are uncomfortable discussing spiritual matters with their patients.	6	5	4	3	2	1
15. To be able to meet the spiritual needs of patients, a health professional needs to have a strong relationship with God.	6	5	4	3	2	1
16. Most health professionals are aware of the need to assess the spirituality of a patient.	6	5	4	3	2	1

APPENDIX C

Spiritual Involvement and Beliefs Scale – Revised (SIBS-R)
(Hatch, et al, University of Florida)

How strongly do you agree with the following statements? Please circle your response.

	Strongly Agree		Mildly Agree		Mildly Disagree		Strongly Disagree
I set aside time for meditation and/or self-reflection	7	6	5	4	3	2	1
I can find meaning in times of hardship.	7	6	5	4	3	2	1
A person can be fulfilled without pursuing an active spiritual life.	7	6	5	4	3	2	1
I find serenity by accepting things as they are.	7	6	5	4	3	2	1
I have a relationship with someone I can turn to for spiritual guidance.	7	6	5	4	3	2	1
Prayers do not really change what happens.	7	6	5	4	3	2	1
In times of despair, I can find little reason to hope.	7	6	5	4	3	2	1
I have a personal relationship with a power greater than myself.	7	6	5	4	3	2	1
I have had a spiritual experience that greatly changed my life.	7	6	5	4	3	2	1
When I help others, I expect nothing in return.	7	6	5	4	3	2	1
I don't take time to appreciate nature.	7	6	5	4	3	2	1

I have joy in my life because of my spirituality.	7	6	5	4	3	2	1
My relationship with a higher power helps me love others more completely.	7	6	5	4	3	2	1
Spiritual writings enrich my life.	7	6	5	4	3	2	1
I have experienced healing after prayer.	7	6	5	4	3	2	1
My spiritual understanding continues to grow.	7	6	5	4	3	2	1
I focus on what needs to be changed in me, not on what needs to be changed in others.	7	6	5	4	3	2	1
In difficult times, I am still grateful.	7	6	5	4	3	2	1
I have been through a time of suffering that led to spiritual growth.	7	6	5	4	3	2	1
I solve my problems without using spiritual resources.	7	6	5	4	3	2	1
I examine my actions to see if they reflect my values.	7	6	5	4	3	2	1

22. How spiritual a person do you consider yourself? (With "7" being the most spiritual)

7 6 5 4 3 2

APPENDIX D

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Date

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Baltimore, MD 21201

Dear Dr. Soeken,

My name is Jacquelyn K. Williams and I am pursuing a Masters of Science Degree in Nursing from the University of Texas-Pan American, Edinburg, Texas. I am writing this letter to request permission to adapt the Health Professional's Spiritual Role Scale for a thesis and permission to publish the results of the research using the scale.

My research proposal and study will investigate the first and second year baccalaureate nursing students' perceptions of spirituality. I want to see if the nursing curriculum objectives have had an impact on these nursing students' perceptions. I feel that the Health Professional's Spiritual Role Scale will be helpful in my endeavor.

I would appreciate your written permission to use this research instrument. Thank you for your assistance. If you have any question, please let me know. I can be contacted at 956-618-4920.

Sincerely,

Jacquelyn Williams, MS, RN, BC
Graduate Student,

Jkw

JACQUELYN K.WILLIAMS

1608 La Vista Avenue
McAllen, TX 78501
956-618-4920
956-630-4729
clarwilliams@att.net

Date

Robert L. Hatch, MD, MPH
Department of Community Health and Family Medicine
P.O. Box 147001
Gainesville, FL 32614

Dear Dr. Hatch,

My name is Jacquelyn K. Williams and I am pursuing a Masters of Science Degree in Nursing from the University of Texas-Pan American, Edinburg, Texas. I am writing this letter to request permission to obtain an updated version and pertinent reliability and validity data pertaining to the Spiritual Involvement and Belief Scale. I am also requesting the use of your scale in a research study that I will be conducting.

Your assistance will be greatly appreciated. Thank you for your assistance. If you have any question, please let me know. I can be contacted at 956-618-4920.

Sincerely,

Jacquelyn Williams, MS, RN, BC
Graduate Student,

Jkw

APPENDIX E

INSTITUTIONAL REVIEW BOARD FOR HUMAN SUBJECTS IN RESEARCH
THE UNIVERSITY OF TEXAS - PAN AMERICAN
1201 West University Drive • Edinburg, Texas 78539-2999 • (956) 381-2287 Office • Fax (956) 318-5301

MEMORANDUM

To: Ms. Jacquelyn K. Williams, Graduate Student, Nursing Dept., Dr. Barbara Tucker, Graduate Advisor, UTPA

From: Dr. Bahram (Bob) Faraji, Chair, Institutional Review Board for Human Subjects in Research BF

Subject: An Investigation of the Pre-Nursing and Second Year Baccalaureate Nursing Students' Perception of Spirituality.

Date: August 26, 2002

The above referenced protocol has been:

____ Approved (committee review)
_X_ Approved (expedited review, IRB# 198)
____ Conditionally approved (see remarks below)
____ Tabled for future consideration-Re-submit with corrections
____ Disapproved (see remarks below)

by the Institutional Review Board Federal Wide Assurance Number (FWA 00000805).

As stipulated in the guidelines of the IRB, this protocol will be subject to annual review by the IRB and any deviations from the protocol or change in the title must be resubmitted to the Board.

For additional information you can contact the IRB University website at http://www.panam.edu/dept/sponpro/Policies/Policies.html

AT THE CONCLUSION OF THE STUDY, YOU MUST FILL OUT THE ENCLOSED REPORT FORM

cc: Dr. Wendy Fowler, VPR

SCHOOL OF NURSING

DEPARTMENT OF EDUCATION,
ADMINISTRATION, HEALTH POLICY
AND INFORMATICS

UNIVERSITY OF MARYLAND

25 August 2002

Jacquelyn Williams, MS, RN, BC
1608 La Vista Avenue
McAllen, TX 78501

Dear Ms. Williams,

Enclosed is a copy of the Health Professional's Spiritual Role Scale that we previously used in our research. The scale consists of two parts. The first part that assesses attitudes toward providing spiritual care is scored using a 1-6 scale with a higher score reflecting a more positive attitude. You'll notice that the scale includes some items that need to be reverse scored. Coefficient alpha is appropriate for assessing the reliability of this scale. I should also note that item 18 is poorly worded and has consistently been problematic on the scale, that is, it doesn't load in factor analysis and it does not contribute to the overall coefficient alpha. The second part of the instrument examines how appropriate the nurse believes that various behaviors are. The items can be summed for a total score or they can be used individually and rank ordered to identify those spiritual care behaviors the nurse perceives as most and least appropriate.

You have my permission to use the scale in your thesis research if you believe it will meet the needs of your research. I am in the process of constructing a new scale, but the manuscript describing the scale and its psychometric properties is not yet ready for journal submission.

Please let me know the overall results of your research.

Sincerely,

Karen Soeken

Karen Soeken, Ph.D.
Associate Professor

655 West Lombard Street • Baltimore, Maryland 21201-1579 • 410 706 7785 • 410 706 3289 *fax*

From: "Robert Hatch" <Hatch@dean.med.ufl.edu> [Save address]
To: clarwilliams@att.net
Subject: SIBS scale
Date: Sat, 17 Aug 2002 15:30:10 -0400

Hi. Jacqueline. Thanks for your inquiry regarding the SIBS. You are of course very welcome to use our scale in your research. We have made substantial revisions since the scale was first published in JFP. However, none of the data regarding revisions has been published yet. I have attached a Word document that includes both a long and a shortened version of the updated scale and unpublished data on them. Both versions have been used by others. Many people prefer the wording of the new version and use it. Others prefer a scale with published reliability and validity data and choose the original published version. The original version was used in two published studies from Britain (1 of Genetic Psychology, March 2001 and Personality and Individual Differences, 30, (2001) 187- 192. Some graduate students have been able to persuade their committees to accept the revised version since it's items are backed by a combination of published and unpublished data. You are welcome to use which ever version best suits your situation and needs. There is no charge for using the scale, and you are free to alter the layout, use just certain items, etc. to fit your needs. If you choose to use the scale, I would greatlyappreciate a summary of your findings at the end of the project.

Good luck with your research! Rob

APPENDIX F

INFORMED CONSENT FORM

1. You are invited to participate in my research study, which is designed to explore the nursing student's perception of spirituality. The research study is conducted by Jacquelyn Williams, MS, RN, a graduate student at University of Texas-Pan American. This study is conducted to fulfill the requirements for the Masters of Nursing degree at the University of Texas Pan-American, Edinburg, Texas.

2. A blank envelope will be distributed along with the surveys. Please complete the three part surveys and place them in the blank size envelope and seal it. Do not put your name on the survey or the envelope. The time required will be approximately 20-30 minutes.

3. Your participation will require the completion of a demographic questionnaire and two survey questionnaires. Some of the questions about personal belief require your thoughtful, honest responses. The questionnaire is similar to those thought-provoking tests or forms you routinely encounter in your role as a student. You are asked to complete the survey to the best of your ability.

4. Your grades will not be jeopardized in any way if you accept or decline to participate in the study. Your identity and answers will remain confidential. All data will be reported in an aggregate form and you will not be identified by name at any time. Participation in this survey is voluntary and you may withdraw at any time without penalty.

5. This research has been reviewed and approved by the University of Texas-Pan American Institutional Review Board-Human Subject In Research Committee as well as the Nursing Department Research Committee. For research related problems or questions

regarding subject's rights, the Human Subject Committee may be contacted through Dr. Bob Faraji, Chair, at 381-2287.

6. I have read and understand the explanations provided to me and voluntarily agree to participate in this study.

Signature of Subject _____

Date_____/_____/_____

Signature of Witness_____

Date_____/_____/_____

APPENDIX G

VITA

Jacquelyn K. Richardson Williams, MS, RN, BC

Higher Education Institutions:	Degree	Date
Oklahoma Baptist University Shawnee, OK	Bachelor of Science in Nursing	May 1975
University of Southern California Los Angeles, CA	Masters of Science in Education	December 1983
University of Texas – Pan American Edinburg, TX	Masters of Science in Nursing	May 2003

Professional Experience:	Dates
United States Air Force Nurse Corps	February 1977–March 1997
Levi Strauss & Company	April 1997–April 2000
University of Texas-Pan American	January 2002–current

Certification:

Nursing Professional Development

Professional Organization Membership:

American Nurses Association

Sigma Theta Tau International Nursing Honor Society

Society of Retired Air Force Nurses, Inc.